STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065274	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute	3185 W Arkansas Ave Denver, CO 80219

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47351

Based on observations and interviews, the facility failed to ensure care for residents was provided timely and in a manner that maintained or enhanced the residents' dignity.

Specifically, the facility failed to provide residents with a dignified existence by ensuring that call lights were consistently answered in a timely manner.

Findings include:

I. Facility policy

The Call Lights: Accessibility and Timely Response policy, revised February 2023, was received from the corporate nurse consultant (CNC) #1 on 2/20/24 at 12:10 p.m. It read in pertinent part, The purpose of this policy is to assure the facility is adequately equipped with a call light at

each residents' bedside, toilet, and bathing facility to allow residents to call for assistance.

Call lights will directly relay to a staff member or centralized location to ensure appropriate response.

All staff members who see or hear an activated call light are responsible for responding. If

the staff member cannot provide what the resident desires, the appropriate personnel should be

notified.

II. Observation

The facility's call light system consisted of call lights in each resident's room at the bedside and in each resident's bathroom. There was an audible sound with the call light activation and on the call board with the resident's room number located directly outside the nurses station at both the Mesa and [NAME] Fe hallways.

Each hallway call light board chimed and lit up according to the resident's room number. The light above each resident's door was activated and lit up once the resident used their call light.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both the Mesa and [NAME] Fe call light systems were observed to monitor the operability of the facility's call light system. On 2/13/24 the following delays in answering resident call lights were observed: At 9:10 a.m. the resident's call light for room [ROOM NUMBER] was activated and the call light board outside the nurse's station blinked off and on. Certified nurse aide (CNA) #3 did not answer the call light until 10:41 a.m. At 9:25 a.m. the resident's call light for room [ROOM NUMBER] was activated. The call light board displayed the resident's room accurately. CNA #3 did not answer the call light until 10:22 a.m. At 10:17 a.m. the resident's call light for room [ROOM NUMBER] was activated and the call light board displayed the resident's room accurately. CNA #3 did not answer the call light until 11:00 a.m. At 11:00 a.m. the resident's call light for room [ROOM NUMBER] was activated and the call light board displayed the resident's room accurately. CNA #3 did not answer the call light until 11:40 a.m. At 2:20 p.m. the resident's call light for room [ROOM NUMBER] was activated. The call light board displayed the resident's room accurately. CNA #3 did not answer the call light until 3:20 p.m. At 2:22 p.m. the resident's call light for room [ROOM NUMBER] was activated. The call light board displayed the resident's room accurately. CNA #3 did not answer the call light until 3:00 p.m. The CNA entered the room, switched off the call light seconds later and exited the room. CNA #3 did not return to the resident's room until 20 minutes at 3:20 p.m. to help the resident. On 2/15/24 the following delays in answering call lights was observed: At 11:10 a.m the resident's call light for room [ROOM NUMBER] was activated. The call light board displayed the resident's room accurately. CNA #2 did not answer the call light until 11:32 a.m. At 11:30 a.m. the resident's call light for room [ROOM NUMBER] was activated. The call light board displayed the resident's room accurately. There were three CNAs standing outside the nurse station talking. Licensed practical nurse (LPN) #6 told two of the CNAs to go to the dining room to assist with lunch and the third CNA to answer the call lights. The third CNA walked in the opposite direction toward another resident room. LPN #6 went back to the nurses station to do some charting. No staff answered the call light in room [ROOM NUMBER] until 12:40 p.m., when LPN #6 got up from the desk to answer the call. III. Resident interviews Resident #6 was interviewed on 2/13/24 at 2:18 p.m. Resident #6 said when he was in his old room back in December 2023, he activated his call light and several times had to wait for two to four hours before a staff member responded. The resident said his old room was between bed assignments for two CNAs and neither CNA would answer his call light because neither knew who was assigned to his room and it was a dead zone. Resident #6 said once he was moved to a new room things got better but he still occasionally had to wait a long time for staff to respond to his call light. (continued on next page)

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Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Resident #17 was interviewed on 2/13/24 at 2:24 p.m. The resident said in late January 2024 her bed was wet with urine and she activated her call light at 6:00 p.m. for assistance. The resident said it took 30 minutes for someone to respond. The resident said a CNA entered her room and turned off the call light and left without asking her what she needed or providing her any assistance. The CNA returned 30 minutes later with a nurse, when the resident asked the staff what took them so long the nurse told the resident she should have activated her call light again so the CNA knew to come back. The resident said she was shocked by the comment.

Resident #16 was interviewed on 2/14/23 at 9:51 a.m. The resident said the night shift was the worst when it came to answering call lights timely and she sometimes waited anywhere from four to six hours for help. Resident #16 said it took two persons to reposition her so sometimes staff responded and left to find a second staff to assist her and it took a long time since there were not enough CNAs.

Resident #18 was interviewed on 2/14/24 at 10:05 a.m. The resident said she did not use the call light because no staff answered the call light. The resident said if she needed something she would yell out loudly for help.

Resident #7 was interviewed on 2/14/24 at 2:17 p.m. The resident said she waited anywhere from 30 to 45 minutes for staff to answer her call light during the evening shift and up to one hour on the night shift. The resident said the staff were either on their phones; she knew this because she could hear and see them in the hall on their phones or taking a long break. The resident said she should not have to wait to use the bathroom but she had no choice because she needed help.

Resident #8 was interviewed on 2/14/24 at 2:22 p.m. The resident said agency staff (both nurses and CNAs) were always on the phone and did not respond to the call lights in a timely manner, especially the CNAs. The resident said she rarely saw more than one CNA during the evening shift.

IV. Record review

Resident grievances were reviewed

On 12/26/23 Resident #6 filed a grievance report that revealed on 12/23/23 the resident had asked for assistance to use the bathroom at 9:00 a.m. and the resident did not receive toileting assistance until 4:00 p. m.

-The grievance form failed to document a resolution other than instruct the resident to get the staff's name so that that particular CNA could be provided education (see resident interview above).

