STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on interviews, observations and record review, the facility failed to ensure resident choices for two (#87 and #57) of three residents reviewed for activities of daily living out of 49 sample residents. Specifically, the facility failed to: -Ensure Resident #87 and #57 received showers consistently according to their choice of frequency; and, -Ensure Resident #87 and #57's preferences were included in their plan of care. Findings include: I. Facility policy and procedure The Bath, Shower policy, revised August 2021, was provided by the nursing home administrator (NHA) on 4/10/24 at 4:41 p.m. It read in pertinent part, It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation. Residents have the choice between bed bath, shower or bath. When residents admit please review the preference sheet with the Resident. Resident may choose the days of the week they choose to bath or shower. We offer the following options to residents: shower, tub bath or bed bath. Residents may change their preferences at any time during the stay. The Activities of Daily Living policy, revised October 2022, was provided by the NHA on 4/10/24 at 4:41 p.m. It read in pertinent part, ADL's (activities of daily living) will be care planned to reflect the resident specific needs. II. Resident #87 (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #87, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included morbid obesity, bipolar disorder, post-traumatic stress disorder (PTSD) and need for assistance with personal care and pain. The 1/14/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a staff interview for cognition. She required supervision for eating and oral hygiene. She required substantial assistance for toileting and personal hygiene. She was dependent for showering. B. Resident interview Resident #87 was interviewed on 4/3/24 at 9:53 a.m. She said she preferred to shower at 7:00 p.m. on Thursdays. She said the facility did not accommodate her shower preferences. Resident #87 said some weeks she missed her shower because the staff did not have time to give her a shower on her preferred day and time. The resident said she preferred to have female caregivers because she had a history of being sexually abused. C. Record review The staff task sheet indicated the resident wanted showers on Thursday nights. The shower documentation from 3/1/24 through 4/7/24 for Resident #87 revealed the resident did not receive a shower on her preferred shower days on 3/7/24, 3/14/24 and 3/21/24. The documentation revealed the resident refused a shower on 3/22/24 at 5:52 p.m. The resident preferred to shower at 7:00 p.m. The ADL care plan, initiated on 3/15/24, revealed the resident had an ADL self care performance deficit related to acute respiratory failure, obesity, bipolar, myopathy (disease affecting the muscles), PTSD, hypertension, contracture to bilateral ankles, gastrostomy status and obstructive sleep apnea. The interventions included in pertinent part: providing one to two staff members for bathing. -The comprehensive care plan did not include the resident's preferred shower days and times or her preference of female caregivers. III. Resident #57 A. Resident status Resident #57, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 CPO, diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), need for assistance with personal care, anxiety, shortness of breath, alcohol abuse in remission and chronic pain. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/15/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS with a score of 12 out of 15. He required partial assistance with eating and oral hygiene. He required substantial assistance for toileting, showering and personal hygiene. B. Resident interview Resident #57 was interviewed on 4/3/24 at 2:08 p.m. He said he was not getting his showers when he preferred them. Resident #57 said he had multiple lung issues that caused him to be short of breath. He said when he showered he needed increased oxygen needs. He said the facility told him that they were unable to provide the increase of oxygen needs to him so he had to take bed baths. Resident #57 said he was afraid to take a shower because the facility was not able to provide the increased oxygen. He said the staff provided him with bed baths instead. He said he preferred to shower as bed baths did not make him feel clean. Resident #57 said he was unsure why the facility was unable to provide him the increased oxygen needs because the previous facility he was at could. He said he would prefer to take a shower more than twice a week. He said his normal routine prior to living in a facility was to wake up, take a shower and enjoy a cup of coffee. C. Record review The staff task sheet indicated the resident wanted to shower on Sunday and Wednesday nights. The shower documentation from 3/1/24 through 4/7/24 for Resident #57 revealed the resident did not receive a shower on his preferred shower days on 3/6/24, 3/10/24, 3/13/24, 3/20/24, 3/27/24, 3/31/24 and 4/3/24. The ADL care plan, initiated on 3/14/24, revealed the resident had an ADL self care performance deficit related to acute on chronic respiratory failure, COPD, chronic pain, neuropathy (nerve pain) and limited mobility. The interventions included in pertinent part: encouraging the resident to participate to the fullest extent possible with each interaction. -The comprehensive care plan did not include the resident's shower preferences. IV. Staff interviews Certified nurse aide (CNA) #9 was interviewed on 4/8/24 at 4:02 p.m. She said there was a binder at the nurses station that had a calendar with each resident's preferred shower days. CNA #9 said Resident #87 preferred to shower Thursday evenings. She said Resident #57 preferred showers on Sunday and Wednesday nights. She said Resident #57 received bed baths because he often got short of breath which caused him anxiety. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assistant director of nursing (ADON) was interviewed on 4/9/24 at 1:35 p.m. The ADON said when a resident admitted to the facility a preference sheet was completed to determine the resident's shower preferences. The ADON said Resident #87 preferred to shower on Thursdays at 7:00 p.m. He said the staff was often busy at that time with meals or assisting other residents. The ADON said sometimes the resident's shower was not always at 7:00 p.m. per her preference. The ADON said they could not always meet her preferences due to staff availability. The ADON said he was not aware of Resident #57's oxygen needs and desire to take a shower over a bed bath. The social services director (SSD) and the corporate social worker (CSW) were interviewed on 4/9/24 at 4:22 p.m. The SSD said the facility had been working with Resident #87 to establish her shower preferences. The SSD said the resident preferred to shower at 2:00 p.m. The SSD said Resident #87 had a very strict schedule that was difficult to work with sometimes. The SSD said he told Resident #87 she needed to have patience with the staff when they were running late on her shower. The SSD said Resident #87 was not thrilled with getting her shower at 2:00 p.m. but she understood that there was more staff available at that time to help her with her shower. The SSD and the CSW said they were not aware Resident #57 had increased oxygen needs when showering. The CSW said they would review the resident's shower preferences to see if they would be able to provide the resident a shower over a bed bath.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews and record review, the facility failed to provide a clean, comfortable, homelike environment for residents for one (#93) resident out of 49 sample residents. Specifically, the facility failed to ensure Resident #93's living space was comfortable to him by having access to fresh outside air. Findings include: I. Facility policy and procedure The Safe, Homelike Environment policy, dated October 2007, was provided by the NHA on 4/10/24 at 4:41 p. m. It read in pertinent part, Comfortable and safe temperature levels means the ambient temperature should be in a relatively narrow range that minimizes residents' susceptibility to loss of body heat and risk of hypothermia/hyperthermia and is comfortable for the residents. A homelike environment is the one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of homelike should include the resident's opinion of the living environment. If and when a resident prefers his or her room temperature be kept below 71 degrees fahrenheit, or above 81 degrees fahrenheit, the facility will assess the safety of this practice on the resident and the resident's roommate. II. Resident #93 A. Resident status Resident #93, under the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician order (CPO), diagnoses included quadriplegia (little to no movement in all limbs), need for assistance with personal care, other specified disorders of teeth and supporting structures and adult failure to thrive. The 2/12/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score of 15 out of 15. He was independent while eating. He was dependent on oral hygiene, toileting, showering and personal hygiene. B. Resident interview and observations (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #93 was interviewed on 4/4/24 at 9:09 a.m. Resident #93 was lying in bed in his room. The resident's room did not have a window. There was a door to enter the resident's room from the hallway and a double door at the back of the room that entered into an atrium (small room enclosed with glass windows). The atrium was an unused space that was locked and inaccessible to the resident. The space has some unused chairs stored inside that could be seen by the resident. The double doors were closed and locked, there was a sign on the door that read not an exit on them. Resident #93 said his room was very hot and he was unable to open the double doors to get fresh air into his room. Resident #93 said the maintenance director (MTD) told the resident he was unable to open the double doors because it was not safe for the resident to be out there. Resident #93 said he wished he was able to open the double doors to the atrium to get fresh air and sunlight into his room. Resident #93 had sweat on his face. He said being hot made him feel sweaty and unclean. The resident's room was hot. He had one fan in the room. He said he got tired of the fan because it was really loud. III. Staff interviews The MTD was interviewed on 4/9/24 at 2:45 p.m. The MTD said the double doors in Resident #93's room opened to an atrium that was not in use and he did not have a key to open the door. The MTD said he could give the resident a fan to cool him down as a solution but said it would be a safety hazard to allow people into the atrium because it could open up the space as a way for unwanted persons to enter the building. The MTD said the resident did not have a window in his room to get fresh air and it was impossible to install a window to the room due to the original structure of the old building. The MTD said he would find a way for the resident to safely open the double doors to the atrium so he would be able to get air circulation in his room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	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** 47960 Based on interviews and record review, the facility failed to ensure four (#79, #60, #31, #13) of four residents reviewed for abuse out of 48 sample residents were kept from mental and verbal abuse, contributing to residents experiencing, among other emotions, anxiety, fear, and humiliation. I. Staff to resident mental and verbal abuse A. In interviews with Resident #79, she stated the activities director (AD) was mean to her, spoke to her rudely, raised her voice at her, and made her feel belittled and like a scolded child on 4/3/24. Resident #79 was upset and was tearful as she recalled the incident. Although three staff who witnessed the incident promptly reported it to the nursing home administrator (NHA), the facility failed for several hours to initiate an investigation or implement corrective actions to protect Resident #79 from further abuse. B. In interviews with Resident #60, he said he was in severe pain from being reclined in his wheelchair for a long time. When he asked certified nurse aide (CNA) #2 to get him out of the wheelchair and into bed, the CNA raised his voice and, in a scolding tone, told him other residents had more important needs and that he would just have to wait. Resident #60 said the CNA made him feel that he was not as important as the other residents. II. Resident to Resident Mental and Verbal Abuse In separate interviews with Resident #13 and Resident #60, the residents said that Resident #31 verbally abused them by using racial slurs and offensive language and making derogatory comments about them. Both residents said they avoided common areas of the facility out of fear and worry that they would be subject to Resident #31's verbal attacks when they were in the same space as Resident #31. Resident #13 said he had to stay in his room more than usual to keep from crossing paths with Resident #31. Resident #13 said this treatment caused him distress and triggered feelings of worry. Resident #60 said he tried to avoid passing by Resident #60 as much as possible because the verbal attacks about his person made him feel bad. Record review and interview revealed the facility failed to take corrective action to prevent further verbal abuse of Resident #13 and #60 by Resident #31. Cross-reference F610; failure to initialize a timely investigation of reports of allegations of abuse. Findings include: I. Facility policy and procedure (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

A. The Abuse policy, revised in October 2022, was provided by the nursing home administrator (NHA) on 4/3/24 at 3:13 p.m. It read in pertinent part:

It is the policy of this Facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.

The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be from abuse, neglect, misappropriation of resident property, and exploitation.

This policy applies to all Facility staff including, but not limited to, employees, consultants, contractors, volunteers, students, and other caregivers who provide care and services to residents on behalf of the Facility.

Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Verbal Abuse includes the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their representatives, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

B. NHA and the social services director (SSD) were interviewed on 4/9/24 at 6:18 p.m. about the facility's response to allegations of abuse.

The NHA said reports of potential abuse should be fully investigated. The NHA said when abuse was alleged, the process was to suspend the staff in question, protect the residents from further harm, make notifications to the power of attorney, and start a report to the State Agency.

The NHA said if a resident's safety was in question, he would also notify adult protection services. He said he would start the investigation by interviewing the resident, then he would interview witnesses and find out if anything similar had happened before, and after completion of the investigation, he would perform a post-incident review.

The SSD said he would interview the residents to find out what happened, whether or not they had fear, and if they felt safe.

The NHA said the SSD took the lead in investigating allegations of abuse and reported findings to the NHA.

II. Staff to Resident mental and verbal abuse - Incident involving the activities director (AD) and Resident #79

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

A. Resident #79

1. Resident status

Resident #79, age over 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, and depression.

The 3/2/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with hygiene, dressing, and transferring herself and did not exhibit any behavioral symptoms or refusal of care.

The resident's comprehensive care plan, revised on 3/24/24, documented Resident #79 had a history of trauma involving an adverse childhood experience and had the potential to demonstrate physical behaviors related to dementia. The interventions included approach in a calm manner, attempt to de-escalate, and implement coping strategies. When agitated, guide away from the source of distress and staff to walk away if the resident becomes aggressive.

2. Resident interview

Resident #79 was interviewed on 4/3/24 at 1:35 p.m. Resident #79 was sniffing and wiping tears from her eyes. She grabbed a tissue, sat down on her bed, and apologized for being so upset. Resident #79 then reported she was very upset over a recent interaction with the AD during and after the resident council meeting that morning.

Resident #79 explained the library book program meant so much to her and said many of the other residents had been asking her when they could get books again. She said she felt bad for the people who could not get out to do things and especially bad for those who were deaf and really enjoyed reading. She began to tear up again and wiped her eyes with a tissue. She said the library books meant a lot to her because she felt the book program really helped others and she enjoyed helping people. She said she felt the AD did not understand how important the books were to her and other residents.

Resident #79 said the AD was very mean to her, raised her voice at her, was very rude, and told her the facility's library book program was not a priority and would not be a priority.

Resident #79 said she was so upset by the way the AD spoke to her that she began crying. She said two therapy staff witnessed the interaction and helped to console her. Resident #79 said the AD's tone was snotty and very belittling. She said it made her feel like a scolded child.

Resident #79 began to cry again and said she did not understand why the AD was so mean to her. She said she was so upset by the interaction that she just wanted to lie down and sleep. Resident #79 said she did not think she would even be able to do her therapy session that afternoon because she was so upset.

3. Report and response of staff witnesses to the incident

a. Speech therapist (ST) #1

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Level of Harm - Actual harm

Residents Affected - Few

ST #1 was interviewed on 4/3/24 at 1:50 p.m. ST #1 said she witnessed an incident/inappropriate interaction between the AD and Resident #79 that occurred around 11:15 a.m. that morning.

She said the AD was speaking to the resident in a manner that was not appropriate and was belittling the resident. She said she did not feel it was appropriate to communicate with residents with dementia in that manner. ST #1 said Resident #79 was crying after the encounter so she and occupational therapist (OT) #1 tried to console the resident. ST #1 said that she observed most of the interaction and OT #1 also heard the end of the interaction between the AD and Resident #79. ST #1 said physical therapist (PT) #1 saw the resident crying after the incident and also tried to console the resident.