V. Staff interviews

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #4 was interviewed on 2/20/24 at 2:08 p.m. CNA #4 said call lings should be answered within five to 10 minutes after a resident activated the call light. CNA #4 said call light response was often delayed if a CNA was in another room with another resident assisting with eating meals, showering or dressing. CNA #4 said the CNAs were assigned 11 residents each which was reasonable and allowed for sufficient time to care for the residents. CNA #4 said if there were residents in their rooms who need help with eating, one CNA would stay on the unit to help that resident eat and the other two CNAs would go to the dining room to assist residents with meals so sometimes there were delays in answering call lights at meal times. CNA #4 said CNAs help each other and it was really about time management rather than a lack of staff. CNA #3 was interviewed on 2/20/24 at 2:24 p.m. CNA #3 said poor call light response was likely due to miscommunication or no communication between CNAs related to who was taking a break or a failure in communicating with the nurses about why and when they were leaving the unit. CNA #3 said another issue with the call light response was the nurses did not answer call lights. CNA #3 said there were exceptions but very few nurses were willing to help answer call lights. CNA #3 said if they worked as a team, the light response would be much better. CNC #1 was interviewed on 2/20/24 at 12:00 p.m. CNC #1 said she and the new nursing home administrator would look into the call light delays.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on interviews and record review, the facility failed to ensure prompt action was taken upon the filing of a grievance of a group. Specifically, the facility failed to follow up with residents' concerns regarding meals, staff cell phone usage, batteries not being charged and trash not being taken out. Findings include: I. Facility policy and procedure The Grievances/Complaints, Filing policy, revised April 2017, was provided by corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. Any resident, family member, or appointed resident representative may file a grievance or complain concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. II. Resident group interview Five residents (#3, #12, #26, #29 and #27), who were identified as interviewable by the facility and assessment, were interviewed on 2/15/24 at 10:34 a.m. All of the residents interviewed said the following: -They had voiced concerns in food committee and resident council that were not addressed; -When concerns were brought up in resident council there was never a resolution; and. -The same concerns were brought up month after month Resident #26 said she found the food committee to be a waste of her time as she had raised concerns and they were never addressed. Resident #3 and Resident #12 said they voiced their food concerns in the resident council and food committee. They said they did not feel their concerns were being addressed. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 said she was afraid to voice her concerns in the resident council. Resident #3 said she thought she would be punished for complaining. Resident #12 said she was the resident president. She said she had brought up concerns in resident council on many occasions that had not been addressed. She felt the resident council meeting was the same concerns over and over again. III. Record review The October 2023 resident council meeting minutes revealed the residents reported there were concerns with staff using their cell phones in care areas, staff not wearing name tags, bedside tables being removed from resident rooms, internet services not working well, trash cans were not being emptied, batteries not being charged regularly, doors not being [NAME] up, cold meals, ancillary services, not enough free activities and funds not being managed properly by the business office. -It documented the cell phone usage was unresolved from the last council meeting and remained unresolved. It documented the batteries and trash bins were a work in process and currently unresolved. The notes documented new signs were going to be put up to keep the doors closed at all times. The cold meals and funds remained unresolved. The December 2023 resident council meeting minutes revealed the residents reported there were concerns with staff still using their cellphones in resident care areas; batteries were not being charged regularly by staff; trash bins were not being taken out when full; there were not enough cost free outings; door being propped open, food being cold, meals being late and funds not being managed properly by the business office. -It documented that cell phone usage was an ongoing problem in modern society and the nursing home administrator (NHA) would continue to educate staff on cell phone use. It documented the batteries and trash bins would be looked further into to resolve the current issue. It documented signs would be posted on the doorway to shut doors at all times. The minutes documented the cold meals would be looked further into. The January 2024 resident council meeting minutes revealed the residents reported there were concerns with staff using their cell phones in resident areas, batteries were not being charged regularly, trash cans were not being emptied, doors being propped open, meals being late and funds not being managed properly by the business office. -It documented cell phones, batteries, trash bins, doors being propped open, meals and funds were an ongoing issue. IV. Staff interviews The social services director (SSD) and the social services assistant (SSA) were interviewed on 2/15/24 at approximately 2:00 p.m. The SSD said anyone could fill out a grievance form. The SSD said the social services department then reviewed and logged the grievance form. The SSD said the form was then given to the department manager it pertained to. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD said the department manager was responsible for completing an investigation and developing a resolution alongside the resident. The SSD said the department manager needed to obtain approval from the resident submitting the grievance form and return it to the social services department. The SSD said the grievance form was then approved by the NHA and filed. The SSD said it was the responsibility of the NHA to ensure the resolution on the grievance was acceptable. The SSD and SSA said they were unsure of who was responsible for filling out grievances forms for concerns that were brought up in the monthly resident council meetings. The SSA said he used to work in the activities department and often took the resident council minutes. The SSA said he was never instructed to write grievance forms for concerns that were brought up in resident council. The activities director (AD) was interviewed on 2/15/24 at 4:25 p.m. The AD said she was new to the activities director role but had worked in the activities department at the facility for about three years. The AD said the resident council minutes were typically documented by herself or one of the activities assistants. The AD said the activities department did not fill out grievances for concerns that were brought up in resident council. The AD said she was unsure who was responsible for filling out grievances for concerns brought up in the council meetings. The AD said the same concerns had been brought up in the last several meetings and had not been resolved. The NHA, CNC #1 and CNC #2 were interviewed on 2/15/24 at 4:30 p.m. They all said concerns that were brought up in resident council needed to be documented on a grievance form and addressed in a timely manner.

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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** 41032 Based on record review, observations and interview, the facility failed to ensure a clean, safe and homelike environment for two (#19 and #11) of 29 sample residents. Specifically, the facility failed to: -Ensure a system was implemented to clean and maintain Resident #19's chew and spit discarded food bucket; and, -Maintain a clean room environment for Resident #19 and Resident #11, who were roommates. Findings include: I. Facility policies The Safe and Home Like Environment policy, revised April 2019, was provided by corporate nurse consultant (CNC) #1 on 2/20/24 at 12:10 p.m. It read in pertinent part: In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. II. Resident #19 A. Resident status Resident #19, under the age of 65, was admitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included schizoaffective disorder, diabetes, acquired absence of parts of the digestive tract and artificial opening of the gastrointestinal tract (for gastric tube feeding). The 1/3/24 minimum data set (MDS) assessment failed to document an assessment of the resident's cognition by completing a brief interview for mental status (BIMS) with the resident or by a staff assessment of the resident's mental status. The 10/12/23 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. The resident did not present with delirium. The assessment revealed the resident had a feeding tube and received caloric intake through the tube feeding. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations and resident interview Resident #19 was interviewed on 2/13/24 at 1:54 p.m. Resident #19 said he ate food but was unable to digest the food because his stomach was disconnected. The food he ate collected at his throat and he had to dispose of it in a bucket he kept at his bedside. Resident #19 said most staff ignored the food waste bucket but eventually a staff would discard the bucket when it was full. -During the interview, a large square bucket (size approximately two gallons) was observed at the resident's bedside. The bucket was approximately two-thirds full of a thick brown liquid substance that resembled a liquid stool. -There was no lid on the container and the substance smelled of rotting food. Resident #19 was interviewed again on 2/15/24 at 10:02 a.m. Resident #19 said he did not want to complain because he and his roommate (resident #11) just moved to the facility and he did not want to be called a troublemaker. -During the interview, Resident #19's room (which he shared with Resident #1) was observed to be very cluttered, and tabletop surfaces for both residents over the bed tables where they ate were heavily soiled with dried food debris and a thick layer of dried liquid. -Both resident's privacy curtains were soiled with brown and black matter and Resident #19's privacy curtain had splattered dried tube-feeding liquid all down the side facing the resident's bed. -The floor was soiled with a black layer of dirt and there were food and dust crumbs and debris around the edges of the room. -There were dead flies on the windowsill and the sink in the room was covered with boxes and other personal care items. The basin of the sink was soiled with a brownish-black layer of dried matter. -The outer sides of the trash can were soiled with several colors of dried matter. On 2/20/24 at 12:33 p.m., the square bucket was observed at the resident's bedside half full with the same consistency substance as observed on 2/13/24. -There was no lid on the bucket and its contents were observable from the door to the resident's room. C. Record review The February CPO documented an order for a regular diet, regular texture and thin liquids consistency for pleasure feeds (allows for minimal oral intake of foods and fluids for people with tube feedings who crave the taste and experience of eating). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse practitioner's visit note dated 10/11/23 documented in pertinent part, Resident #19 had a rupture of the esophagus, in July 2018 and has a gastric tube for nutrition with a stoma with an ostomy bag to the anterior (front) neck. The resident drank fluids and ate food for pleasure which was then collected in a bag and the resident then emptied the bag from his neck to a trashcan several times a day. Resident managed the ostomy bag and reported changing it daily. The resident's care plan, revised 10/29/23, revealed the resident had a diet order for pleasure eating. -The care plan failed to have a care plan focus to identify the resident's esophageal ostomy bag and implement interventions to manage the discarded food and liquid waste in a sanitary and hygienic manner. D. Staff interviews Licensed practice nurse (LPN) #9 was interviewed on 2/13/24 at 1:59 p.m. LPN #9 said the certified nurse aides (CNA) were supposed to empty Resident #19's discarded food bucket every shift. III. Resident #11 A. Resident status Resident #15, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 CPO, diagnoses included quadriplegia, benign prostatic hyperplasia with lower urinary tract infection and diabetes. The 2/14/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident needed substantial assistance with personal grooming and was dependent on staff to complete most activities of daily living (ADL). The resident did not reject or refuse care. B. Resident interview and observation Resident #11 (who was Resident #19's roommate) was interviewed on 2/15/24 at 10:02 a.m. Resident #11 said the staff did not clean his room regularly and he thought it could be cleaner. He said staff did not clean his table and rarely mopped the floor (see observation of room above under Resident #19). IV. Staff interviews The nursing home administrator (NHA) and CNC #1 were interviewed together on 2/20/24 at 1:37 p.m. The NHA said she was implementing a rounding program where assigned staff would be responsible for bringing building and housekeeping concerns to the NHA and maintenance director's (MTD) attention. The NHA said one of the residents expressed interest in working with the MTD to tour the building and recommend improvement projects including cosmetic upgrades and housekeeping projects. The resident had been tasked with forming a committee of four to five interested residents to work with the MTD on proposing building improvement projects to the maintenance department.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on interviews and record review, the facility failed to ensure one (#4) of three residents out of 29 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to provide a resolution to Resident #4's grievance, which he had communicated to staff on multiple occasions, regarding the resident's missing cigarettes and money. Findings include: I. Facility policy and procedure The Grievances/Complaints, Filing policy, revised April 2017, was provided by corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response. II. Resident #4 A. Resident status Resident #4, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included depression, hypoglycemia (low blood sugar) type one diabetes mellitus, gastroparesis (slowed movement of the stomach), visual loss, need for assistance with personal care, schizophrenia (mental illness), cocaine dependence and heart failure. The 12/27/23 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. He required set-up assistance for eating. He required supervision for oral hygiene, toileting and personal hygiene. He required substantial assistance for showering. He was able to express his ideas and wants. B. Resident interview (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4 was interviewed on 2/13/24 at 12:59 p.m. Resident #4 said he was sent to the emergency room in January 2024 for low blood sugar. Resident #4 said he carried a lanyard around his neck that had a key to his locked dresser. Resident #4 said the staff were aware not to take the lanyard off of him. Resident #4 said when he woke up in the hospital, he realized his lanyard was not around his neck. Resident #4 said when he returned to the facility from the hospital he was missing two packs of cigarettes and $50 from his locked dresser. Resident #4 said he told the previous nursing home administrator (NHA) that he was missing cigarettes and money. Resident #4 said the previous NHA told the resident she was not going to do an investigation of the missing items and would not replace them. Resident #4 said he had notified several other staff members including licensed nurse staff of the missing items and nothing had been done to resolve his concern. C. Record review A request was made for the investigation and grievance regarding Resident #4's missing cigarettes and money. CNC #1 said there was no documentation that an investigation or grievance form had been filled out regarding Resident #4's concerns. III. Staff interviews The social services director (SSD) and the social services assistant (SSA) were interviewed on 2/15/24 at approximately 2:00 p.m. The SSD said anyone could fill out a grievance form. The SSD said the social services department then reviewed and logged the grievance form. The SSD said the form was then given to the department manager it pertained to. The SSD said the department manager was responsible for completing an investigation and developing a resolution alongside the resident. The SSD said the department manager needed to obtain approval from the resident submitting the grievance form and return it to the social services department. The SSD said the grievance form was then approved by the NHA and filed. The SSD said it was the responsibility of the NHA to ensure the resolution on the grievance was acceptable. The SSD and the SSA said they were both new to their positions. The SSD and the SSA said they had briefly heard, in passing, that Resident #4 had concerns regarding missing items. CNC #1 was interviewed on 2/15/24 at 3:27 p.m. CNC #1 said she had reviewed some of the filed grievance forms for the last few months. CNC #1 said the grievance forms did not have appropriate resolutions. CNC #1 said the facility had put a process improvement plan in place but it did not meet the correct criteria and would not be effective. CNC #1 said she would assist the facility in implementing corrective action in order to ensure grievances were addressed appropriately and in a timely manner. CNC #1 said there were no grievance forms regarding Resident #4's missing money and cigarettes. CNC #1 said she replaced the resident's cigarettes and money today (2/15/24).

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F 0677 Level of Harm - 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** 46022 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for one (#15) of four residents reviewed for ADL care assistance out of 29 sample residents. Resident #15 admitted to the facility for long term care on 2/28/22 with diagnoses of depression, quadriplegia (decreased or no movement of all four limbs), neurogenic bowel (decreased bowel movements), neuromuscular dysfunction of bladder (decreased bladder movement) and colostomy status (an opening into the colon from the outside of the body). The resident was dependent on staff for all of his ADLs. The resident expressed not getting out of his wheelchair, not bathing or receiving oral hygiene in weeks and not getting assistance with his meals regularly. The resident felt uncomfortable, itchy and his skin was burning due to not being bathed and wearing the same clothes for days. The resident said his current status affected his state of mind, he was frustrated and did not want to live anymore. Due to the facility's failure to provide adequate assistance to Resident #15 for his ADLs, the resident experienced a decline in his state of mind. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADLs), Supporting policy, revised March 2018, was provided by corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It revealed in pertinent part, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene (bathing, dressing, grooming, and oral care); mobility (transfer and ambulation, including walking); elimination (toileting), dining (meals and snacks); and, communication (speech, language, and any functional communication systems). Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	II. Resident #15 A. Resident status Resident #15, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included sepsis (infection of the blood), urinary tract infection (UTI), depression, quadriplegia (decreased or no movement of all four limbs), neurogenic bowel (decreased bowel movements), neuromuscular dysfunction of bladder (decreased bladder movement) and colostomy status (an opening into the colon from the outside of the body). The 2/10/24 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. Resident #15 was dependent on staff for all ADLs including bathing, personal hygiene and eating. The assessment documented the resident had an indwelling catheter, colostomy, had a UTI within the last 30 days and had septicemia (blood infection). The resident's mood interview revealed the resident scored a 15 on the depression scale indicating the resident was experiencing moderate to severe depression. The interview revealed the resident had little interest or pleasure in doing things; was feeling down, depressed or hopeless; was having trouble falling asleep, staying asleep or sleeping too much; was feeling tired or having little energy; had a poor appetite; was feeling bad about himself; had troubles concentrating; had thoughts he would be better off dead or of hurting himself in some way. The resident did not reject care assistance or present with any behavioral symptoms. The 3/28/23 MDS assessment documented the resident interview for daily preferences indicated it was very important for the resident to choose what to wear; choose between a tub bath, shower, bed bath or sponge bath; choose bedtime; and be able to go outside to get fresh air when the weather was good. B. Resident interview and observation Resident #15 was interviewed on 2/13/24 at 4:07 p.m. Resident #15 said he had a lot of concerns regarding his care. Resident #15 said he refused to go to bed because he was afraid the staff would leave him in bed and he would not have access to his call light for assistance. -During the interview, Resident #15's call light was not within reach. His call light was clipped onto his bedside table. The bedside table was pushed up against his roommate's bed. Resident #15 was unable to get his power wheelchair close enough to the call light to initiate it. Resident #15 had a call light that was activated by the resident blowing into it. Resident #15 said he preferred to stay in his power wheelchair so if he needed help he could use his wheelchair to go down the hallway and find staff. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Resident #15 said he preferred to have showers on Tuesdays, Thursdays and Saturdays before breakfast was served. Resident #15 said he received pain medication around 4:00 a.m. to 5:00 a.m., 12:00 p.m. and in the evening. Resident #15 said he had a lot of pain due to his condition and preferred to have a shower in the morning after his first dose of pain medication because he was in the least amount of pain at that time. -During the interview, Resident #15 had body odor, food on his clothes, his teeth were yellow and he had bad breath. Resident #15 said he often stayed in the same clothes for four to five days at a time. Resident #15 said he was embarrassed and felt like his body and breath smelled bad. Resident #15 said he had a catheter. He said his catheter was not emptied for an extended period of time in January 2024. He said his catheter backed up and soaked all of his clothes. He said because of this, he got a urinary tract infection (UTI) and ended up with sepsis. Resident #15 said he got a wound on his scrotum because of the moisture from the catheter backing up. He said the staff at the facility did not clean his scrotum well which also led to the development of the wound. Resident #15 said when he got to the hospital his clothes were soaked in urine from his shoulders to his toes. Resident #15 said his skin was itchy and dry. Resident #15 said he would ask staff to lotion his hands and feet but they would tell him they were busy. -Resident #15's hands and feet were observed to be dry and flaky. Resident #15's toenails were long and beginning to curl around the tip of his toes. Resident #15 said the staff only assisted him with eating french fries for lunch. -The resident's lunch tray was on his bed that had a sandwich, a glass of milk and a dessert all which were wrapped in plastic wrap. Resident #15 was interviewed again on 2/14/24 at 8:59 a.m. Resident #15 said he refused to shower yesterday (2/13/24) because he was in a lot of pain. Resident #15 said he did refuse care at times because he did not feel the staff knew what they were doing. Resident #15 said he was unsure of the last time he had a shower or had his teeth brushed. Resident #15 was observed to have a one inch hole in the tubing of his catheter. Resident #15 said his body was itching and it felt like his skin was burning because his clothes were so wet due to the hole in his catheter tubing. Resident #15 said when his clothes were wet it caused him to have spasms that caused him to sweat and caused pain. Resident #15 said his clothes were soaking wet. Resident #15 had sweat dripping from his forehead which he said was a symptom of his body spasms. Resident #15 said the care he received affected his state of mind. He said he felt frustrated and did not want to live anymore. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	Resident #15 began crying during the interview. During the interview, Resident #15 continued to have body odor, bad breath and yellowed teeth. Resident #15 had a white build-up around his mouth. He said he was extremely thirsty and starving. Resident #15 said his colostomy was full of gas that morning (2/14/24). Resident #15 said he had not been assisted with his breakfast and he was so hungry his stomach was full of gas. -Resident #15 had a breakfast tray on his bedside table that had half a bagel and two links of sausage. -Resident #15's lunch tray from 2/13/24 remained on his bed. The sandwich and dessert were still wrapped in plastic wrap. Resident #15 said the staff did not assist him with his meal for lunch the previous day (2/13/24). -There was a glass of milk on the resident's table that was room temperature to touch and had a dead fly in it. C. Record review The ADL care plan, initiated on 1/2/23 and revised on 9/26/23, revealed Resident #15 had an ADL self-care performance deficit due to a traumatic spinal cord injury [AGE] years ago resulting in quadriplegia. The interventions included providing the resident with an electric wheelchair for mobility, providing total assistance with bathing, checking and trimming nails as needed, providing total assistance for bed mobility, providing total assistance for dressing, providing total assistance with eating, providing total assistance for personal hygiene and oral care, providing total assistance for toileting, providing total assistance of two staff members and mechanical lift for transfers, providing physical and occupational evaluations as needed and providing a restorative nursing program. The psychosocial care plan, initiated on 9/26/23, revealed Resident #15 had a history of refusing care and services which were within his rights. Resident #15 frequently refused to go to bed and refused care and treatments. Resident #15 frequently attempted to split staff and make false allegations of being denied care. Two staff members should be present when providing care to the resident. The interventions included providing behavioral and psychological services as indicated, collaborating with the interdisciplinary team to identify underlying causes of refusals, determining Resident #15's experiences and preferences to eliminate triggers, encouraging active participation with care, encouraging to set up a schedule for care which was acceptable for him, informing the resident of risks and ramifications of continued non-compliance and re-approaching the resident when he refused care. The 1/15/24 emergency department encounter note documented in pertinent part, The resident had significant skin breakdown around his abdominal wall and his scrotum and was soaked in urine upon arrival. According to the resident and staff interviews, the resident was supposed to be bathed three times per week. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	-However, his bathing day preferences were not indicated in the medical record. The November 2023 shower documentation revealed Resident #15 received a bath on 11/9/23, 11/11/23, 11/16/23 and 11/25/23. -It indicated Resident #15 was provided bathing on four of 13 opportunities. The December 2023 shower documentation revealed Resident #15 received a bath on 12/14/23, 12/16/23, 12/21/23, 12/23/23, 12/28/23 and 12/30/23. -It indicated Resident #15 was provided bathing on six of 13 opportunities. The January 2024 shower documentation revealed Resident #15 received a bath on 1/2/24, 1/6/24 and 1/23/24. -It indicated the resident was provided bathing on three of 12 opportunities. The February 2024 shower documentation revealed Resident #15 received a bath on 2/6/24 and 2/13/24. -It indicated Resident #15 was provided bathing on two of six opportunities. -However, despite the shower records documenting the resident received a bath on 2/13/24, Resident #15 said he refused his shower on 2/13/24 due to pain (see resident interviews above). -Certified nurse aide (CNA) #1 said he did not provide Resident #15 a shower on 2/13/24 because the resident refused. -Review of the resident's medical record revealed there were no progress notes to indicate why the resident refused showers on multiple dates or that the staff had attempted to try at another time to complete the shower when he refused. -The medical record did not reveal the resident preferred to shower prior to breakfast related to his pain levels. III. Staff interviews CNC #1 was interviewed on 2/14/24 at 10:08 a.m. CNC #1 said she had just visited with Resident #15. CNC #1 said Resident #15 had a hole in his catheter tubing and his clothes were soaked in urine. CNC #1 said the staff were replacing the catheter and providing the resident with dry clothing. CNC #1 said she was unsure why CNA #1 documented the resident had a shower yesterday (2/13/24) because it was clear the resident had not had a shower in awhile. CNC #1 said the care Resident #15 received was not acceptable. CNC #1 said the resident had emotional harm and was in distress when she was in his room that morning (2/14/24). (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	CNC #1 said Resident #15 had been admitted to the hospital in January 2024 with sepsis related to a UTI. CNC #1 said the UTI was related to the resident's poor hygiene (cross-reference F690 for catheter care). CNA #1 was interviewed on 2/15/24 at 10:05 a.m. He said there was a piece of paper in the nurses station that had the shower schedule on it. CNA #1 said Resident #15 preferred to have showers on Tuesdays, Thursdays and Saturdays. CNA #1 said he did not give Resident #15 a shower on 2/13/24. CNA #1 said Resident #15 refused his shower and only wanted to be shaved. CNA #1 said he did not remember documenting that he gave Resident #15 a shower on 2/13/24. CNA #1 said Resident #15 refused his shower on 2/13/24 because he was in pain. CNA #1 said he wrote that the resident refused due to pain and put it in a box outside the director of nursing's (DON) office. CNA #1 said he did not talk to the licensed nurse on the unit regarding the resident's shower refusal due to pain. CNC #1 was interviewed again on 2/15/24 at 3:27 p.m. CNC #1 said the staff spoke with Resident #15 regarding his shower time. CNC #1 said it made sense that Resident #15 preferred to have his showers prior to breakfast due to his pain levels. CNC #1 said she would assist the facility in creating new shower preferences for all of the residents who resided at the facility. CNC #1 said there were a lot of holes in Resident #15's shower documentation indicating he missed showers. CNC #1 said some days it was documented that he had several showers. CNC #1 said the staff needed education on proper shower documentation. Cross-reference: F726 for staff competencies. CNC #1 was interviewed again on 2/20/24 at 12:37 p.m. CNC #1 said Resident #15's concerns regarding his care were valid. CNC #1 said she understood why Resident #15 refused care at times. CNC #1 said the facility needed to rebuild rapport with Resident #15 to help reduce his care refusals. CNA #2 was interviewed on 2/20/24 at 1:56 p.m. She said CNAs were responsible for providing oral care to the residents. CNA #2 said oral hygiene should be performed when getting the resident ready for the day and when assisting them to bed.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to ensure one (#4) of three sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan of 29 sample residents. Specifically, the facility failed to provide regular and consistent supervised guidance to assist Resident #4 to make educated decisions on determining an appropriate sliding scale insulin dose based on blood glucose assessment and carbohydrate intake and document those efforts per physician's orders. Findings include: I. Facility policy and procedure The Diabetes-Clinical Protocol, revised November 2020, was provided by the corporate nurse consultant (CNC) #1 on 2/19/24 at 4:30 p.m. It read in pertinent part, The Physician and staff will summarize factors that are contributing to, or conditions that are affected by the residents diabetes or glucose intolerance and will assess the impact of diabetes on the individual's function and quality of life. The Physician will address complications such as dyslipidemia, coronary artery disease, neuropathy, and nephropathy based on the individual's overall condition, prognosis, function, and treatment preferences. Risk of hypoglycemia should be considered in any treatment plan, as it is a significant and high-risk complication of treatment. It may be necessary to accept somewhat higher blood sugars in order to minimize the risk of hypoglycemia. The idea of a diabetic diet is outdated and dietary restriction may be liberalized in most patients. The Physician will order desired parameters for monitoring and reporting information related to blood sugar management: the staff will incorporate such parameters into the Medication Administration Record and care plan. II. Resident #4 A. Resident status Resident #4, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included depression, hypoglycemia (low blood sugar) type one diabetes mellitus, gastroparesis (slowed movement of the stomach), visual loss, cocaine dependence, need for assistance with personal care, schizophrenia (mental illness), cocaine dependence and heart failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/27/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required set-up assistance for eating and supervision assistance with oral hygiene, toileting and personal hygiene. The resident displayed verbally aggressive behaviors and negative behaviors symptoms not directed towards others but the assessment documented that the resident did not reject evaluation of care necessary to achieve the resident's goals for health and wellbeing. B. Resident interview Resident #4 was interviewed on 2/13/24 at 12:59 p.m. He said the food was often served late. He said it was difficult to manage his diabetes since the meals were frequently late. He said the facility did not follow standardized portion sizes. Resident #4 said he was blind so it made it difficult for him to know how many carbohydrates he was consuming when the portion sizes were different each day. Resident #4 said his insulin was often late which caused his blood sugar to drop. He said he had been to the hospital three times related to his blood sugar dropping in the 20-40's. Resident #4 said he did not remember what happened during the three incidents of his blood sugar dropping. He said he woke up in the emergency room when they occurred and was unable to recall. C. Record review A review of the resident's physician's orders revealed the following order for management of diabetes mellitus: Novolog injection solution (insulin aspart), inject subcutaneously, at 7:30 a.m., 11:00 a.m., 4:00 p.m., and 9:00 p.m. as per sliding scale, before meals, for type 1 diabetes mellitus with hyperglycemia. Administer as supervised self-administration. Resident may titrate insulin dosing as requested for carbohydrate counting, do not exceed 12 units. Document in progress note for self titration. If blood glucose (BG) is 0-70 notify provider and initiate hypoglycemic protocol. Inject subcutaneously if BG is 71-149 give 0 units; if 150-199 give 2 units; if 200-249 give 4 units; if 250-299 give 6 units; if 300-349 give 9 units; if 350-399 give 11 units; 400-450 give 12 units. Call physician if BG is greater than 450, ordered date 8/4/23. Insulin glargine subcutaneous solution 100 unit/ml, inject 9 unit subcutaneously in the morning at 8:00 a.m., for type I diabetes mellitus, start date 1/13/24. Insulin glargine subcutaneous solution 100 unit/ml, inject 9 unit subcutaneously one time a day at 5:00 p.m., for type I diabetes mellitus, start date 1/12/24 -A review of progress notes revealed the nursing staff were not documenting the insulin dosage administered or rationale for the dose administered if not in line with the physician's order. -Progress note documentation failed to explain the supervision and guidance efforts of the nurses administering the resident's sliding scale insulin dose or how the dosing was determined based on assessment of the resident's BG level and carbohydrate intake. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-It was unclear if the resident was advised on selecting the proper dosage or if the nursing staff accepted his dosage decision without discussion and appropriate nursing assessment based on the physician order and including an assessment of his daily carbohydrate intake. -A review of the medication administration record (MAR) records revealed insulin administration doses inconsistent with the physician's order for dosing per BG level assessment. A hospital treatment note, dated 8/17/23, revealed Resident #4 was brought to the emergency roiagnom on [DATE]. The note documented in pertinent part, Patient brought in due to altered mental status and agitation. Arriving at the emergency room agitated requiring chemical and mechanical restraints at times. BG (blood glucose) level tested at 44 on arrival. Normalized after starting D5W (dextrose five percent in water intravenous (IV) infusion). Assessment plan continues D5W for now. BG again at 41 this morning 8/16/23; the patient refused juice, D50 (used to treat low BG) given. Hold long acting insulin, continue sliding scale insulin. The patient's evening BG was greater than 400 so restart lantus (long acting insulin. Resume his insulin home regimen at discharge. Diagnosis included infection, thyrotoxicosis (excessive thyroid activity), hypoglycemia (low blood glucose). He does not have thyrotoxicosis with normal free T4 (thyroid level lab), likely secondary to a urinary tract infection and hypoglycemia. Patient was much better today as BG was better and infection being treated. The 8/26/23 hospital progress note documented in pertinent part, the resident presented to the emergency room after emergency services found his blood glucose to be 20. The physician's highest concern was for an inadvertent insulin overdose. The resident was diagnosed with hypoglycemia and a urinary tract infection. The diabetic care plan, initiated on 9/20/23, revealed the resident had type one diabetes mellitus that was managed by insulin and diet. Resident #4 could titrate his insulin dosing as requested for carbohydrate counting. Resident #4 was not to exceed 12 units of insulin per physician order and his history of diabetes. The interventions included administering medications as ordered, educating the resident on