ST #1 said after the resident calmed down, she went with OT #1 and PT #1 to report the incident to the NHA. ST #1 said they felt more comfortable reporting the incident together because they believed their observations would be better received and not ignored if all three of them reported what they observed as a group since the allegation was against a member of the leadership team.

ST #1 was interviewed a second time on 4/9/24 at 2:26 p.m. ST #1 said the AD sounded stressed and very busy. ST #1 said the tone of the AD was not appropriate since the resident had dementia. She said she did not feel it was her job to define abuse but it was her responsibility to report any incident that was concerning and she felt this incident fell into that category.

b. PT #1 was interviewed on 4/3/24 at 1:53 p.m.

PT #1 said he did not witness the incident but he did see Resident #79 crying after it was over. He said he helped to console her and went with ST #1 and OT #1 to report the incident to the NHA.

c. OT #1

OT #1 was interviewed on 4/3/24 at 1:55 p.m. OT #1 said she heard the end of the interaction between the AD and Resident #79. The OT said the AD used an inappropriate tone of voice with Resident #79. OT #1 said the resident was very upset and was seen crying by the end of the resident and AD's encounter. OT #1 said she, ST #1, and PT #1 consoled the resident because she was so upset and tearful. OT #1 said the interaction was very concerning and they felt it needed to be reported to the NHA so that is what they did.

OT #1 was interviewed again on 4/9/24 at 2:05 p.m. OT #1 said the AD's tone of voice during the incident with Resident #79 was very stern, direct, and inappropriate. OT #1 said the comment made by the AD that stuck out most to her was when the AD told Resident #79 that the library book program was not a priority. OT #1 said she defined verbal abuse as any type of talk that made a person feel bad or upset.

d. The activities assistant (AA) #1

AA #1 was interviewed on 4/9/24 at 2:45 p.m. AA #1 said he only observed the end of the incident between Resident #79 and the AD. When he saw them they were standing in the hall in front of the activities room. AA #1 said Resident #79 started to walk away from the AD and then started talking again but could not remember what the resident said. AA #1 said the AD apologized to Resident #79 for losing her cool in her office.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Facility response - failure to initiate an investigation or implement corrective actions for several hours to protect Resident #79 from further abuse. The NHA was interviewed on 4/3/24 at 2:00 p.m. The NHA said the staff that reported the incident between the AD and Resident #79 did not tell him that they thought the incident was verbal abuse so he did not start an investigation or take any action to suspend the AD. The NHA said he would look into it further and, depending on his findings, the AD might be sent home. An interview with the NHA on 4/3/24 at 4:30 p.m. revealed he had suspended the AD pending investigation. However, the AD continued to work in the facility without restricted access to interact with Resident #79 or other residents in the facility for five hours after the incident that morning and for two hours after he received reports of the incident from staff who witnessed it. C. The AD was interviewed on 4/10/24 at 3:15 p.m. The AD said the incident began after the resident council meeting when Resident #79 came to her office to talk about the library book program. The AD said she told Resident #79 that it would take time to get it set up as other items had to be relocated first. She said she told Resident #79 that she did not have an immediate solution and the resident became very upset and told the AD that the AD did not care about the library book program. The AD said she did not handle the situation very well and ended the conversation with Resident #79 by saying, If you don't like any of my solutions then we have nothing else to talk about. The AD said she tried to apologize to Resident #79 but the resident did not want to hear it. The AD said she had reflected on the interaction with Resident #79 and said she did not do a good job of de-escalating the resident. The AD said she needed more training and should remember that the facility was home for the residents and she had to respect that. She said if she were in that situation again, she would ask the resident for a break to regroup and settle herself down. The AD said Resident #79 kept talking over her and interrupting her so she raised her voice toward the resident because she did not like being interrupted. D. Facility investigation - failures in the facility investigation (Cross-reference F610) 1. The facility investigation was provided by the NHA on 4/10/24 at 2:10 p.m. The investigation, dated 4/3/24, documented Resident #79 reported the AD was snotty and she did not like her tone of voice. Resident #79 reported she had tried to talk to the AD about supplies needed for the library book program. The resident was placed on increased monitoring. Resident #79 was interviewed by the SSD as a part of the investigation. The investigation interview read: There was a Lengthy meeting with Resident #79 this afternoon to discuss resident council and interactions after resident council. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Oakwood Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 5301 W 1st Ave Lakewood, CO 80226	

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

The resident was noted to be calmly resting in her room when I knocked and entered her room. She reported to me that the day hadn't gone very well. Residents expressed frustration regarding the library books that she had previously managed and how many of the residents attended Bingo at the same time she used to set up the library. She reported that she has been waiting for space/supplies to continue with the library books but it hadn't happened yet. She also expressed frustration that everything is changing. She stated that the new activities lady was snotty and that she didn't like her tone of voice. I asked her if she was afraid of anyone here and she stated, Absolutely not. Throughout our meeting her mood varied, however frequently throughout our conversation the resident was joking and laughing. The meeting concluded when physical therapy (PT) came to work with her and she reported to PT that she's having a much better day.

The investigation documented that Resident #79 was noted by staff who observed the incident to be tearful at the time of the incident.

The facility investigation did not document that an allegation of verbal abuse was substantiated. It concluded that the resident raised her voice during the incident and the AD was attempting to diffuse the interaction. A staff witness said the AD's tone was stern and aggravated. Other staff thought the AD was professional.

2. Failures in facility investigation (Cross-reference F610)

The corporate social worker (CSW) was interviewed on 4/10/24 at 2:45 p.m. She said she interviewed the AD but did not document the interview, she only took notes in her personal notebook which she did not share. She said she did not interview AA #1 regarding his statement that he overheard the AD apologizing to Resident #79 for losing her cool.

A review of the facility's investigation did not explain which staff thought the AD was professional in her response to the resident and if those staff had witnessed the incident or part of the incident, or had only heard about the incident from other staff witnesses.

47422

III. Staff to resident mental and verbal abuse - Incident involving CNA #2 and Resident #60

A. Resident #60

1. Resident status

Resident #60, under age 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included schizoaffective disorder, chronic pain, cognitive-communication deficit, and a history of traumatic brain injury.

The 2/28/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident had functional limitations in both lower extremities (hips, knees, ankles, and feet) and was fully dependent on staff to complete all activities of daily living (ADL), was not able to walk and used a wheelchair.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the resident's record revealed a self-care performance care plan, revised on 3/1/24, related to weakness, impaired cognition, hypertension, psychosis, and osteoarthritis. Interventions included Resident #60 required physical assistance from two staff members with any transfers. 2. Resident interview and observations Resident #60 was interviewed on 4/9/24 at 10:42 a.m. Upon entering the room, Resident #60 was observed in a reclined position in his mechanical wheelchair in his room. The resident had been crying and said he was in severe pain from being reclined for a long time and he could not adjust the position of the wheelchair because it was broken. Resident #60 said he needed to get up out of his wheelchair. Resident #60 said he had asked certified nurse aide (CNA) #2 to get him out of the wheelchair and into bed but CNA #2 just yelled at him. During the interview, CNA #2 appeared in the resident's doorway and entered the room. Resident #60 asked CNA #2 again if he could get him into bed. CNA #2 raised his voice and, in a scolding tone, said to Resident #60 that there were other residents who had more important needs who were wet and needed to be taken care of first because it was a priority to take care of wet residents first. CNA #2 told Resident #60 that he would just have to wait until he had time to come back and help him. After CNA #2 left the room, Resident #60 said the way CNA #2 treated him had made him feel as if he was not as important as the other residents. Resident #60 said he was so uncomfortable and in pain from sitting so long that he just wanted to be repositioned for some relief. B. Facility Response The NHA was interviewed on 4/9/24 at 11:00. The NHA said when residents required assistance they should have been cared for, especially residents who had visible discomfort and distress. He said any staff member who was unable to assist residents in a timely manner was to notify the charge nurse and reach out to other staff for assistance. He said CNA #2 was having a difficult time assisting all his assigned residents in a timely manner but should have reached out for help. The NHA suspended CNA #2 pending an investigation. IV. Resident-to-resident mental and verbal abuse - Incidents involving Residents #60, #13, and #31 A. Residents #60, #13, and #31 1. Resident #60 status - see above 2. Resident #13 status Resident #13, age under 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included paraplegia related to a gunshot wound, cognitive-communication deficit, and schizoaffective disorder. The 2/19/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment revealed the resident had not exhibited any behavioral symptoms. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the resident's record revealed Resident #13 had a mental health care plan initiated on 3/7/24, revised 4/4/24, which documented that the resident was at risk for re-traumatization related to a history of trauma involving a shooting and losing his brother at a young age. Additionally, the resident was at risk for ineffective coping related to psychiatric diagnosis. Interventions included: Adjust the environment to be more individually preferred and homelike, document behaviors, and response to interventions. The care plan listed two triggers for his post-traumatic stress disorder (PTSD) related to violence, including talking about violence and violent movies. An ineffective coping care plan initiated on 3/23/24, revealed the resident had ineffective coping skills related to schizoaffective disorder, hallucinations, and a history of trauma. Interventions included an adjusted environment to be more individualized and homelike and encouraged contact with a support system. 3. Resident #31 status Resident #31, under the age of 65, was admitted on [DATE] with an initial admitted [DATE]. According to the April 2024 CPO, diagnoses included multiple sclerosis, hyperlipidemia, lymphocytopenia, and personality disorder. The 2/28/24 minimum data set (MDS) assessment revealed the resident's cognitive status was intact with a brief interview for a mental status score of 15 out of 15. The behavior section indicated verbal behavioral symptoms directed toward others with a frequency of every one to three days. B. Incidents of mental and verbal abuse by Resident #31 toward Resident #13 and #60 on 3/5/24 and 3/10/24 1. Investigative report of resident-to-resident mental and verbal abuse on 3/5/24 a. Facility investigation The facility investigation of an allegation of verbal/mental abuse occurring on 3/5/24, documented that Resident #31 was observed to be verbally aggressive with Resident #13 and Resident #60. Resident #31 was heard by a staff witness calling Resident #13 racial slurs and telling him to go back to [NAME]. Resident #31 then called Resident #60 offensive names and made negative comments about his weight. Staff responded and separated the residents from each other. The director of nursing (DON) and the SSD tried to de-escalate the situation and calm Resident #31. Resident #31 remained agitated and started throwing his food and plate. The facility called the police to ensure the safety of facility residents. The police arrived and were able to calm Resident #31. Resident #31 went to his room and remained there for the rest of the night. Resident #13 and #60 were offered psychosocial support and Resident #31 was placed on frequent checks and referred for a psychiatric evaluation and behavioral health services. (continued on next page)

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F 0600

Level of Harm - Actual harm

Residents Affected - Few

The SSD interviewed the assailant, Resident #31. The SSD described Resident #31's demeanor as agitated and frustrated. Resident #31 said he had been frustrated because his housing transition application was being delayed. Resident #31 told the SSD, I can say what I want, I have First Amendment rights to do whatever I want.

The SSD interviewed Resident #13 who said Resident #31 used racial slurs to call him names and told him to go back to [NAME]. Resident #60 told the SSD that Resident #31 used foul language and made negative comments about his weight. The investigator said neither victim was fearful.

The investigator concluded that the allegation was substantiated based on staff witness statements.

b. Failure of the facility to take corrective action to prevent further mental and verbal abuse of Resident #13 and #60 by Resident #31.

-The facility did not make any changes to Resident #13 and #60's care plans related to the potential for repeated incidents of verbal abuse and emotional distress by Resident #31.

-The facility investigation did not pursue questioning of Resident #13 or Resident #60, both of whom were at risk for re-traumatization, to identify other emotional responses characteristic of being a victim of mental and verbal abuse and identify any behavioral changes in Resident #13 and Resident #60.

-The facility investigation failed to contain any staff witness statements about the details of the incident, what each resident said and did, or how staff responded to de-escalate the incident and protect the residents from further abuse.

However, a progress note in Resident #13's electronic medical record (EMR) dated 3/5/24 that was not a part of the investigation packet (see above) read:

Incident note. Late entry: Clarification note on 3/11: Nurse (working) on[the] floor (the unit) was standing at nurses' station when Resident #31 said to Resident #13 (explicit language), go back to [NAME] you (derogatory term) the Resident #31 said he would hit him (Resident #13) with his wheelchair if he didn't get the (explicit language) out of the way. This nurse stood in between the residents and asked them to separate. Resident #13 told Resident #31[that] he doesn't need to be talking to anyone like that.

Resident #31 was yelling out at the nurses' station (explicit language) and was moving closer with his [m]otorized chair (to Resident #13) Resident #13 was able to get around Resident #31 and return to his room on his unit. Facility leadership and the police were notified of the incident. Psychosocial assessment [was] performed on [Resident #13] and [the] resident denies feeling fearful or afraid. Will continue with the current plan of care.

-The note did not document who conducted the psychosocial assessment, when the assessment was completed, or if the assessor explored emotions other than fear of the assailant related to [Resident #13's] emotional status and existing psychiatric conditions that might be an outcome or side effect of the incident.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Investigative report of resident-to-resident mental and verbal abuse on 3/10/24 a. The facility investigation, for an allegation of verbal/mental abuse occurring on 3/10/24, documented Resident #31 was observed by nursing staff to be blocking the hallway path and was verbally harassing and cursing at residents that happened to walk by. When Resident #13 attempted to pass, Resident #31 was observed to say I'm not moving for him and then used racial slurs against Resident #13. The nursing staff asked Resident #31 to move several times but he refused and he would not move. A few minutes later Resident #31 turned his aggression against Resident #60, making derogatory comments about his weight. Resident #31 became increasingly angrier and started yelling profanities and cuss words at staff and despite many efforts, staff was not able to calm him down or determine the cause of his behavior. Resident #31's physician gave an order for the resident to be sent to the hospital for a full evaluation but the paramedics and police refused to take the resident to the hospital. The facility placed the resident on one-to-one monitoring to ensure the safety of all residents until the interdisciplinary (IDT) could determine the root cause for the change in the resident's behavior. The investigation determined that the resident's behavior may have been related to a similar change in behavior that was observed on 3/9/24 when Resident #31 was rude to another resident. The SSD interviewed Resident #31. Resident #31 said he did say stuff to Resident #13 and #60 but said he could not remember exactly what he had said. He then expressed frustration about wanting to leave the facility to move to his own apartment. A review of hallway security footage confirmed staff witness and resident accounts of what happened. Follow-up actions included: A plan to consult with the facility's medical director to meet resident's needs and to develop a plan to keep all residents safe. The SSD was to continue psychosocial monitoring to address Resident #31's behaviors. -Resident #13 and Resident #60 were offered counseling to manage their feelings around the incident of verbal abuse. -The IDT met and discussed a possible discharge plan for Resident #31 if his behavior continued but discharge plans were not initiated at that time. b. Failure of the facility to take corrective action to prevent further mental and verbal abuse of Resident #13 and #60 by Resident #31. -No changes were made to Resident #31's care plan following the incident and the facility gave no documentation of their findings. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The facility investigation did not pursue questioning of Resident #13 or Resident #60, both of whom were at risk for re-traumatization, to identify other emotional responses characteristic of being a victim of verbal abuse and identify any behavioral changes in Resident #13 and Resident #60. -The facility investigation failed to contain any staff witness statements about the details of the incident, what each resident said and did, or how staff responded to de-escalate the incident and protect the residents from further abuse. A progress note in resident #31's EMR that was not a part of the investigative packet read: Incident note. Late entry: Clarification note on 3/10/24. At approximately 1:10 p.m. on 3/10/24, Resident #31 was sitting in the hallway near the nurses station. He began verbally harassing and cursing at other residents [who] happened to walk by. Resident #13 attempted to propel himself in his motorized wheelchair past Resident #31 who was blocking the hallway and refused to move. [The] nurse witnessed Resident #31 refusing to move and verbalizing I am not moving for him. And then said to Resident #13, Hey aren't you from Nigeria? Oh wait, that's because you are a (racial slur). [The] nurse calmly asked Resident #31 to move several times to which he refused. Resident #13 sat quietly during Resident #31's episode and did not respond to his (Resident #31's) comments. [The] nurse was able to redirect Resident #31 but a few minutes later he (Resident #31) called Resident #60 fat. Leadership and police were notified. Resident #31's behavior required police intervention. The resident's physician wrote an order to send the resident to the hospital for further evaluation and treatment but the resident refused care [to go]. Paramedics were unable to take [the] resident due to refusal. Police were then called and spoke to the Resident but unable to do anything further. Resident [#31] was then placed on one to one monitoring. C. Resident interviews 1. Resident #60 was interviewed on 4/9/24 at 9:13 p.m. Resident #60 said Resident #31 had called him names and cursed him out and the facility would not do anything about it. He said the things Resident #31 said were hurtful and offensive, such as comments about his weight and disability. He said Resident #31 had done this more than once and Resident #60 just wanted it to stop. Resident #60 said he did not provoke Resident #31 in any way and took extra precautions going out of his way to avoid passing by Resident #31 because he did not want to be verbally attacked again. He said Resident #31's comments affected him negatively and made him feel bad about himself. Resident #60 said he was scared of Resident #31 and was still fearful that the resident would be verbally aggressive to him if they were to be in the same area. He said he knew it would happen again. He said he avoided parts of the facility to stay away from Resident #31. He said the facility had not put any protective measures in place to keep the situation from happening again. 2. Resident #13 was interviewed on 4/4/24 at 3:10 p.m. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #13 said Resident #31 made rude and racist remarks to him on several occasions. He said he did not ever provoke Resident #31 and tried every way possible, including staying in his room when possible, to avoid Resident #31 so Resident #31 would not say anything to attack him again. Resident #13 said that the incidents on 3/5/24 and 3/10/24 were not the first times he was yelled at and call[TRUNCATED]

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47960

Based on interviews and record review, the facility failed to initiate and complete a thorough investigation of alleged violations and take appropriate corrective action following the investigation. Particularly relevant when the allegation was verified for one (#79) of four residents reviewed for abuse out of 48 sample residents to alleviate after effects contributing to residents experiencing, among other emotions, anxiety, fear, and humiliation.

Specifically, the facility failed to, for Resident #79:

-Complete thorough investigations of the alleged violation of mental and verbal abuse that included sufficient evidence to allow the nursing home administrator (NHA) to determine what actions were necessary to protect the resident from further abuse that contributed to residents experiencing, among other emotions, anxiety, fear, and humiliation;

-Gather all pertinent unbiased observations to identify pertinent facts of the events that occurred before, during and immediately following the incident to determine necessary interventions to prevent further abuse and alleviate after effects felt by the resident victim. This would include observations of the assailant's behavior; words; gestures; facial expression; demeanor; tone and volume of voice; proximity and assailant and victim during the incident; and other applicable responses;

-Consider potential bias between alleged abuser(s) and witnesses; and,

-Take a timely response to an allegation of mental and verbal abuse and initiate an investigation with a timely response.

Findings include:

I. Facility Policy

The Abuse: Prevention of and Prohibition Against Policy, revised October 2022, was provided by the NHA on 4/3/24 at 3:00 p.m. and it read in pertinent part,

All identified events are reported to the Administrator immediately.

-A licensed nurse will immediately examine the resident upon receiving reports of alleged physical or sexual abuse.

-The findings of the examination shall be recorded in the resident's medical record. All allegations of abuse, neglect, misappropriation of resident property, and exploitation will be promptly and thoroughly investigated by the Administrator or his/her designee.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Upon receiving a report or allegation of a potential violation of this policy involving the taking, keeping, using, or distributing photos or video recordings, the Administrator or his or her designee will analyze the allegations and determine whether the conduct at issue implicates resident privacy or security as protected by the Health Insurance Portability and Accountability Act (HIPAA). Any such actual or potential violation will be managed as per the Facility's HIPAA policies and procedures. The investigation will include the following: -An interview with the person(s) reporting the incident; -An interview with the resident(s); -Interviews with any witnesses to the incident, including the alleged perpetrator, as appropriate; -A review of the resident's medical record; -An interview with staff members (on all shifts) who may have information regarding the alleged incident; -Interviews with other residents to whom the accused employee provides care or services or who may have information regarding the alleged incident; -An interview with staff members (on all shifts) having contact with the accused employee; and -A review of all circumstances surrounding the incident. The investigation, and the results of the investigation, will be documented. If an allegation of abuse, neglect, misappropriation of resident property, or exploitation is reported, discovered or suspected, the Facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation: -Respond immediately to protect the alleged victim and integrity of the investigation; -Examine the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; -Increase supervision of the alleged victim and residents; -Make room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; -Protect the involved persons from retaliation; and -Provide emotional support and counseling to the resident during and after the investigation, as needed. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

If the allegation of abuse, neglect, misappropriation of resident property, or exploitation involves an employee, the Facility will:

-Immediately remove the employee from the care of any resident.

-Suspend the employee during the pendency of the investigation.

II. Mental/verbal abuse by staff towards Resident #79

1. Resident #79

A. Resident status

Resident #79, age over 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety and depression.

The 3/2/24 minimum data set (MDS) assessment revealed the resident had a mild cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. She was independent with hygiene, dressing and transferring herself and did not exhibit any behavioral symptoms or refusal of care.

B. Resident interview

Resident #79 was interviewed on 4/3/24 at 1:35 p.m. Resident #79 was sniffing and wiping tears from her eyes. She grabbed a tissue, sat down on her bed, and apologized for being so upset. Resident #79 then reported she was very upset over a recent interaction with the AD during and after the resident council meeting that morning.

Resident #79 said the AD was very mean to her, raised her voice at her, was very rude, and told her the facility's library book program was not a priority and would not be a priority.

Resident #79 said she was so upset by the way the AD spoke to her that she began crying. She said two therapy staff witnessed the interaction and helped to console her. Resident #79 said the AD's tone was snotty and very belittling. She said it made her feel like a scolded child.

C. Facility Investigation (Cross-reference F600 for abuse)

An allegation of mental verbal abuse was reported to the facility NHA on 4/3/24 at approximately 12:30 p.m. by facility staff witnessing the activities director (AD) speaking in a mean and belittling manner that caused the resident emotional distress.