medications and potential side effects, referring to nephrology as indicated, allowing Resident #4 to adjust his own insulin needs based on blood sugar levels and food consumed and monitoring the resident's blood sugar before each meal and before bedtime. A progress note dated 12/25/23 read in pertinent part: Patient's BG was 524, patient refusing to allow this nurse to call the provider to request to give insulin of 12 units. Call placed to the provider and awaiting a response. Provider to potentially order additional units. Patient will not allow this nurse to give any insulin, Patient states it will kill him if he takes the required units. Patient was educated on the need to avoid letting BG go any higher; the patient continued to decline medication treatment, awaiting provider call back. A nurse practitioner note, dated 12/26/23, read in pertinent part: Reason for visit: hyperglycemia. Insulin dependent diabetes with hypoglycemia. Patient with hypoglycemic episode this morning, patient negotiated his insulin needs with the nurses as per usual and is now normoglycemic (normal BG). The patient is empirically well versed about his own diabetes condition and insulin sensitivity, allowed to titrate his insulin dosing within orders specified at MAR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/16/24 physician progress note documented in pertinent part, The resident was seen today (1/16/24) and was in no acute distress. The resident was sent out to the emergency department 1/14/24, for a hypoglycemic episode in which he was unconscious. Condition resolved. -Medication orders: 1/16/24, unchanged insulin glargine subcutaneous solution 100 unit/ml. Route: subcutaneously. Inject 9 unit subcutaneously in the morning for type I diabetes mellitus. 8/14/23 unchanged novolog injection solution (insulin aspart). Route: subcutaneously. Inject as per sliding scale, supervised self-administration (see order above). -Resident refuses to allow others to dictate his insulin dosage. Patient continued to have labile (hard to control BG levels characterized by wide variations of highs and lows) BG levels. III. Staff interviews CNC #1 and the nursing home administrator (NHA) were interviewed on 2/15/24 at 11:39 a.m. They said they had received reports that the resident was acting weird. They said they believed the resident was under the influence of methamphetamines and were going to obtain a drug test. The RD and the NSD were interviewed together on 2/15/24 at 11:59 a.m. The RD said Resident #4 did not want nutrition education when it was offered to him previously. The RD was interviewed again on 2/15/24 at 1:23 p.m. The RD said he was unable to find documentation in Resident #4's medical record that diabetic nutrition education had been offered to the resident. The RD said he attempted to provide Resident #4 diet education on 2/15/24 (during the survey process). The RD said the resident was upset regarding the portion sizes at the facility. The RD said Resident #4 said the portion sizes were never consistent which made it difficult to dose his insulin correctly. Cross-reference F691 for nutrition and F803 for portion sizes. CNC #1 was interviewed on 2/20/24 at 12:37 p.m. CNC #1 said diabetic education should have been offered to Resident #4 and documented in his medical record if he refused it. CNC #1 said diabetic education was part of diabetic management. CNC #1 said she was unable to find any information on why Resident #4 was able to titrate his insulin. CNC #1 said that was not within normal standards of practice for a resident to titrate their own insulin. CNC #1 said Resident #4 smoked marijuana, was blind and had other comorbidities that could contribute to Resident #4 not being able to correctly dose his own insulin. CNC #1 said the resident had been to the emergency room multiple times related to low blood sugar.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review, observations and interviews, the facility failed to ensure five residents (#1, #23, #9, #13 and #4) of seven residents received adequate supervision to ensure an environment free from risk of accidents and hazardous situations out of 29 sample residents. Specifically, the facility failed to: -Effectively assess Resident #1's care needs for cognition, employment risk, community safety, substance use disorder, and desire to leave the facility then develop a comprehensive care plan in line with the resident goals that ensure health and safety; -Implement effective interventions to prevent resident #1 from eloping, being unsupervised in an unsafe environment, and becoming a missing person after the resident medical provider identified the resident as being a flight risk and unable to care for himself; -Provide education for all staff on appropriate interventions to protect a resident who was at risk for elopement and unsafe in the community; -Provide Resident #23 adequate supervision, oversight, and assistance while smoking and prevent the resident's smoking behavior from putting other residents at risk of health and safety; -Conduct quarterly assessments of Resident #23's smoking ability for continued supervision needs; -Ensure accurate minimum data set (MDS) assessments for both Resident #1 and #23; -Develop and implement a person-centered care plan that identified Resident #13 and #9's fall risk and put effective interventions into place to reduce falls; -Ensure a registered nurse (RN) assessment was completed and documented following sustained falls by Resident #13; -Ensure neurological checks were completed per stands of practice for Resident #13 and Resident #9; and, -Develop and implement a person-centered care plan that identified Resident #4's substance abuse disorder and put interventions into place. Findings include: I. Facility policy (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Safety and Supervision of Residents policy, revised July 2017, was received on 2/20/24 at 12:20 p.m. from CNC #1. It read in pertinent part: Our facility strives to make the environment as free from accidents hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The risks of environmental hazards include Falls, Smoking, unsafe wandering . II. Missing person A. Facility policy The Wandering and Elopements policy, revised March 2019, was provided on 2/20/24 at 12:10 p.m. by corporate nurse consultant (CNC) #1. It read in pertinent part: The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. Policy Interpretation and Implementation 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the resident from leaving in a courteous manner; b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises. 3. If a resident is missing, initiate the elopement/missing resident emergency procedure: a. Determine if the resident is out on an authorized leave or pass; b. If the resident was not authorized to leave, initiate a search of the building(s) and premises; and c. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and (as necessary) volunteer agencies (emergency management, rescue squads). 4. When the resident returns to the facility, the director of nursing services or charge nurse (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shall: -Examine the resident for injuries; -Complete and file an incident report; and -Document relevant information in the resident's medical record. The Emergency Procedure- Missing Resident policy, revised August 2018, was provided on 2/20/24 at 12:10 p.m. by CNC #1. It read in pertinent part: Resident elopement resulting in a missing resident is considered a facility emergency. Policy interpretation and implementation 1. Residents at risk for wandering and/or elopement will be monitored and staff will take necessary precautions to ensure their safety. 2. Staff will implement the protocol for missing residents immediately upon discovering that a resident cannot be located. -Neither policy above provided staff any guidance on how to respond to a vulnerable resident when the resident was found and refused or when returned to the facility. Additionally, there was no procedure for training staff particularly non-nursing staff or staff not familiar with a resident on what residents were at risk for elopement and needed staff ongoing monitoring when the resident was in the community and was refusing to return to the safety of the facility. B. Resident #1 1. Resident status Resident #1 under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included a history of substance use disorder, encephalopathy (a condition that causes brain dysfunction that can appear as confusion, memory loss, and personality change most often caused by infection, exposure to toxins or other underlying condition), anoxic (lack of oxygen) and brain injury due to cardiac arrest. According to the 12/15/23 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of six out of 15. The assessment documented that the resident did not present with wandering behavior. 2. Resident interview Resident #1 was interviewed on 2/14/24 at 10:33 p.m. Resident #1 said he was bored in the facility and was not sure why he was there. He said he was used to being homeless and used to hang out in the back of a local fast-food restaurant where the manager used to let him sleep and give him food. Resident #1 said his family put him in the facility and he did not understand that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A social services note dated 11/24/23 documented that the resident told the social services director (SSD) I'm trying to get out of here, how do I do that. The SSD educated this resident on the discharge planning process. The resident responded, Well I'm trying to get out of here, like now. The SSD asked the resident where he would go. The resident responded, Well I'm homeless, I'm just going to go and be homeless, like that's fine. The SSD educated this resident on the risks vs benefits of discharging back out to the streets without proper housing. The resident stated, No it's fine. I just need to find my body, like I don't even know where I am right now. The SSD educated this resident on where the facility was located. The resident was very confused during the conversation with the SSD and struggled with understanding that he had been placed at a nursing facility. The resident continued to talk about leaving. The SSD educated this resident on discharging against medical advice and what that entailed. The resident expressed his understanding. The resident agreed that at this time he would not make any attempts to leave. -There was no documentation that the resident responsible party was notified about his expressions to leave the facility or his confusion about the above discussion on the risk of living in the streets given his impaired cognition and the events that led him to his admission to a long-term care facility. There was no documentation that the resident was assessed for