Although three staff who witnessed the incident promptly reported it to the nursing home administrator (NHA), the facility failed for several hours to initiate an investigation or implement corrective actions to protect Resident #79 from further abuse.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation documentation and interviews revealed that an investigation into the allegation of mental and verbal abuse was not started timely and the assailant was not suspended until over five hours after the incident of mental verbal abuse occurred. The assailant remained working in the facility with unrestricted access to interact with Resident #79 and other residents in the facility. The investigation documented that Resident #79 was noted by staff who observed the incident to be tearful at time of incident. The witness statements failed to document specific facts of the investigation detailing what the witness observed and heard during the reported incident. Instead of describing location and time of the incident; how close the staff assailant was to Resident #79 during the course of incident; who else was in the immediate area/potential witnesses; the exact words the AD used when communicating with Resident #79; staff assailants demeanor, gestures, tone and volume of voice; resident response; other witnesses names; and any other pertinent details witness statements gave a brief description of the incident. Additionally, the investigation report failed to document the investigators findings, conclusion and recommendations to prevent further abuse and emotional distress towards resident #79. -The investigation did not document who the staff witnesses were or what they observed and/or heard from the initiation and end of the incident. -The investigation did not ask how the alleged perpetrator and victim acted towards one another prior to and after the incident. -The investigation did not document if the alleged assailant and/or victim exhibited any behaviors that would provoke one another. -The facility did document that the investigator asked the resident if she was fearful of the staff assailant (AD) but failed to explore with the resident how the incident affected her emotionally and how the AD's words and behavior made her feel and or explored any other potential emotional factors that might occur after experiencing mental or verbal abuse. -Witness statements further documented the witnesses opinion on whether or not the incident rose to a level of abuse with no justification or evidential facts to support their opinion. D. Witness statements The activities assistant (AA) #3 provided a statement on 4/3/24 at 3:15 p.m. It read in pertinent part, Asked if she witnessed any verbal or emotional abuse towards Resident #79 from the AD? No, felt she answered all the questions. The AD did say that the library is not a priority but they would get to it. -However, the witness statement did not say what the AD's tone of voice was, where the two were positioned during the interaction or if there were any hand gestures by anyone involved. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The occupational therapist (OT) #1 provided a witness statement on 4/3/24 no time identified. It read in pertinent part, The AD's voice was stern and mean. Asked OT #1 if she felt that verbal or emotional abuse happened she stated No, but the interaction was not appropriate. We discussed the word mean during interview and what she felt was mean about the interaction, OT #1 feels it was just stern. She didn't feel that mean met the criteria for reporting abuse. -However, the witness statement did not say the volume of the AD's voice, if there were any interruptions, where the two were positioned during the interaction or if there were any hand gestures by anyone involved. AA #1 provided a witness statement on 4/3/24, no time identified. It read in pertinent part, Did you feel at any point the AD was verbally or emotionally abuse towards Resident #79 or other residents? No. AA #1 stated the AD apologized for losing her cool and that Resident #79 seemed upset. -However, the witness statement did not say if there were any interruptions, or if there were any hand gestures by anyone involved. AA #2 provided a witness statement on 4/3/24, no time identified. It read in pertinent part, Did you witness the AD being verbally or emotionally abusive? No, AA #2 thought she was professional. -However, the witness statement did not say the volume of the AD's voice, if there were any interruptions, where the two were positioned during the interaction or if there were any hand gestures by anyone involved. The witness statements provided were all typed and signed by the witnesses. -However, the statements were not individualized or unique to the person who witnessed the incident and contained the same first paragraph word for word. E. Staff interviews The corporate social worker (CSW) was interviewed on 4/10/24 at 2:45 p.m. The CSW said she interviewed the AD and took some notes in her personal notebook but did not ask the AD to write up her statement or document the interview in the investigation report. The CSW did not provide her note for review. The CSW said she did not interview AA #1 regarding his statement that he overheard the AD apologizing to Resident #79 for losing her cool. Speech therapist (ST) #1 was interviewed on 4/3/24 at 1:50 p.m. The ST said the incident between the AD and Resident #79 occurred around 11:15 a.m. that morning. ST #1, OT #1 and PT #1 went together to report the incident to NHA around 12:30 p.m ST #1 said they felt more comfortable reporting the incident together because they believed their observations would be better received if they all three reported what they observed as a group so the report would not be ignored since the allegation was against a member of the leadership team. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PT #1 was interviewed on 4/3/24 at 1:53 p.m. PT #1 said he did not witness the incident but he did see Resident #79 crying so he helped to console her and went with ST #1 and OT #1 to report the incident to the NHA around 12:30 p.m. OT #1 was interviewed on 4/3/24 at 1:55 p.m. OT #1 said she heard the end of the interaction between the AD and resident #79. OT #1 said the interaction was very concerning and felt it needed to be reported to the NHA so she went with PT #1 and ST #1 around 12:30 p.m. to report their concerns. The NHA was interviewed on 4/3/24 at 2:00 p.m. The NHA said the staff that reported the incident between the AD and Resident #79 did not tell him that they thought the incident was verbal abuse so he did not start an investigation or take any action to suspend the AD. -The AD continued to work in the facility without restricted access to interact with Resident #79 or other residents in the facility. The NHA was interviewed on 4/3/24 at 4:30 p.m. The NHA said he had just suspended the AD pending investigation. The NHA was interviewed with the social service director (SSD) on 4/9/24 at 6:18 p.m. The NHA said reports of potential abuse should be fully investigated. The NHA said when abuse was alleged the process was to suspend staff in question; protect the residents from further harm; make notifications to the power of attorney; and start a report to the state agency. -However, the alleged staff assailant was not suspended until over 5 hours after the incident of verbal abuse occurred. The AD was interviewed on 4/10/24 at 3:15 p.m. The AD said the incident began after the resident council meeting when Resident #79 came to her office to talk about the library book program. The AD said she told Resident #79 that it would take time to get it set up as other items had to be relocated first. She said she told Resident #79 that she did not have an immediate solution and the resident became very upset and told the AD that the AD did not care about the library book program. The AD said she did not handle the situation very well and ended the conversation with Resident #79 by saying, if you don't like any of my solutions then we have nothing else to talk about. The AD said she tried to apologize to Resident #79 but the resident did not want to hear it. The AD said she had reflected on the interaction with Resident #79 and she did not do a good job of de-escalating the resident. The AD said she needed more training and should remember that the facility was home for the residents and she had to respect that. She said if she were in that situation again she would ask the resident for a break to regroup and settle herself down. The AD said Resident #79 kept talking over her and interrupting her so she raised her voice towards the resident because she did not like being interrupted.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47422 Based on observations, record review and interviews, the facility failed to provide the necessary services to maintain personal hygiene for one (#60) of six residents reviewed for services to maintain highest practicable quality of life out of 49 sample residents. Specifically, the facility failed to provide bathing/showering assistance, grooming for nail care, assistance to change and put on clean clothing. Findings include: I. Facility policy The Activities of Daily living (ADL) policy was provided by the nursing home administrator (NHA) on 4/10/24 at 4:14 pm. It revealed in part, Residents who are unable to carry out activities of daily living (ADL) will receive necessary services or support from staff to maintain: ADL documentation will be maintained in the electronic health record under tasks, care plan, assessments, and therapy documentation including the following areas of care: eating, grooming, personal hygiene, communication, oral hygiene, transfers and ambulation. ADL's will be carefully planned to reflect the resident's specific needs. II. Resident #60 A. Resident status Resident #60, under age 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included schizoaffective disorder, chronic pain, cognitive communication deficit and history of a traumatic brain injury. The 2/28/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had functional limitations in both lower extremities (hips, knees, ankles and feet) and was fully dependent on staff to complete all ADLs. He was not able to walk and used a wheelchair. B. Observations On 4/3/24 at 2:32 p.m., Resident #60's fingernails were observed to be long and discolored. Resident #60's fingernails were visibly soiled and had a dark substance under several nails. His shirt was dirty and his hair was greasy but pulled back. On 4/4/24 at 11:00 a.m., Resident #60's fingernails were observed to be long and discolored. Resident #60's fingernails were visibly soiled and had a dark substance under several nails. Resident #60's hair was greasy and he was visibly frustrated that he was not receiving showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/8/24 at 4:30 p.m., Resident #60's fingernails were observed to be long and discolored. Resident #60's fingernails were visibly soiled and had a dark substance under several nails. Resident #60 was in tears and frustrated that he could not bathe until his shower day. C. Resident interview Resident #60 was interviewed on 4/3/24 at 2:32 p.m. Resident #60 said since he arrived at the facility he had not had his fingernails trimmed and had to bite them off to maintain grooming of his fingernails. He said the facility did not offer showers to him on a regular basis and he only received two showers in the past 30 days. He said he received one bed bath but he did not like it because staff was unable to get him clean enough. Resident #60 said his preference and request was specifically to get showers. He said he did not like feeling dirty all the time and wanted the facility to assist him so that his hygiene improved. He said that the facility accused him of refusing showers but he said the refusals were for bed baths not opportunities to get a shower. He said the facility staff did not want to shower him once he got out of bed and complained to him that it was too much work and took too much time because they had to get a second staff member to assist with the hoyer lift getting him undressed and then hoyer lift him to a shower chair and reverse the process once the shower was complete. D. Record review A self care performance care plan, revised 3/1/24, documented the resident needed assistance with bathing and grooming needs due to weakness, impaired cognition, hypertension, psychosis and osteoarthritis. Interventions included two staff assistance with bathing and transfers. -The care plan did not document if the resident refused showers. The point of care response chart documented the resident was care planned for receiving shower assistance on Wednesdays and Saturdays during the day shift. The shower documentation from 3/13/24 through 4/6/24 was reviewed for Resident #60. The documentation revealed Resident #60 received a shower on 3/13/24 and 3/16/24 and a bed bath on 4/4/24. -Out of eight opportunities for the resident to receive a shower from 3/13/24 through 4/6/24, Resident #60 only received two showers and one bed bath. -The documentation did not indicate the resident had refused any of his shower opportunities. E. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 4/8/24 at 4:14 p.m. CNA #4 said Resident #60 refused care sometimes and was hard to work with. She said he had long nails that should have been trimmed but she said she was unsure whose responsibility it was to trim his nails. CNA #4 said the resident was offered to be changed but he sometimes refused. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the resident's medical record did not document any instances of refusals to have his nails trimmed or cleaned and the resident said he only refused bed baths because they didn't make him feel clean. The resident said it was the staff who were not meeting his need for care planned showers and saying showering would take them too long, they did not have time and if he wanted bathing assistance he would have to take a shower. (see resident interview above.) The NHA was interviewed on 4/9/24 at 11:00. The NHA said when residents required assistance they should have been cared for, especially residents who had visible discomfort and distress. He said any staff member who was unable to assist residents in a timely manner was to notify the charge nurse and reach out to other staff for assistance. The assistant director of nursing (ADON) was interviewed on 4/9/24 at 2:28 p.m. The ADON said Resident #60 had a history of refusals for most cares but he had seen the resident be compliant with staff when approached in the right manner. He said the resident should not have had visibly dirty and ungroomed nails, especially if the resident wanted assistance. He said he would follow up with the resident in the next 24 hours to ensure he received the care he needed.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews and record review, the facility failed to manage pain in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for two (#57 and #87) of two residents reviewed for pain out of 49 sample residents. Specifically, the facility failed to: -Offer person-centered non-pharmacological pain interventions for Resident #57; and, -Follow physician orders for pain parameters when administering as needed pain medications for Resident #57 and Resident #87. Findings include: I. Facility policy and procedure The Pain Management policy, revised November 2019, was provided by the nursing home administrator (NHA) on 4/10/24 at 4:41 p.m. It read in pertinent part, It is the policy of this facility to provide an environment and programs that assist each resident o attain or maintain the resident's highest practicable physical, mental and psychosocial well being. Residents are provided and receive the care services needed according to established practice guidelines. Resident pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome. Purpose: the facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by: screening to determine if the resident has been or is experiencing pain; comprehensively evaluation of the pain. Licenses nurse will complete the Pain evaluation in (electronic medical record system); and, using pharmacological and/or non-pharmacologic interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals. Monitor pain status and treatment effects on a regular basis. Consult physician for additional interventions if indicated. II. Resident #57 A. Resident status Resident #57, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), need for assistance with personal care, anxiety, shortness of breath, alcohol abuse in remission and chronic pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/15/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) with a score of 12 out of 15. He required partial assistance with eating and oral hygiene. He required substantial assistance for toileting, showering and personal hygiene. The resident received scheduled pain medication. The resident had received as needed pain medication or was offered as needed pain medication and declined. The resident had not received non-medication interventions for pain. The resident reported he frequently had pain. He said his pain frequently made it difficult for him to sleep at night, made it difficult to participate in therapy activities and limited his day-to-day activities. The resident reported his pain level as an 8 out of 10. B. Resident interview and observation Resident #57 was interviewed on 4/3/24 at 2:11 p.m. Resident #57 said he had chronic pain throughout most of his body. The resident said he took pain medications. He said he preferred to have non-pharmacological pain interventions since he was a recovering drug and alcohol addict. Resident #57 said heat packs would help his pain significantly but the facility did not offer that to him. Resident #57 was in pain during the interview. He was grimacing and trying to reposition himself in his wheelchair. Resident #57 requested the interview to stop due to his pain level and it was immediately reported to the nurse. C. Record review The February 2024 CPO revealed Resident #57 had the following as needed physician orders for pain management: -Acetaminophen Oral Tablet 325 milligrams (mg) (Acetaminophen, give two tablet by mouth every four hours as needed for mild pain 5-10, ordered 8/7/23; and, -Hyrdocodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give one tablet by mouth every six hours as needed for pain 8-10, ordered 8/7/23. A review of Resident #57's February 2024 medication administration record (MAR) (2/1/24 to 2/29/24) documented the resident was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 3 on 2/9/24 and 2/15/24. The resident was administered Hydrocoodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 6 on 2/8/24, 2/19/24, 2/20/24, 2/21/4, 2/26/24 and 2/28/24. The resident was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 7 on 2/4/24 and 2/9/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The pain parameters specified in the physician orders for the Acetaminophen and the Hydrocodone-Acetaminophen overlapped. The Acetaminophen Oral Tablet 325 mg specified for a pain level of 5-10 and the Hydrocodone-Acetaminophen Oral Tablet 5-325 mg specified for a pain level of 8-10. The physician orders did not have an as needed pain medication for a pain level less than 5. The March 2024 CPO revealed Resident #57 had the following as needed physician orders for pain management: -Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give one tablet by mouth every six hours as needed for pain level of 5-10 out of 10, ordered on 8/7/23; and, -Tylenol Tablet 325 mg (Acetaminophen), give two tablets by mouth every four hours as needed for pain level of 1-4 out of 10, not to exceed three grams in 23 hours, ordered 8/7/23. A review of Resident #57's March 2024 MAR (3/1/24 to 3/31/24) documented the resident was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 2 on 3/4/24, 3/5/24 and 3/6/24. The resident was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 3 on 3/30/24. The resident was administered Tylenol Tablet 325 mg when he reported his pain level as a 6 on 3/8/24. The resident was administered Tylenol Tablet 325 mg when he reported his pain level at a 7 on 3/21/24 and 3/25/24. The resident was administered Tylenol Tablet 325 mg when he reported his pain level at a 9 on 3/29/24. The April 2024 CPO revealed Resident #57 had the following as needed physician orders for pain management: -Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (Hydrocodone-Acetaminophen), give one tablet by mouth every six hours as needed for pain level of 5-10 out of 10, ordered on 8/7/23; and, -Tylenol Tablet 325 mg (Acetaminophen), give two tablets by mouth every four hours as needed for pain level of 1-4 out of 10, not to exceed three grams in 23 hours, ordered 8/7/23. A review of Resident #57's April 2024 MAR (4/1/24 to 4/8/24) documented the resident was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg when he reported his pain level at a 2 on 4/2/24 and 4/4/24. The 3/5/24 pain management review assessment documented the resident had complaints of pain to his back. The resident did not have pain during the interview or had pain in the last five days -However, Resident #57 was administered Hydrocodone-Acetaminophen Oral Tablet 5-325 mg on 3/4/24 for a pain level of 2). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident reported his pain was worse in the afternoon and it was an aching pain. The resident reported the pain affected his sleep and emotions. Feeling fatigued and physical exercise made the residents' pain worse. The resident reported warm packs, distraction, repositioning and rest would help his pain. The resident reported his pain was well managed. The resident reported his acceptable pain level as a 3. The resident made negative verbalizations and vocalizations, facial expressions and had behaviors when he had pain. The staff would continue with the residents current plan of care. -However a review of the resident's EMR did not reveal the resident had been offered warm packs to assist with his pain. The 3/5/24 pain interview documented the resident had frequent pain within the last five days. The resident reported pain occasionally affected his sleep and interfered with his day-to-day activities. The resident reported his pain as moderate. The pain care plan, initiated on 3/14/24, revealed the resident had acute and chronic pain related to neuropathy and chronic pain. The interventions included: monitoring and documenting for the probable cause of each pain episode, removing causes of pain when possible monitoring and document for side effects of pain medication, monitoring and recording pain characteristics, monitoring and recording signs and symptoms of non-verbal pain, notifying the physician if interventions are unsuccessful or if current complain is a significant change from residents past experience of pain, observing and reporting changes in usual routine, conducting a pain assessment every shift and reporting to the nurse any change in usual activity attendance patterns or refusal to attend activities related to signs and symptoms of pain. -However, the person-centered non-pharmacological pain intervention of heat packs was not included in the comprehensive plan of care. III. Resident #87 A. Resident status Resident #87, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 CPO, diagnoses included morbid obesity, bipolar disorder, post-traumatic stress disorder (PTSD), need for assistance with personal care and pain. The 1/14/24 MDS assessment revealed the resident was cognitively intact with a staff interview for cognition. She required supervision for eating and oral hygiene. She required substantial assistance for toileting and personal hygiene. She was dependent for showering. The resident was on a scheduled pain medication regimen. She received as needed pain medications or was offered as needed pain medications and declined. She did not receive non-medication interventions for pain. The resident had frequent pain. Pain frequently interfered with therapy activities and her day-to-day activities. The resident reported her pain at a 9 out of 10. B. Record review The February 2024 CPO revealed Resident #87 had the following as needed physician orders for pain management: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 5 mg by mouth every four hours as needed for pain rated 3-5 out of 10, ordered 1/19/24; -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 10 mg by mouth every four hours as needed for pain rated 6-8 out of 10, ordered 1/19/24; and, -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 15 mg by mouth every four hours as needed for pain rated 9-10 out of 10, ordered 1/19/24. A review of Resident #87 February 2024 MAR (2/1/24 to 2/29/24) documented the resident was administered Oxycodone 5 mg when she reported her pain level at a 6 on 2/16/24, 2/22/24 and 2/25/24. The resident was administered Oxycodone 5 mg when she reported her pain level at a 7 on 2/11/24, 2/12/24, 2/17/24, 2/23/24 and 2/27/24. The resident was administered Oxycodone 5 mg when she reported her pain level at an 8 on 2/8/24. The resident was administered Oxycodone 5 mg when she reported her pain level at a 9 twice on 2/8/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 0 on 2/16/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 3 on 2/3/24, 2/9/24, 2/15/24 and 2/17/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 4 on 2/3/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 9 on 21/24 and 2/3/24. The resident was administered Oxycodone 15 mg when she reported her pain level at a 0 on 2/24/24. The resident was administered Oxycodone 15 mg when she reported her pain level at a 5 on 2/16/24. The resident was administered Oxycodone 15 mg when she reported her pain level at a 7 on 2/21/24. The resident was administered Oxycodone 15 mg when she reported her pain level at an 8 on 2/15/24. The March 2024 CPO revealed Resident #87 had the following as needed physician orders for pain management: -Tylenol Tablet 325 mg (Acetaminophen), give two tablet by mouth every four hours as needed for pain level of 1-4 out of 10, not to exceed three grams in 24 hours; -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 5 mg by mouth every four hours as needed for pain rated 6-7 out of 10, ordered 1/19/24; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER: Oakwood Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 5301 W 1st Ave Lakewood, CO 80226	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 10 mg by mouth every four hours as needed for pain rated 8-9 out of 10, ordered 1/19/24; and, -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 15 mg by mouth every four hours as needed for pain rated 10 out of 10, ordered 1/19/24. A review of Resident #87 March 2024 MAR (3/1/24 to 3/31/24) documented the resident was administered Tylenol 325 mg when she reported her pain level as a 5 twice on 3/17/24. The resident was administered Tylenol 325 mg when she reported her pain level at a 7 on 3/23/24. The resident was administered Oxycodone 5 mg when she reported her pain level at a 5 on 3/30/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 4 on 3/30/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 6 on 3/31/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 7 on 3/21/24, three times on 3/22/24, 3/23/24, 3/24/24 and 3/26/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 10 on 3/27/24. The resident was administered Oxycodone 15 mg when she reported her pain level at an 8 on 3/25/24. The resident was administered Oxycodone 15 mg when she reported her pain level at a 9 on 3/27/24 and 3/31/24. The April 2024 CPO revealed Resident #87 had the following as needed physician orders for pain management: -Tylenol Tablet 325 mg (Acetaminophen), give two tablet by mouth every four hours as needed for pain level of 1-4 out of 10, not to exceed three grams in 24 hours; -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 5 mg by mouth every four hours as needed for pain rated 6-7 out of 10, ordered 1/19/24; -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 10 mg by mouth every four hours as needed for pain rated 8-9 out of 10, ordered 1/19/24; and, -Oxycodone HCI Oral Tablet 5 mg (Oxycodone HCI), give 15 mg by mouth every four hours as needed for pain rated 10 out of 10, ordered 1/19/24. A review of Resident #87 April 2024 MAR (4/1/24 to 4/8/24) documented the resident was administered Tylenol 325 mg when she reported her pain level as a 5 on 4/8/24. The resident was administered Tylenol 325 mg when she reported her pain level at a 6 on 4/8/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident was administered Oxycodone 5 mg when she reported her pain level at a 5 on 4/4/24, 4/5/24 and 4/7/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 4 on 4/4/24. The resident was administered Oxycodone 10 mg when she reported her pain level at a 5 on 4/5/24 and 4/7/24. The resident was administered Oxycodone 15 mg when she reported her pain level at an 8 on 4/1/24. -A review of the March 2024 and April 2024 CPO revealed the resident did not have an as needed pain medication for when she reported her pain level at a 5. The 10/8/23 monthly medication review completed by the pharmacist documented the resident had received Oxycodone for pain level of 3-6 out of 10 or pain documented as a 0 and 2, please check documentation as this is a medication error and needs to be addressed. The 3/4/24 Pain Management Review assessment documented the resident complaint of pain to her back and legs. The resident reported she did not currently have pain but had pain within the last day. The resident had daily pain or pain several times a day. The resident had back and muscle pain that was worst in the early morning, mid-morning, afternoon and late evening. The resident described her pain as aching. The resident said her pain affected her sleep and emotions. The resident said physical activity and feeling fatigued made her pain worse. The resident said warm packs, breathing and relaxation, distraction and rest helped. The resident said Oxycodone and Tylenol helped her pain. The resident said her pain was very well managed. The resident reported her acceptable pain level as a 3. The resident made negative verbalizations and vocalizations, facial expressions and had behaviors when he had pain. The staff would continue with the residents current plan of care. The 3/25/24 Pain Interview assessment documented the resident frequently had pain that occasionally affected her sleep, therapy activities and day-to-day activities. The resident reported her pain as moderate. The pain care plan, initiated on 3/15/24, revealed the resident had potential for acute and chronic pain related to neuritis (nerve inflammation) and neuralgia (sharp nerve pain). The residents' acceptable level of pain was 2 out of 10. The interventions included: anticipating and meeting the residents need for pain relief and responding immediately to any complaint of pain, following the pain scale to medicate as ordered, providing non-pharmacological interventions, notifying the physician if interventions were unsuccessful, observing and reporting changes in usual routine and completing a pain assessment every shift. IV. Staff interviews Certified nurse aide (CNA) #9 was interviewed on 4/8/24 at 4:02 p.m. She said Resident #57 often complained of generalized pain. CNA #9 said when the resident reported pain she told the licensed nurse on duty. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 4/9/24 at 12:14 p.m. RN #3 said if a resident had multiple as needed pain medications the physician would put specified pain parameters within the physician's order. RN #3 said the licensed nurses had to follow the pain parameters for as needed pain medications. The assistant director of nursing (ADON) was interviewed on 4/9/24 at 1:35 p.m. The ADON said Resident #57 had pain and Resident #87 had chronic pain. The ADON said person-centered pain parameters should be offered to the residents. The ADON said the licensed nurses had to follow the pain parameters for administering as needed pain medications specified in the physician's order. The ADON said he would complete education with the staff on administering pain medications per physician's orders. The ADON said the director of nursing (DON) completed the pain assessment for Resident #57 regarding the heat packs being helpful for the resident's pain. The ADON said he would follow-up with the DON regarding the residents' preferred non-pharmacological pain interventions. V. Facility follow-up The facility provided documentation indicating licensed practical nurse (LPN) #5 was provided education on 10/17/23 regarding administering pain medications per the CPO pain parameters for follow-up regarding the pharmacist altering the facility of the medication error for Resident #87. -However, the facility continued to administer as needed pain medications outside the physician ordered pain parameters for Resident #87's pain medications.

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

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 41032

Based on observations, record review and interviews, the facility failed to effectively address the care and treatment needs of residents in the secured dementia care unit for the residents to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being and provide person-centered care for ten (#84, #78, #71, #89, # 8, #97, #90, #69, #41 and #52) of 18 residents residing on the secured unit out of 49 sample residents.

Specifically, the facility failed to:

-Provide a consistent and engaging activity program that was meaningful for Resident #84, #78, #71, #89, # 8, #97, #90 and #69, all of whom resided in the secure unit;

-Offer and provide Resident #84, #78, #71, #89, # 8, #97, #90, #69, #41 and #52 unrestricted access to supplies and items for independent activities;

-Interact in a safe, non-confrontational and appropriate manner with Resident #71;

-Provide adequate supervision to keep Resident #78, who had been involved in a previous resident-to-resident altercation in another resident's room, from wandering into other residents' rooms; and,

-Ensure Resident #84 received the necessary services to promote person-centered care while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety.

Findings include:

I. Facility policy

The Care of Dementia policy, revised July 2007, was provided by the nursing home administrator (NHA) on 4/10/24 at 4:14 p.m. It read in pertinent part: It is the policy of this facility that all residents will have an individualized plan of care and have the least restrictive approaches to care. Staff are offered specialized training in the care of the dementia population, appropriate approaches to care and managing behaviors.

1. The interdisciplinary staff will initiate a thorough clinical assessment. The monitoring of mood, behavior and/or any psychosocial-related issues to identify possible underlying medical problems that may be causing the behavioral problems.

2. Social Services will also meet with the resident and attempt to identify possible psychosocial issues that may be causing behaviors and to develop a baseline social history

3. The Interdisciplinary team (IDT) will review the findings of evaluations and develop a plan of care addressing the resident's needs

(continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89 was in the common area eating a snack. When she finished her snack she took her twin baby dolls to her room. Resident #89 had a strong body odor and the back of her dress was soiled wet from the waistline. The resident's two baby dolls were heavily soiled around the mouth with dried food on and inside of their mouths. Both doll's clothing was soiled with a dried substance making the doll's clothing stiff and crusty. - The staff did not accompany Resident #89 to her room to offer to assist her in getting cleaned up or cleaning up her baby dolls. The daily chronicle reading and exercise group began at approximately 9:36 a.m. Six residents initially joined the circle to participate and Resident #8 sat in the back of the room and actively participated in the activity. Three other residents sat to the side with their heads down dozing and/or staring off into space. Two residents engaged in conversation, when prompted, as the daily chronicle newsletter was read the others were dozing or not paying attention. One resident got up from the group and walked down the hall. The residents were more active with the group activity once the exercise session began but still needed to be prompted to participate. Resident #52 exited his room asking staff what there was to do and he was alerted at that time of the group activity. He rolled his wheelchair to the group and joined. The residents who participated seemed to enjoy the activity. -There was no alternative activity offered to the residents who were not interested in the group activity. The CNAs observed the activity from a distance but did not participate or attempt to engage any other resident in the activity. CNA #3 walked the hall at the other end of the unit. CNA #3 was interviewed at 9:43 p.m. CNA #3 said CNA #4 was assigned to provide one-to-one supervision for Resident #84 because Resident #84 had been aggressive towards her peers in the past. CNA #3 said he provided oversight to the rest of the residents on the unit and the nurse assisted as needed and during break times to ensure all residents on the unit were safe. The group activity ended at 10:46 a.m. and staff started to clean up the common space area tables. Approximately 10 minutes after the activity concluded, Resident #8 was still sitting in the back of the room. She started to express anxiety and called out saying I need something to calm down repeating herself several times. -Staff did not respond to Resident #8's repeated statements that she needed something to calm down. Resident #84 got up from the group circle and started to wander up and down the hall and in and out of her room. The assigned one-to-one sitter, CNA #4, followed and monitored her from a distance but did not attempt to engage the resident in conversation or independent activity. Resident #84 was interviewed at 10:50 a.m. Resident #84 was able to follow the conversation and initiate questions. Resident #84 was curious about what was going to happen and if there was something she was supposed to be doing. The staff did not engage her or try to get her involved in any of her care-planned preferred activities (see Resident #84's care plan below). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Residents #78 and #71 were wandering the halls separately. Resident #71 was unable to engage in conversation and was concentrating on her walking path but seemed to have no destination. When resident #71 got to the end of the hall, she tugged on the exit door. After several minutes of not being able to open the door, she turned around and walked back the other way. Resident #78 walked up and down the hall circling the same short distance of hall space as if she was looking for something but forgot what. After the group activity, nursing staff offered residents additional snacks but did not attempt to engage the residents in further activities. Registered nurse (RN) #2 was interviewed at 11:05 a.m. RN #2 said the unit had 18 residents and was usually staffed by one nurse and two CNAs and a sitter to monitor resident #84 due to her aggressiveness towards other residents for both the day and night shifts. RN #2 said there was usually enough staff unless the resident started to express negative and aggressive behaviors then it was hard to manage all of the residents and ensure safety. RN #2 said there were a lot of therapy staff on the unit that day but it was not typical. -Therapy staff were entering the unit conducting some observational assessments and taking some less impaired residents off the unit for therapy sessions. At 11:30 a.m. Resident #89 returned to the common area, dressed in the same outfit as before, still with body odor but the back of her dress had dried. Her twin dolls were still soiled (see observation above). -No staff attempted to get her to return to her room to change her clothing or clean up her twin dolls. Residents were seated for lunch from 11:45 a.m. to 12:30 p.m. At 1:13 p.m., after finishing lunch, Resident #78 got up and wandered the hall and began entering other residents' rooms (see observations under resident-to-resident altercation below). At approximately 1:30 p.m. a therapy staff member, who had just entered the secure unit, said to Resident #78 Oh, there you are as she walked past Resident #78. -The therapy staff member continued walking down the hall without further engaging Resident #78 in conversation. Resident #78 approached with a worried look on her face and asked if there was any place special she needed to go, saying I'm lost. Resident #78 repeated this line of questioning several times and was eventually directed to the common area where she met up with resident ##84 and the two walked the hall as CNA #3 followed behind them. As they walked the hall, Resident #84 and Resident #78 could be heard saying there was nothing to do. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff directed the two residents to the common area where they sat together and continued their conversation that there was nothing to do. Resident #78 told Resident #84 That's the way it is. Resident #84 responded, I'm bored. -Staff did not attempt to engage Resident #78 and Resident #84 in a meaningful activity. The secure unit was observed again on 4/3/24 continuously from 3:00 p.m. to 4:10 p.m. Resident #84 and Resident #78 were seated in the common area talking. Resident #84 said There's nothing to do and Resident #78 said, No, just relax. -Again, staff did not acknowledge the residents' statements or attempt to provide them with a meaningful activity. At 3:20 p.m., several residents arrived in the common area and staff passed out snacks and beverages. CNA #3 went down the hall to check on residents while RN #2 started a conversation with three residents who were in the common area about their past jobs. RN #2 said to one of the male residents Were you mean to your employees like you are mean to me? The resident started to defend himself saying no I was a good boss. RN #2 replied, Do you promise because you are mean to me. The conversation about past jobs continued for a few more minutes then changed to a discussion on pets and dogs. -Staff did not offer residents an afternoon activity (structured or otherwise). Resident #90 who had been in her room sleeping with the door closed could be heard yelling out loudly in nondescript sounds. -The staff did not respond to Resident #90's yelling or go to check on the resident. The secure unit was observed on 4/4/24 at 12:45 p.m. continuously from 1:20 p.m. to 2:20 p.m. At 12:45 p.m. residents were observed wandering the halls, sitting at tables in the common area and sleeping at the tables. -None of the residents were provided with independent activities such as coloring, puzzles, cards, books, or other activities of interest. At 1:20 p.m. there was no change in the activity level and no supplies for independent activities were provided to residents. Resident #69 was standing in the hallway for over five minutes holding three notebooks asking others where he was supposed to report and asking if they were in the military. Residents # 84 and #78 were wandering the hall. Resident # 71 was attempting to get up from her chair and staff quickly prompted her to sit back down. Resident #71 sat back down. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #71 was not offered any type of activity to distract her from trying to get up from her chair and she tried several more times to get up. At 1:59 p.m., AA#1 entered the unit and announced to residents that he would be offering beverages and would be starting trivia. Many residents accepted the snacks and beverages offered but only a few residents showed interest in the trivia activity once it started. -There were no offerings of independent or alternative activities for the residents who were not interested in the trivia session. Resident #8 remained in her room. Resident #8 was interviewed at 2:02 p.m. Resident #8 pointed to a large plastic bag on her floor in the corner and said the bag had been there for a while and no one would help her hang up her clothing that was in the bag. The bag was tied up and the contents were unknown. The resident said she enjoyed the piano and would like to play the piano that was in the alternative common area and listen to piano music. -The second large common space on the unit was not being used except for a few residents who sat in the room's quiet space. The secure unit was observed on 4/8/24 from 10:00 a.m. to 12:10 p.m. At 10:00 a.m. the unit television in the main dining room was playing music and the staff were standing off to the side of the room watching the residents but there was no staff-to-resident engagement and no independent activities supplies offered to residents or out for residents to use as they chose. Residents were dozing and or staring off into space. Resident #69 was standing in the hallway. He asked where he was supposed to be and asked others if they were military. The resident was hard to understand and some staff did not understand him. He kept repeating his questions. Staff from off the unit said hello to him but did not engage him in conversation or find staff who could better understand his questions. Resident #90 was sitting at a table in the main common area dozing. Staff approached the resident with a snack. The resident did not eat the snack left in front of her. After approximately 45 minutes, a different staff member sat with Resident #90 to assist her with her snack and engage her in conversation. Resident #90 ate the snack and started talking and laughing with the staff member. Halfway through the snack, the staff member walked away and Resident #90's mood quickly changed from laughing to hanging her head and staring at the table where she sat. At 10:22 a.m., Resident #69 continued to stand in the hall walking a few feet back and forth. He remained in the hall in the same area until 11:10 a.m. when a physical therapist came and took him off the unit to the therapy gym. At 10:58 a.m. staff passed out more snacks to residents sitting idle in the common area. Resident #84 was wandering the hall and other residents were dozing or staring off into space at common area tables. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #89 was sitting alone in the sunroom staring out the window. Staff brought her several snacks which she did not eat. Resident #89 had her twin baby dolls with her. The dolls continued to have faces soiled with dried crusted food and soiled clothing (see observation from 4/3/24 above). Resident #89 tried to feed the baby dolls her applesauce. Ten other residents sat in the main common area either dozing, staring off into space or intermittently walking the halls circling the length of the shorter hallway. -There were no structured or independent activities offered and no activity supplies out for residents to access if they chose to engage in an activity of choice. Licensed practical nurse (LPN) #3 was interviewed at 12:05 p.m. LPN #3 said there was usually a morning activity provided by activities staff. The morning activity included reading the daily chronicle newsletter and a weekly exercise group. LPN #3 said therapy staff would take some residents off the unit for activities like Bingo or dancing that were provided on the non-secure unit, but there was no programming provided to residents who were not interested or capable of leaving the unit for regular structured activities other than the readings and exercise group. LPN #3 said the activities staff did not leave activity supplies out on the unit for residents to use independently or with staff so he would try to tell the residents jokes and keep them engaged. LPN #3 said sometimes the activities staff would come back in the afternoon but he did not know what the afternoon activity consisted of because there was no activities schedule posted on the secure unit. LPN #3 said he did not know what he could provide to the residents to facilitate activities but they did have the television and music stations to turn on for residents. LPN #3 said most of the time the residents just sat and listened to music. The secure unit was observed on 4/9/24 continuously from 8:43 a.m. to 10:30 a.m. Residents were sitting in the common area dozing, staring off into space and some were wandering. -There were no independent activity supplies out and available to residents who chose to engage in a preferred independent activity. At 8:50 a.m. Resident #84 was wandering the hall and kept asking what there was to do. Resident #84 said, I'm scared. When asked why she was scared she said, Because I don't know what to do. Resident #84 continued wandering and asking what she should be doing for the next fifty minutes. -Resident #84's one-to-one staff member, CNA #5, failed to recognize or respond to the resident's expression of distress. CNA #5 did not make any attempts to reassure Resident #84 or attempt to engage the resident in an activity of interest. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #5 was interviewed at 9:05 a.m. CNA #5 said Resident #84 was not agreeable to completing hygiene tasks or doing anything other than walking the halls. CNA #5 said she supported Resident #84 in getting daily exercise by walking up and down the halls with her. CNA #5 said she tried to get the resident to take a shower and change her clothing regularly but the resident continually refused. CNA #5 said the only way she knew how to get the resident to shower was to tell the resident her family was coming to visit even though that was untrue. CNA #5 said that the method never worked. CNA #5 said the resident had a small incontinent episode earlier that morning and her pants were wet but the resident refused to change so her pants just dried while she wore them. Resident #84 was in the same outfit she had been wearing since 4/3/24 her hair was matted in the back and starting to look stringy. The resident's neck was visibly dirty and had a build-up of green matter which staff believed was from a necklace she refused to remove. CNA #6 was interviewed at 9:30 a.m. CNA #6 said he occasionally worked in the secure unit but did not know what the activities program included. He said he looked for an activity schedule posting for the secure unit but was unable to locate any such posting. CNA #6 said the activities staff did not leave any supplies on the unit for resident use when they were not present on the unit and he did not know where to find any supplies to offer the residents. CNA #5 was interviewed again at 9:42 a.m. CNA #5 said the residents liked to watch the Price is Right and other game shows but staff mostly left the television tuned to the music station. CNA #5 did not know where to find any activity supplies to offer residents in between the scheduled activities or when they were not interested in the programming offered. Resident #84 was pacing in a six-foot path verbalizing that she wanted something to do and wanted to get out of here. Resident #84 tried lying down but did not even get both legs in the bed before she was up again and pacing in short circles saying that she did not want to miss her snack. Resident #84's one-to-one staff member did not engage with the resident and continued to observe the resident from a distance. The resident was encouraged to go to the common area where other staff were serving snacks but she declined. At 9:40 a.m., AA #1 arrived in the unit. AA #1 passed out the daily chronicle and invited residents to join the reading. AA# 1 served beverages to the residents and, without setting the residents up in a group circle or having the residents reposition so they were facing him as he read the daily chronicle and bible verse, he started the readings. One resident directed AA #1 to sit by her so she could better hear him. Several residents wandered away and some dozed off. Resident #84 got up and left the room and commented on how boring the reading was, saying [NAME], [NAME], [NAME]. At 10:20 a.m., after completing the reading activity, AA #1 turned the television on to the music station and informed staff he would try to return in the afternoon to provide additional activity programming but did not know what the activity would be. The secure unit was observed on 4/10/24 from 9:18 a.m. to 10:30 a.m. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:33 a.m. Resident #84 was observed with her one-to-one staff member, CNA #7. The CNA was engaged in conversation with Resident #84. After noticing the resident needed her shoes adjusted, CNA #7 was able to convince Resident #84 to return to her room so she could assist her with her shoes and socks. CNA #7 was interviewed at 9:43 a.m. CNA #7 said she had worked with Resident #84 in the past and, after talking with the resident about her favorite things earlier that morning, she was able to get the resident to change into clean clothing from the outfit she had been wearing for the past several days. B. Additional staff interviews The social service director (SSD) was interviewed on 4/10/24 at 10:59 a.m. The SSD said no single staff member was responsible for managing the secure unit programming. She said all of the interdisciplinary team (IDT) members managed the programming on the secure unit. Each member of the team gave their impressions and perspective on how the unit should be managed. The SSD said the IDT tried to provide the residents with independent activities of interest. The SSD did not explain how this process was carried out and did not know where the supplies for independent activities were stored. AA #1 and AA #2 were interviewed on 4/10/24 at 12:01 p.m. AA #1 said they provided the secure unit residents with two structured sessions daily, one session in the morning and one in the afternoon. AA #2 said the department did not have an activities calendar or a specific plan for what activity they provided to the residents on the secure unit like the department had for the residents on the non-secure unit. Instead, the activities staff determined the activities session based on the residents' mood. AA #2 said the morning activity usually consisted of providing a beverage and activities staff reading the daily chronicle to the residents followed by reading of a bible passage and exercise group. The afternoon activity was usually snacks followed by a craft project, exercise group, music or a game of trivia. AA #2 said there should be a box in the nurse's office that contained coloring supplies, word puzzles, books, magazines and other items that the nursing staff could provide to the residents. AA #2 said she had been working with the residents in the secure unit for the past three years and was familiar with most of the residents in the unit. AA #2 said the activities director (AD) was in the process of working on individualized activity assessments for each resident but they did not know where any of the completed assessments were located. AA#2 said they did not leave any activity supplies out for residents to access independently because residents would take things and the supplies would then not be available for resident use. AA#2 said they were also concerned that some residents might try to eat the activity supplies. -However, residents eating non-food items was not observed during the survey. (continued on next page)

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F 0744

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The corporate social worker (CSW) was interviewed with the NHA on 4/10/24 at 1:59 a.m. The CSW said the facility took an IDT approach to managing the secure unit. IDT members identified concerns and suggested approaches to provide consistent care to residents on the unit.

The CSW said there should have been a posted activity calendar on the unit and she would contact the AD to get the calendar and make sure that it was posted in the secure unit.

The CSW said she would like to see a consistent schedule of activities to provide routine and consistency for the residents. She said the activity calendar should look relatively the same day to day so the residents had a set routine and knew what to look for and what to expect.

The director of rehab (DOR) was interviewed on 4/10/24 at approximately 4:15 p.m. The DOR presented three boxes containing independent activities designed specifically for three separate residents in the secure unit.

A box for Resident #90 contained a brand-new baby doll and two other boxes contained coloring pages, colored pencils, matching cards, playing cards and other supplies that could be provided to the designated resident for independent activities or be used with staff and the designated resident.

The DOR explained that each box had been designed by a consultant who previously worked with the facility. The DOR said each resident was provided a busy box designed with the interest in mind and there were written instructions on how staff were to use the box's contents with the resident it was designed for.

The DOR said the boxes were stored in the resident's closets and she did not know why staff were unaware the boxes were available. The DOR said she just completed staff training on where to access activities and supplies for 11 staff members who were assigned to work with residents on the secure unit.

The DOR provided a copy of the training curriculum provided to the staff members on 4/10/24 (during the survey), it read: In-service Topic: Location of activity supplies in memory care unit Date: 4/10/2024. Instructor: DOR

During downtime, the residents on the secured unit have access to activities/supplies that are located within the nursing station. Please be aware of the location of the activities/supplies within the cabinets and drawers in the nursing station.

C. Follow up

The CSW provided a copy of the secure unit activities schedule on 4/10/24 at approximately 2:10 p.m. and said the activities calendar would be posted on the secure unit. It read:

7:00 a.m. - 8:00 a.m. Breakfast activities. Breakfast Set Up. Breakfast time with music or movies.

9:00 a.m. - 11:00 a.m. Morning activities: Puzzles; Daily chronicles; Coffee and snack time; Music or movies; Morning stretches.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:00 a.m. - 1:00 p.m. Lunch activities: Lunch set up; Lunch time with music or movies; Clean up time. 1:00 p.m. - 4:00 p.m. Afternoon activities: Music and movies; Arts and crafts; Puzzles; Banking; Country cart; Afternoon snack. 4:00 p.m. - 5:30 p.m. Dinner activities: Dinner activities; Dinner set up; Dinner time with music or movies; Clean up time. 5:30 p.m. - 6:00 p.m. Evening activities: Movies; Coloring; Independent activities; Aromatherapy and relaxation. -The activity schedule was not consistently followed (see observations above). III. Facility failures for Resident #71 A. Observations On 4/3/24 at 3:08 p.m., Resident #71 picked up a towel from a chair in the common area. RN #2 asked the resident for the towel. When resident #71 would not release the towel, RN #2 tried to pull the towel from the resident's grip. RN #2 and Resident #71 got into a tug-of-war with the towel until the resident reluctantly released the towel and proceeded to wander the hall. RN #2 folded the towel and placed it back on a chair in the common area. On 4/9/24 at 9:59 a.m. Resident #71 was observed pushing a dining room chair across the floor. CNA #3 approached and tried to take the chair from the resident. The resident would not let go of the chair. CNA #3 and Resident #71 began tugging the chair back and forth. The resident would not let go and they were struggling with the chair up in the air leaving the resident unsupported except for her hold on the chair. CNA #3 was able to get Resident #71 to release her grip on the chair and remove the chair from the resident's walking path. The resident wandered out of the common area and down the hall. B. Interviews The NHA and the CSW were interviewed on 4/10/24 at 1:59 a.m. The CSW said the staff should not be struggling with residents over nonessential objects. She said staff should offer the resident a diversion or a more appropriate object to hold. IV. Facility failures for Resident #78 A. Resident to resident altercation between Resident #78 and Resident #41 on 3/7/24 A facility investigation, dated 3/7/24, documented that a resident-to-resident altercation occurred on 3/7/24 at approximately 5:30 p.m. Resident #41 was in her room when Resident #78 wandered into the room. Staff were not aware that Resident #78 had wandered into Resident #41's room until they heard yelling and responded to Resident #41's room. Upon entering the room, staff found the residents in the bathroom and witnessed Resident #41 holding Resident #78 by the hair in the bathroom. Staff redirected Resident #41 to let go of Resident #78's hair and escorted Resident #78 out of the room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The residents were examined for injuries and neither resident was observed to be injured. Resident #41 was placed on one-on-one supervision until the IDT could determine a long-term plan moving forward to keep residents safe. -There was no documentation that Resident #78 was placed on increased monitoring to ensure she did not wander into other residents' rooms. Both residents were interviewed. Resident #41 was interviewed and she said that Resident #78 entered her room and she wanted her out. Resident #78 said she did not do anything to Resident #41. Neither resident remembered the incident the next day. B. Resident observations and interview Resident #78 was observed wandering into Resident #41's room on 4/3/24 at 1:15 p.m. without staff noticing. On 4/3/24 at 1:13 p.m., after finishing lunch, Resident #78 got up and wandered the hall. Staff were not observing her location. Resident #78 wandered into Resident #92's room and. shut the door behind her. Resident #92 had a stop sign on her door which did not distract Resident # 78 from entering the room. Resident #78 was in the room for a few minutes before Resident #92 was heard yelling at her to get

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on interviews and record review, the facility failed to assist residents in obtaining routine or emergency dental services, as needed for four (#57, #40, #93 and #84) of four residents reviewed for dental services out of 49 sample residents. Specifically, the facility failed to ensure: -Resident #57 was provided follow-up dental services recommended by the dentist; -Resident #40 was provided dentures in a timely manner; -Dental services were offered to Resident #93; and, -Refer Resident #84 to a dental specialist as recommended by the facility dentist for follow up on the resident's dental issues. Findings include: I. Facility policy and procedure The Dental Services policy, dated November 2007, was provided by the nursing home administrator (NHA) on 4/10/24 at 4:41 p.m. It read in pertinent part, It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care. 'Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairts), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, taking impressions for dentures and fitting dentures. Emergency dental services includes services needed to treat an episode of acute pain in teeth, gums, or palate; broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist. Residents and/or resident representatives, during the admission process, are notified of dental services available under the State plan (state-run programs), and of the potential charges that may apply in the case of routine or emergency dental care provided by outside resources. The facility will assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #57 A. Resident status Resident #57, age 66, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), need for assistance with personal care, anxiety, shortness of breath, alcohol abuse in remission and chronic pain. The 2/15/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) with a score of 12 out of 15. He required partial assistance with eating and oral hygiene. He required substantial assistance for toileting, showering and personal hygiene. The MDS assessment indicated the resident had no dental issues. -However, the resident had broken teeth and had been recommended to have all teeth extracted. B. Resident interview and observation Resident #57 was interviewed on 4/3/24 at 2:05 p.m. He said he saw the dentist a few months ago for a full work-up. He said it was determined he needed all of his teeth pulled and to have dentures made. Resident #57 said his teeth caused him some discomfort. He said he had not received any follow-up from the facility as to when his next appointment would be. Resident #57's teeth were broken. C. Record review The 11/2/23 dental note documented the resident had a cleaning completed. The dentist recommended brushing gently with a soft or extra soft toothbrush. The resident had cavities in almost every tooth. The resident had poor oral hygiene. The dentist spoke to the resident and informed him that dentures would be a good idea. The resident was having sensitivity and agreed on getting full dentures. The 11/20/23 dental note documented the resident had not had extractions yet but was interested because the teeth were causing him pain. The resident had spreading cavities. The 11/22/23 dental done documented the resident had the option to save the teeth. The resident said he would rather pull the teeth and get dentures. The note documented to consult the dentist for extractions and dentures. The 1/12/24 dental consult note documented the resident was in pain and wanted his teeth extracted. The note documented the resident's nurse was concerned for the patient due to the pain and would like to know how soon the resident could get the work done on his teeth. The note said to rush the residents status with the social worker to get the work done before the resident got an infection. The note documented the social worker was talked to about the situation and the social worker said they were trying to get the resident back on Medicaid services so he could get the work done as soon as possible. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/18/24 dental re-evaluation note documented the resident was partially edentulous, had poor oral hygiene, the tissue was inflamed and red, he had heavy amounts of plaque. The note documented the resident had chronic cavities throughout his mouth. The treatment plan documented debridement was completed via hand scaling. Silver diamine fluoride was added to several teeth. The resident was having pain in his teeth and was bed bound. The dentist prescribed amoxicillin 500 milligrams (mg) once a day and 20% Benzocaine to all teeth to get ride of sensitivity. The next visit was to send a pre authorization for treatment and to complete extractions. The 1/25/24 dental note documented the resident's nurse was asking if the resident was supposed to continue on antibiotics until the resident got the teeth extractions. The dentist said to finish the course of antibiotics. The dentist gave the resident topical Benzocaine to keep the pain under control and referred the resident to a dentist for extractions. The 2/15/24 dental note documented the resident was seen by another dentist for full mouth extractions and when that was finished he needed dentures made immediately. -The resident was interviewed on 4/3/24 and was still waiting on follow-up to have his teeth extracted. The resident had been waiting five months since the dentist recommended to have his teeth pulled and dentures made due to the resident having multiple cavities and pain. -A review of the resident's comprehensive care plan revealed the resident's dental issues were not addressed in the resident's plan of care. The resident had a physician order for Orajel Mouth/Throat Gel 10% (Benzocaine -Dental), apply to affected teeth topically every four hours as needed for dental pain, ordered 1/25/24. -The resident did not receive the Orajel from 4/1/24 through 4/8/24. III. Resident #40 A. Resident status Resident #40, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 CPO diagnoses, included need for assistance with personal care, depression and hypertension (high blood pressure). The 1/28/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS with a score of 11 out of 15. She required supervision for eating and oral hygiene. The assessment indicated the resident had no dental issues. -However, the resident was edentulous (had no teeth). B. Resident interview (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #40 was interviewed on 4/3/24 at 10:16 a.m. The resident said she had no teeth. The resident said she was waiting for her dentures to be made. The resident said it was difficult for her to eat with no teeth. The resident said she had not received any follow-up regarding the progress of her dentures being made. C. Record review The 9/19/23 dental note documented the resident was healing from teeth extractions well. The next visit would include full mouth x-rays and first impressions if the insurance approved. The 11/16/23 dental note documented the residents first impressions were completed for upper and lower dentures. The resident was fully healed post dental extractions. The resident was notified it would take several visits for dentures to be made and fit properly. The 1/3/24 dental note documented the resident was fully edentulous. The dentist documented the next visit was for the residents' bite registration. -There were no additional dental visits after 1/3/24 regarding follow-up for Resident #40's dentures. -A review of the resident's comprehensive care plan revealed the resident's dental issues were not addressed in the resident's plan of care. IV. Resident #93 A. Resident status Resident #93, under the age of 65, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included quadriplegia (little to no movement in all limbs), need for assistance with personal care, other specified disorders of teeth and supporting structures and adult failure to thrive. The 2/12/24 MDS assessment revealed the resident was cognitively intact with a BIMS with a score of 15 out of 15. He was independent for eating. He was dependent for oral hygiene, toileting, showering and personal hygiene. The assessment indicated the resident had no dental issues. B. Resident interview Resident #93 was interviewed on 4/4/24 at 9:05 a.m. He said he had tooth pain. He said one of his teeth on the right side of his mouth broke off several years ago and the nerve was poking through which made it very sensitive. The resident said he chewed on the left side of his mouth to help with the pain. Resident #93 said he had asked the nurses and the social services director (SSD) to see the dentist on many occasions. Resident #93 said he had not seen the dentist since he was admitted to the facility on [DATE] despite him asking several times. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review A request was made for dental visit notes for Resident #9 on 4/5/24. The SSD said the resident had not been seen by the dentist since he was admitted to the facility (see interview below). -A review of the resident's comprehensive care plan revealed the resident's dental needs were not addressed in the resident's plan of care. The resident had a physician order for Orajel 3X Toothache and Gum Mouth/Throat Gel 20-0.26-0.15% (Benzocaine-Menthol-Zinc Chloride), apply to upper right tooth/bum topically every six hours as needed for pain apply to affected area while awake before meals, ordered 2/6/24. -The resident had not received the medication from 4/1/24 through 4/8/24. V. Staff interviews Certified nurse aide (CNA) #9 was interviewed on 4/8/24 at 4:02 p.m. CNA #9 said Resident #57 had several missing and broken teeth. CNA #9 said the resident's teeth were rotting. CNA #9 said the resident reported pain to his teeth at times. CNA #9 said Resident #93 reported mouth pain but was good at brushing his teeth when the staff assisted him in getting the toothbrush ready. The SSD was interviewed on 4/8/24 at 4:18 p.m. The SSD said he had worked at the facility since November 2023. The SSD said the ancillary services were very inconsistent at the facility. The SSD said he terminated the contract with the dental services and obtained a contract with a new dentist to provide services to the residents. The SSD said Resident #57 did not qualify for emergency dental services because he did not have severe pain. The SSD said the previous dentist would not visit residents in their rooms and Resident #57 preferred to stay in his room. The SSD said Resident #57 was awaiting tooth extractions. The SSD said Resident #40 was supposed to have dentures being made. The SSD said the resident had been waiting several months for the dentures. The SSD said he was not sure when the resident would receive her dentures. The SSD said Resident #93 admitted to the facility in February 2024. The SSD said Resident #93 had not been seen by the dentist since he was admitted . The SSD said the resident had not been seen by the dentist since he was trying to transition to a new facility dentist. The SSD said he had not considered assisting Resident #93 in visiting a dentist outside the facility since he did not express the pain was that bad to him. The SSD was interviewed again on 4/10/24 at 10:56 a.m. The SSD said there was not a plan in place for residents to receive dental services while the facility was transitioning to a new facility dentist. 41032 (continued on next page)

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	065248	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VI. Resident #84 A. Resident status Resident #84, age 78, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included dementia with behavioral disturbance, anxiety and a need for assistance with personal care. The 3/20/24 MDS assessment revealed the resident usually understood conversations but missed some or parts of the intent of the message and was able to make herself understood. The resident was assessed to have severely impaired cognition as evidenced by a BIMS score of three out of 15. The MDS did not document any dental concerns. The resident presented with physical and verbal behavioral symptoms directed toward others, wandered daily and rejected care evaluation and care daily assistance with activities of daily living (ADL). The resident and or resident representative said it was important to the resident to choose her clothing, receive a shower, care for personal belongings and participate in favorite activities. B. Resident representative interview Resident #84's representative was interviewed on 4/8/24 at 3:06 p.m., The resident representative said the facility was not assisting with setting up a dental appointment for Resident #84. Resident #84 was in need of dental services and she had been calling the facility social worker for several months. The social services worker never called her back. The resident representative said she planned to be present for Resident #84's dentist appointment so the resident would cooperate with care, but she needed the facility to communicate with her to get the appointment set up. C. Record review A dental note dated 11/16/23 read: Today's Note: Tooth #9 has not been extracted. The patient does not want to get an extraction done at this time. We will keep the root tip treated regularly with SDF (a colorless liquid that is applied to teeth with a small brush. It contains silver, which kills germs that can cause tooth decay, as well as fluoride to prevent, slow down, or stop decay) and keeps an eye for infection. A dental note dated 12/4/23 read: Today's Note: Tooth #7 needs a filling, root tip for tooth #9 needs extraction. The patient wants work done, refer to (name of dental specialist). A dental note dated 1/25/24 read: Today's Note: Silver diamine was applied to tooth #7 and tooth #9 root tip to arrest caries process. The pulp vitality test was negative for tooth #7 and #9 was negative. (Resident #84 wants to get tooth #7 treated and tooth #9 root tip extracted. Refer to (name of dental specialist) to get tooth #7 treated and tooth #9 extracted. The patient would not let us do the treatment. -A review of the resident's medical record and progress note failed to show documentation of the recommended referral to the dental specialist being made. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews CNA #3 was interviewed on 4/8/24 at 1:02 p.m. CNA #3 said Resident #84 was not a good eater and sometimes complained of tooth and mouth pain. She was reluctant to let staff assist her with ADLs, especially oral care, so staff did not know the condition of her teeth. CNA #3 said the resident's family was able to get her to take a shower and perform grooming tasks when they visited but their visits were infrequent. The SSD was interviewed on 4/8/24 at 4:18 p.m. The SSD said he was having trouble for over five months getting consistent dental services from the existing provider the facility was contracted to use. The SSD said he worked with the dental provider to rotate services to the various residents so each resident could be seen and they did have access to emergency dental care when needed. The SSD said he was aware of Resident #84 need for dental services and had discussed this with the resident's guardian and additionally talked to the resident earlier that morning. Licensed practical nurse (LPN) #3 was interviewed on 4/8//24 at 3:42 p.m. LPN #3 said Resident #84 had expressed a desire to get her tooth fixed so he did put her on the dental list and he was not sure when she would see the dentist. LPN #3 said the resident had her dental issue for a few months. LPN #3 said the resident did not let staff do much for her or look at her teeth so he was not sure of the extent of her dental needs but knew she needed dental work completed.

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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 46022

Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.

Specifically, the facility failed to:

-Ensure housekeeping staff changed gloves and performed hand hygiene consistently when appropriate;

-Ensure housekeeping staff performed hand hygiene appropriately when performed;

-Ensure housekeeping staff properly used a disinfectant chemical when cleaning resident rooms and bathrooms;

-Ensure tracking, offering and administration of the COVID-19 vaccination;

-Follow infection control practices during wound care; and,

-Ensure proper hand hygiene was conducted during medication administration.

Findings include:

I. Housekeeping

A. Facility policy and procedure

The Infection Control Policy and Procedure for Housekeeping services, dated January 2009, was provided by the maintenance director (MTD) on 4/9/24 at 2:22 p.m. It read in pertinent part, It is the policy of this facility to require effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites. Frequent cleaning of the facility's interior will aid in physically removing and reducing microorganisms' potential contribution to the incidence of health-associated infections (HAI).

Personnel working in resident areas will follow strict hand washing procedures.

A hospital-grade disinfectant/detergent registered by the federal EPA (Environmental Protection Agency) will be used.

The Hand Hygiene policy, dated October 2022, was provided by the nursing home administrator (NHA) on 4/10/24 at 4:41 p.m. It read in pertinent part, Hand hygiene is one of the most effective measures to prevent the spread of infection. Studies show that effective hand decontamination can significantly reduce the rate of healthcare associated infection.

All personnel shall follow the handwashing/hand hygiene procedure to help prevent the spread of infections to other personnel, residents, and visitors.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wash hands with soap and water for the following situations: when hands are visibly soiled and after caring fo ra resident with known or suspected Clostridiales (c.) difficile or Norovirus infection during an outbreak, or if infection rates of C. Difficile Infection. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: before and after coming on duty; before and after direct contact with residents; before preparing or handling medications; before performing any non-surgical invasive procedures; before donning (putting on) sterile gloves; before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's intact skin; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment, etc.; after removing gloves; before and after eating or handling food; before and after assisting a resident with meals; after personal use of the toilet or conducting your personal hygiene; and, after removing and disposing of personal protective equipment. Washing hands: vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under moderate stream of running water, at a comfortable temperature. How water is unnecessarily rough on hands; rinse hands thoroughly under running water; hold hands lower than wrists; do not touch fingertips to inside of sink; dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel; discard towels into trash; use lotions throughout the day to protect the integrity of the skin. Using Alcohol-Based Hand Rubs: apply generous amount of product to palm of hand and rub hands together; cover all surfaces of hands and fingers until hands are dry; and follow manufacturers' directions for volume of product to use. B. Disinfectants used in the facility The BNC-15 instructions were retrieved from https://www.spartanchemical.com/about/news/bnc-15/ on 4/16/24. It read in pertinent part, BNC-15 offers three minutes disinfection for most common bacteria and viruses. The NABC Concentrate Non-Acid Disinfectant Bathroom Cleaner instructions were retrieved from https://www.spartanchemical.com/about/news/bnc-15/ on 4/16/24. It read in pertinent part, Contact time: Leave surfaces wet for 10 minutes. C. Observations of housekeeping staff on 4/9/24 At 8:52 a.m. housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER]. She used alcohol based hand rub for nine seconds. Her hands were still visibly wet when put on a pair of gloves. HSKP #1 spray a couple squirts of the BNC-15 chemical on a towel. HSKP #1 entered the room and began wiping off the bedside table. The bedside table did not appear wet. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSKP #1 returned to the housekeeping cart and disposed of the dirty towel. HSKP #1 got another towel and sprayed a couple squirts of the BNC-15 chemical on the towel. HSKP #1 entered the room and used the towel to wipe off the sink, the counter surrounding the sink and the mirror. HSKP #1 picked up the resident's tooth brush and other toiletry items to clean under with the same towel. The surfaces were not visibly wet after HSKP #1 wiped them down with the towel. HSKP #1 returned to the housekeeping cart and disposed of the dirty towel. HSKP #1 got another towel and sprayed a couple squirts of the BNC-15 chemical on the towel. HSKP #1 did not change her gloves or perform hand hygiene. HSKP #1 grabbed a bucket with a toilet brush that was filled with bathroom cleaner. HSKP #1 entered the room and used the towel to wipe off the toilet and grab bar in the bathroom. The surfaces were not visibly wet after she wiped the surfaces with the towel. HSKP #1 used the toilet brush to clean the inside of the toilet. At 8:56 a.m. returned to the housekeeping cart. She disposed of the towel and put the toilet brush bucket on the cart. Without changing gloves or performing hand hygiene, HSKP #1 grabbed the broom and began sweeping the bathroom and the room. HSKP #1 got the dustpan and swept the debris into it. HSKP #1 returned to the housekeeping cart and put the dustpan and the broom away. HSKP #1 got a mop head and began mopping the room. HSKP #1 picked up the resident's shoes and the trash can to mop underneath them. HSKP #1 returned to the cart and disposed of the mop head. HSKP #1 got another mop head and mopped the bathroom. HSKP #1 touched door knob to the room with her gloved hands. HSKP #1 disposed of the mop head and put the mop head back on the housekeeping cart. HSKP #1 removed her gloves and entered the room. HSKP #1 turned on the sink and washed her hands. HSKP #1 used her clean hands to turn off the sink. HSKP #1 turned the sink back on and got a paper towel to dry her hands. HSKP #1 used the paper towel she dried her hands with to turn off the sink. HSKP #1 then used the same paper towel to wipe off the sink and the counter surrounding the sink. HSKP #1 returned to the housekeeping cart and said she was done cleaning the room. At 10:59 a.m. HSKP #2 exited room [ROOM NUMBER] with gloves on. HSKP #2 disposed of a dirty mop head, got a new mop head and returned to room [ROOM NUMBER] to mop. HSKP #2 took the mop head off the mop and disposed of it. HSKP #2 applied hand sanitizer on her hands and began rubbing them together. With visibly wet hands HSKP #2 picked up a towel on her cart and dried her hands on the towel. HSKP #2 put gloves on and entered room [ROOM NUMBER]. HSKP #2 flushed the toilet and moved the toilet riser out of the bathroom. HSKP #2 took the trash out of two trash cans and then put new trash bags in the trash cans. HSKP #2 said she was hot and opened the window with the same gloved hands. HSKP #2 went around the room and began picking up trash that was on the bedside table and the counter near the sink. HSKP #1 touched the resident's newspaper with the same gloved hands and then put it back on the counter next to the sink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interviews The director of nursing (DON) was interviewed on 4/10/24 at 2:15 p.m. She said the proper steps of wound care were to check the orders, gather the supplies, use hand sanitizer or wash hands, put the supplies on the bedside table, wash hands and put gloves on, remove the old dressing, clean the wound, wash hands and put on new gloves and apply the new dressing. She said failure to follow proper infection control practices during wound care could cause the wound to become infected which would prolong healing. IV. Hand hygiene during medication administration A. Observations On 4/8/24 at 7:26 a.m., medication administration was observed with licensed practical nurse (LPN) #1. She opened the medication cart and began preparing the medications for Resident #7. -She did not wash or sanitize her hands. LPN #1 administered the medications to Resident #7 in his room and returned to the medication cart. At 7:32 a.m. LPN #1 prepared the medications for Resident #39 and walked to the resident ' s room to give the medications. At 7:37 a.m. she exited the residents room. LPN #1 put hand sanitizer in her right hand only and rubbed that hand by itself. At 7:43 a.m. LPN #1 began preparing medications for Resident #23. LPN #1 dropped a medication on the floor, put on one glove, picked it up with the gloved hand and put the medication in a medication cup. She covered the medication cup with her glove and put it in the top drawer of the medication cart. LPN #1 walked to the main medication room to look for medication. She did not find the medication and returned to the medication cart. At 8:04 a.m. LPN #1 finished preparing the medications and administered them in the resident ' s room. At 8:07 a.m. LPN #1 exited the resident ' s room. -She did not perform hand hygiene when she exited the room or when she returned to the medication cart. At 8:15 a.m. LPN #1 began preparing medications for Resident #32. She walked to the resident ' s room and administered the medications. At 8:32 a.m. LPN #1 finished administering the medications to the resident and walked to the sink in the resident ' s room to wash her hands. She washed her hands with soap and water, however it was only for six seconds. B. Staff interviews The corporate clinical consultant (CNC) was interviewed on 4/9/24 at 3:20 p.m. She said staff should wash their hands with soap and water for 20 seconds or rub their hands together for 20 seconds with hand sanitizer between each resident during medication administration. She said failure to do so could spread germs and cause residents to get sick. (continued on next page)

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	065248	A. Building B. Wing	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 4/10/24 at 3:15 p.m. She said it was important for staff to wash their hands with soap and water or use hand sanitizer for 20 seconds between each resident during medication administration. She said failure to do so could spread infection among residents.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for five (#63, #68, #84, #3 and #31) of five residents reviewed for immunizations out of 49 sample residents. Specifically, the facility failed to: -Ensure Resident #63, #68, #84, #3 and #31's electronic medical record (EMR) was up to date with their vaccination history; and, -Determine which pneumococcal vaccine was given to Resident #63, #68, #84, #3 and #31 and determine if additional doses were needed. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2022, retrieved on 4/16/24, from: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf, in pertinent part: Routine vaccination - pneumococcal -For those ages 19 to 64 with an additional risk factor or another indication was: One (1) dose PCV15 (pneumococcal 15-valent conjugate vaccine PCV15 Vaxneuvance) followed by PPSV23 (pneumococcal 23-valent polysaccharide vaccine PPSV23 Pneumovax 23)or one (1) dose PCV20 (pneumococcal 20-valent conjugate vaccine PCV20 Prevnar 20). (see notes) -For those over the age of 65 who meet age requirement and lack documentation of vaccination, or lack evidence of past infection was: One (1) dose PCV15 followed by PPSV23 or one (1) dose PCV20. Special situations: Age 19-[AGE] years with certain underlying medical conditions or other risk factors who have not previously received a pneumococcal conjugate vaccine or whose previous vaccination history is unknown: One (1) dose PCV15 or one (1) dose PCV20. If PCV15 is used, this should be followed by a dose of PPSV23 given at least 1 year after the PCV15 dose. A minimum interval of 8 weeks between PCV15 and PPSV23 can be considered for adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak to minimize the risk of invasive pneumococcal disease caused by serotypes unique to PPSV23 in these vulnerable groups. -Note: Immunocompromising conditions include chronic renal failure, nephrotic syndrome, immunodeficiency, iatrogenic immunosuppression, generalized malignancy, human immunodeficiency virus (HIV), Hodgkin disease, leukemia, lymphoma, multiple myeloma, solid organ transplants, congenital or acquired asplenia, sickle cell disease, or other hemoglobinopathies. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Note: Underlying medical conditions or other risk factors include alcoholism, chronic heart/liver/lung disease, chronic renal failure, cigarette smoking, cochlear implant, congenital or acquired asplenia, CSF (cerebral spinal fluid) leak, diabetes mellitus, generalized malignancy, HIV, Hodgkin disease, immunodeficiency, iatrogenic immunosuppression, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, solid organ transplants, or sickle cell disease or other hemoglobinopathies. II. Facility policy and procedure The Immunizations-Influenza and Pneumococcal policy, revised October 2022, was provided by the nursing home administrator (NHA) on 4/3/24 at approximately 11:00 a.m. It read in pertinent part, It is the policy of this facility to offer and administer influenza and pneumococcal immunization to eligible residents after providing education the risks and potential side effects of the vaccine(s) and obtaining consent. Eligibility to receive the vaccines may include, but is not limited to current vaccine status, season/time of year, medical contraindications, or resident preference/choice. To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal disease by ensuring that each resident is informed about the benefits and risks of immunizations; and has the opportunity to receive the influenza and pneumococcal vaccine(s), unless medically contraindicated, declined or was already immunized. Receipt of vaccinations is essential to the health and well-being of long-term care residents. Establishing an immunization program against influenza and pneumococcal disease facilitates achievement of this objective. Influenza outbreaks place both the residents and staff at risk of infection. Pneumococcal pneumonia, a type of bacteria pneumonia, is a common cause of hospitalization and death. Residents will be screened at the time of admission to determine vaccine status and eligibility, using current CDC (Centers for Disease Control)/ACIP (Advisory Committee on Immunization Practices) guidelines, to receive either/both the influenza or pneumococcal vaccine. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. Information related to education provided regarding the benefits and risks of immunization and the administration or refusal of or medical contraindications to the vaccines will be documented in the resident's medical record. Document that the resident either received the influenza and/or pneumococcal immunization or did not received the influenza and/or pneumococcal immunization due to medical contraindications or declination. Documentation will also include any adverse effects experienced by the resident related to vaccination(s). III. Resident #63 A. Resident status Resident #63, age 70, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included dementia and abnormal weight loss. The 3/11/24 minimum data set (MDS) assessment revealed the resident was not up to date on her pneumococcal vaccination and she had not been offered the pneumococcal vaccination. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review -A review of the resident's EMR on 4/4/24 revealed there was no documentation indicating the resident had received or been offered a pneumococcal vaccination. IV. Resident #68 A. Resident status Resident #68, age 70, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hypertension (high blood pressure), Alzheimer's disease and depression. The 2/16/24 MDS did not indicate if the resident was up to date on his pneumococcal vaccination. The MDS assessment indicated the pneumococcal vaccination had not been offered. B. Record review -A review of the resident's EMR on 4/4/24 revealed the resident had not received the pneumococcal vaccination after the resident's representative consented for the resident to receive the vacation on 11/11/22. V. Resident #84 A. Resident status Resident #84, age 78, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included heart disease, chronic obstructive pulmonary disease (COPD), need for assistance with personal care and dementia. The 3/20/24 MDS assessment indicated the resident was not up to date on the pneumococcal vaccination and had not been offered the vaccination. B. Record review -A review of the resident's immunization record in the EMR on 4/4/24 revealed the resident had not been offered or received a pneumococcal vaccination. The infection preventionist (IP) said the immunization tab in the EMR was the facility's system on tracking if immunizations had been offered, refused and/or given. The IP said the immunization tab should be up to date with all of the information (see interview below). VI. Resident #3 A. Resident status Resident #3, age 72, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 CPO, diagnosis included dementia and multiple sclerosis (deterioration of the muscles). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/31/24 MDS assessment indicated the resident was not up to date on the pneumococcal vaccination and did not state a reason why. B. Resident representative interview Resident #3's power of attorney (POA) was interviewed on 4/8/24 at 9:26 a.m. She said she wanted the resident to be vaccinated for pneumonia every year. She said the facility had not contacted her recently to obtain consent. The POA said she had requested the IP to administer the pneumococcal vaccination several times and had never received follow-up. C. Record review -A review of Resident #3's EMR on 4/4/24 revealed the resident had received the Pnuemovax dose one on 1/11/19. The POA declined an additional dose of the Peumovax on 9/16/21. VII. Resident #31 A. Resident status Resident #31, age 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 CPO, diagnoses included multiple sclerosis. The 2/28/24 MDS assessment did not indicate if the resident was up to date on the pneumococcal vaccination. The assessment documented the resident had not been offered the pneumococcal vaccination. B. Record review -A review of the resident's EMR on 4/4/24 revealed the resident had not received the pneumococcal vaccination after the resident consented for the resident to receive the vacation on 1/30/23. VIII. Staff interviews The IP was interviewed on 4/4/24 at 12:32 p.m. The IP said had worked at the facility for almost a year and had been in the IP and director of nursing (DON) role. The IP said she was responsible for looking up the resident's immunization history upon admission. The IP said she used the state immunization system to determine which immunizations the resident had received. The IP said she would input the information into the resident's EMR under the immunization tab. The IP said she utilized the immunization tab in the EMR to track immunizations. She said the immunization tab should indicate when a resident had received or refused all immunizations. The IP said she identified the resident's EMR was not up to date on 3/31/24. The IP said she implemented a process improvement plan (PIP). The IP said she had begun going through all of the resident's medical records and reviewing the state immunization system to determine which vaccinations the residents had received and which residents were due for vaccinations. The IP said the PIP would include an audit of all of the residents that resided at the facility. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP said she had not been reoffering the pneumonia vaccination after a resident had refused but going forward she was going to re-offer the vaccination quarterly at the care conferences. The IP said Resident #63, #68, #84, #3 and #31's EMR was not up to date with the correct information. The IP said she would conduct research to determine if the resident had received the pneumonia vaccination and if they were due for additional doses of the vaccination. The IP said she was aware the current immunization tracking system was not effective and that was why she implemented the PIP. The IP was interviewed again on 4/4/24 at 4:27 p.m. The IP said she did some research and determined Resident #63 had received a dose of the pneumonia vaccination in 2018 and 2020. The IP said this needed to be included in the resident's EMR. The IP said she Resident #31 had consented to receive the pneumonia vaccination and never received it. The IP said the consent forms did not indicate which pneumonia vaccination they were offering the residents. The IP said she would update the consent forms and add it to the PIP. The IP was interviewed again on 4/4/24 at 5:11 p.m. The IP said a new company took over the facility on 3/1/24. The IP said she had lost access to the state immunization system. The IP said she realized this week that the immunization system needed to be updated. The IP was interviewed again on 4/8/24 at 12:01 p.m. The IP said she did a whole house audit over the weekend to determine who needed to be offered the pneumonia vaccination. The IP said she began updating the resident's EMR with the correct vaccination history. The IP said there was a systematic issue that was causing immunizations not to be offered, given and documented in the medical record. The IP said the PIP had not been finished. She said there were eight to 10 more residents that needed to be offered the pneumonia vaccination. IX. Facility follow-up The facility provided additional information 4/5/24. The information indicated Resident #63 had received the Prevnar 13 on 11/9/18 and the PPSV23 vaccination on 10/28/2020. The resident was not eligible for a vaccination. -However, the facility had not identified that the resident had received the vaccinations and included the information in her medical record. The information indicated the facility could not confirm Resident #68 had received the pneumococcal vaccination after consent was provided on 11/11/22. The facility said they reoffered the vaccination and the resident declined on 4/5/24 (during the survey process). The information indicated the facility re-offered the pneumococcal vaccination to Resident #84's POA on 4/5/24 and the POA consented for Resident #84 to receive the pneumococcal vaccination. (continued on next page)

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