elopement risk, community safety or further consideration for how to maintain his safety given his lack of capacity for decision-making (see 10/11/23 hospital note above). Provider notes dated 11/24/23, 11/27/23, 11/30/23, 12/4/23 and 12/5/23 documented the same concern that the resident was a flight risk as was documented in the 11/21/23 provider medical exam note (see above). A social services note dated 12/1/23 revealed that the social services assistant (SSA) informed the SSD that Resident #1 had his belongings packed and stated he was going to leave. The SSD spoke to the resident and asked where he was going; the resident stated (the location where he spent when homeless). The SSD asked the resident if there was a specific place at that location where he was going, the resident stated, No, that's just where I'm going; I'm homeless and I stay over there. The SSD asked this resident how he was going to get there. He responded, I'm going to walk. The SSD asked this resident if he knew how far it was, and the resident stated, It's just up the street. The SSD informed the resident that it was a very far walk from here and that it was unsafe for him to walk that far. The resident responded, Well I can't stay here, I Need to leave. The SSD asked this resident where he was going. The resident stated, I have to go find a job. The nursing home administrator (NHA) approached at this time, and the SSD and the NHA discussed with this resident finding a job at the facility. The NHA was able to walk this resident back to his room and discuss further options for working at the facility. The resident was placed on 15-minute checks. The registered nurse (RN) on duty informed. -There was no documentation that the resident responsible party was notified or consulted about the resident's continued desire to leave the facility against medical advice. Nurse note dated 12/6/23 at 12:30 p.m. documented: Resident was last seen in his bed this morning at around 7:00 a.m. He appeared to be sleeping. A few hours later I was looking for the resident to give him his medications and could not find him. Housekeeping told me she had seen him take his things and leave the building approximately 45 minutes earlier. after searching for the resident the ADON (assistant director of nursing) was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 12/6/23 at 4:17 p.m. read in pertinent part: At 11:00 a.m., SSD notified that the resident was not in the facility and was at a bus stop nearby. The transportation coordinator drove to the bus stop to get this resident and bring him back to the facility, resident adamantly refused to return at this time. The transportation coordinator informed SSD that the resident was refusing to return. The leadership members were notified (none of whom were still employed in the facility). SSD went to meet with this resident at the bus stop, but by the time SSD arrived resident was no longer there. SSD and the transportation coordinator drove up and down (street name) looking for this resident, but he was unable to be found. SSD filed a missing person report with the police department. -At 4:00 p.m. the SSD was informed that the resident was seen in a grocery store (approximately 430 miles from the facility). The police were notified for assistance to bring the resident back to the facility. Hospital treatment notes dated 12/8/23 documented Resident #1 presenting via emergency medical services (EMS) after a bystander called for (due to the resident presenting with) altered mentation (mental status). The resident was reportedly drinking alcohol outside of a grocery store with his friends when a bystander called. On exam here, the resident was clinically intoxicated with slurred speech, and ethanol odor on breath. Vital signs were normal on room air. Ambulation trial unsuccessful. The resident will require time to sober. -The hospital emergency room notes revealed the hospital personnel, based on the resident interview and the circumstance of the resident's admission believed the resident had been discharged from a rehab facility four months prior and was homeless at the time of admission (12/8/23). Following treatment, on 12/9/23, the hospital social worker not knowing the resident was currently living in a long-term care facility called a rideshare cab for the resident to drive the resident to his family home. The resident failed to show up for the arranged ride. The resident was readmitted on [DATE]. Hospital emergency room notes dated 12/10/23 documented: Patient is presenting for the second time in the past 10 hours, this time due to social work issues and back pain. The patient was admitted in November at (facility name) long-term care facility, but he reports that he left later that month because he thought he was discharged . He states that he has not eaten anything in the past few days, but has been drinking alcohol. Per EMS, the patient was found on the ground of a parking lot at a grocery store with alcohol found on the scene. The patient presents in a typical fashion with alcohol intoxication. He has slurred speech. He is willing to remain here until sober. The patient was able to ambulate with a somewhat unsteady gait. However, the patient uses a walker at baseline. The patient left his walker where he was found outside of the grocery store today. Will place an order to get the patient a new walker before discharge. Patient has no other acute complaints at this time other than chronic left hip pain associated with a fall 8 days ago. Patient has been evaluated for this multiple times with no evidence of fracture or other injury). (The resident) said he had nowhere to go and would sleep next to a dumpster. The resident was seen in the emergency room and evaluated by me for alcohol intoxication. The patient's ethanol blood lab test (collected 12/10/23) results revealed the resident's blood alcohol level/count (BAC) of 0.08 percent at 211 milligrams (mg) per deciliter (dL); a normal level should be less than 10 mg/dL. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A blood alcohol level of 200mg/dL, may cause a person to experience blackouts. A hospital note dated 12/11/23 documented the SW (social worker) consulted for homelessness. SW completed a chart review and saw that the patient was placed in an LTC (long-term care) facility on 11/17/23 following an inpatient stay. The patient states his back is hurting and he has been hanging out at a local restaurant where 'the manager takes care of me and lets me eat for free'. SW asked the patient about the nursing facility and he was not sure if he had ever been there. The patient states he knows he fell and he doesn't remember a lot of things. The patient confirmed he would like to be in a nursing facility as he cannot care for himself. SW placed a phone call to the facility and spoke with a registered nurse (RN). The RN confirmed the patient had been residing there and reported that 'he escaped' on the morning of 12/6/23. The RN was not able to speak to the patient's ability to return to the facility and asked that we call back in the morning to speak with SW and the administrator at the facility. Following treatment, the resident was discharged on [DATE] back to the facility. Provider note dated 12/12/23 documented that Resident #1 was seen in the facility for readmission after leaving the facility against medical advice and was now returned to the facility by the police on 12/12/23. Patient has persistent memory impairment; he vaguely remembers leaving the facility but does remember having his 'trophies' confiscated on the way back in. His only complaint today is chronic back pain and feeling tired. -Impaired long and short-term memory.since/due to anoxic brain injury he cannot remember to follow instructions. -The resident's medical record failed to show documented proof that the interdisciplinary team (IDT) assessed the resident's care needs and developed appropriate interventions to ensure the reading's health and well-being following the resident's elopement and being missing with whereabouts unknown to the facility for four days. There was no documentation to show that the IDT conducted a full assessment of the resident's needs, particularly around elopement behavior; community safety; inability to make safe; and sound decisions related to cognition; substance use disorder; and an expressed desire to return to homelessness. -A review of the resident's comprehensive care plan initiated 12/23/23 and reviewed 1/5/23, revealed the facility failed to develop a care plan focus/concern to address the resident's elopement behavior and failed to have a care plan focus/concern to address the resident's cognitive deficits; poor short and long-term memory deficits; poor safety awareness; and assessed lack of capacity for decision making. The care plan did not have a care focus for the resident substance use disorder. The NHA and SSD were interviewed on 2/14/24 at 10:33 a.m. Neither the NHA who had been employed for only three days and the SSD who had been employed for the past six weeks were aware of the incident involving the resident's elopement and status as a missing person but said they would look into the incident. The maintenance director (MTD) was interviewed on 2/14/24 at 12:05 p.m. THE MTD said he was repairing the front door the day Resident #1 eloped and saw the resident leave but at the time he was unaware that Resident #1 was even a resident of the facility so he did not know there was a concern for the resident's well-being. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MTD said non-nursing staff were provided basic training upon hire about resident elopement and procedures for assisting in a search for missing residents; however non-nursing staff did not given information on any specific resident who was assessed to be an elopement risk so they often did not know which resident should not be leaving the building unaccompanied by a staff member. Receptionist (REC) #1 was interviewed on 2/14/24 at 2:08 p.m. REC #1 said the elopement binder was the facility guide to who was at risk for elopement but the binder was not up to date with resident and current information. The plan was to get the binder updated this week. REC #1 said she was not sure what information was missing from the binder. Three of the four residents included in the elopement binder were documented to have a wander guard. REC #1 said the facility did not currently have wander guards and none of the residents in the binder had an active wander guard. -A review of the binder revealed that Resident #1 was not included in the binder as being at risk for elopement. Licensed practical nurse (LPN) #9 was interviewed on 2/13/24 at 11:33 a.m. LPN #9 said she was agency staff she worked in the building on occasion and she was not aware that Resident #1 eloped from the building and was a flight risk. CNC #1 was interviewed on 2/20/24 at 10:48 a.m. CNC #1 said the facility did not have a record of investigating Resident #1's elopement and it was not care planned. CNC #1 said the facility did not have a record of elopement training for non-nursing staff. III. Resident needing supervision smoking in the facility A. Facility policy The Smoking policy, revised October 2023, was received on 2/20/24 at 12:20 p.m. from CNC #1. It read in pertinent part: Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated smoking areas, which are located outside the building. Smoking is not allowed inside the facility under any circumstance. Resident smoking status is evaluated upon admission. -A resident's ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive). -Any smoking-related privileges, restrictions, and concerns (for example, the need for close monitoring) are noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. -Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. -Staff members and volunteer workers are not permitted to purchase and/or provide any smoking items for residents. -This facility maintains the right to confiscate smoking items found in violation of our smoking policies. Confiscated resident property is itemized and ultimately returned to the resident, or his or her legal representative. B. Resident #23 1. Resident status Resident #23, under the age of 65, was admitted on [DATE]. According to the February 2024 CPO, diagnoses included multiple sclerosis, dementia with behavioral disturbance, bipolar disorder and tobacco use. According to the 1/31/24 MDS assessment, the resident had continuous difficulty focusing attention, for example, being easily distracted or having difficulty keeping track of what was being said. The resident's BIMS was not assessed through resident participation nor did the staff provide an assessment of the resident's cognitive status. The assessment documents the resident displayed verbal behavioral symptoms directed toward others but did not reject evaluation or care. The assessment documented the resident had lower extremity (hip, knee, ankle and foot) impairment on both sides and used a manual wheelchair to get around. Functional ability otherwise was not assessed. The 10/31/23 MDS assessment document that the resident was assessed has moderately impaired cognition with a BIMS exam score of 12 out of 15 and no negative behavioral expressions. 2. Resident interview Resident #23 was interviewed on 2/19/24 at 2:30 p.m. Resident #23 said was upset with the staff because she wanted to go out and smoke and did not feel the staff took her out as often as they should. 3. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident's care plan, last reviewed on 10/5/23, documented that the resident required staff supervision and a smoking apron while smoking. The goal of the care focus was to reduce the risk of the resident being injured from unsafe smoking practices. Interventions included: -Inform resident #23 about smoking risks and the benefits of smoking cessation aids, initiated 12/8/22; -Instruct and inform Resident #23 about the facility policy on smoking: locations, times, safety concerns; and any changes, revised 3/3/18; -Monitor the resident for any unsafe smoking practices. Observe clothing and skin for signs of cigarette burns initiated 4/24/15; -Provide staff supervision and a smoking apron while the resident was smoking, revised 3/3/18. -Provide the required adaptive equipment (cigarette extender) while smoking, revised on 2/18/23; -Notify the charge nurse immediately if Resident #23 was suspected of violating the facility's smoking policy, revised 3/3/18; -Re-evaluate Resident #23 for safe smoking abilities on a quarterly and as-needed basis, making changes to the care plan, as needed, revised 8/22/18, and, -Staff were to light and extinguish the resident's cigarettes at the assigned smoking time, revised 2/18/23. The most recent smoking assessment dated [DATE] documented, the resident was an unsafe smoker and must be supervised at all times when smoking. The assessor commented the resident required staff supervision due to an inability to light her own cigarettes; handle lit cigarettes securely and safely; and was not able to prevent ashes or lit material from falling onto herself while smoking and inhaling or while holding smoking items. The resident was not able to independently or safely get all ashes into an ashtray or extinguish cigarettes [NAME] and completely after smoking. The resident did not keep a lighter under her control/possession. The assessment documented the resident has oxygen awareness and understood why oxygen must always be turned off and removed before lighting cigarettes and removed oxygen and left the tank and tubing in the facility's designated area at least 20 feet away prior to entering the smoking area. The assessment documented that the resident did not endanger others while smoking. -The facility failed to conduct regular quarterly smoking assessments in order to ensure the resident was complying with smoking safety and that care-panned interventions continued to be appropriate. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated 1/25/24 at 2:45 a.m. revealed Resident #23 was found smoking in her room while wearing oxygen. Four smoked cigarettes and ashes were also found on the floor. Cigarettes and lighter were removed from the resident's room and placed in the nurse's station for safety. The resident was very upset, calling staff names and using foul language. The resident called the police because her cigarettes were taken from her and she did not want to be at the facility any longer. The police talked with the resident about the dangers of smoking while wearing oxygen and smoking inside the facility. The resident calmed down after speaking with the police. A psychiatric visit note dated 1/30/24 documented the resident was seen for treatment of psychiatric symptoms. The resident's medical record revealed the resident was presented with a host of behaviors since the last psychiatric visit including smoking in her room and flying into rage when staff intervened (see note above). The resident had impaired judgment. The resident was seen and consented to meet and was very cooperative. -The resident's medical record failed to document evidence that the IDT assessed the resident's unsafe behavior and care plan to ensure the interventions were appropriate to ensure the resident's safety and the safety of other residents in the facility. 4. Interviews Resident #8 was interviewed on 2/14/24 at 2:17 p.m. Resident #8 said in late January 2024 she was awakened by the smell of cigarette smoke finding her roommate smoking cigarettes inside of the room. Resident #8 said the smoke was making her cough and feel short of breath. Resident #8 said she had respiratory issues and was using oxygen at the time. Resident #8 said she was very worried for her safety because the room was filled with smoke and she was unable to catch her breath. Resident #8 was worried about the risk of fire due to the smoke and oxygen being in use. Resident #8 said she activated her call light immediately upon waking and realizing what was happening. It took staff 20 minutes for staff to respond to the call light. Resident #8 said staff responded and told Resident #23 that smoking was not allowed inside of the facility and took her cigarettes away, Resident #8 said the entire incident made her unsafe. Licensed practical nurse (LPN) #7 was interviewed on 2/20/24 at 10:35 a.m. LPN #7 said he had heard about Ressidnet #23 smoking in her room. LPN #7 said he did not know how Resident #23 got the lighter and cigarettes since she was to be supervised while smoking and her cigarettes and lighter were supposed to be locked up and provided to her in the presence of staff for supervision purposes. LPN #7 said that residents who required staff to assist and supervise them while smoking should only be provided one cigarette at a time and the remaining unsmoked cigarettes were to be locked up for safekeeping between allowed smoking times. LPN #7 said he was agency staff and did not know who was responsible for completing smoking reassessments or how other residents were reassessed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA and CNC #1 were interviewed on 2/20/24 at 10:48 a.m. The NHA who had only been employed by the facility for the past 10 days was unaware of the incident where the resident was found smoking inside of the facility but was concerned due to hearing additional reports that this might not be an isolated incident and that other residents may also be smoking unsafely inside and outside of the facility. The NHA said she was unable to find any documentation of the incident or that previous administration had investigated how the resident obtained the cigarettes and lighter and why the resident was able to smoke four cigarettes before staff intervened, but said the residents' smoking activities needed further investigation. CNC #1 said the newly hired leadership team (the NHA, the DON, and the corporate consultation team) discussed resident smoking practices and determined the facility needed to develop and implement a new smoking policy and procedures for assessing each resident's smoking ability followed by a comprehensive review of the residents who smoked care plans to ensure appropriate interventions were in place and ensure all residents smoker and nonsmoker were safe while in the present of a resident who participates in smoking activities. CNC #1 said the facility hired a security guard who would be involved in helping to identify and report unsafe mocking practices and concerns for the leadership team to track, trend and gain better control over. CNC #1 said many of the residents were able to go out into the community and bring back cigarettes and lighters. Sometimes these items get into the hands of residents who need supervision with smoking without staff awareness. This was challenging because[TRUNCATED]

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews and record review the facility failed to consistently provide catheter care, treatment and services to minimize the risk of urinary tract infections for two (#15 and #11) of three residents reviewed for catheter care out of 29 sample residents. Resident #15 admitted to the facility for long term care on 2/28/22 with a diagnosis of depression, quadriplegia (decreased or no movement of all four limbs), neurogenic bowel (decreased bowel movements), neuromuscular dysfunction of bladder (decreased bladder movement) and colostomy status (an opening into the colon from the outside of the body). The facility failed to provide the resident with catheter care per standards of practice, which resulted in Resident #15 being admitted to the hospital on 1/14/24 and diagnosed with severe sepsis (blood infection) related to a catheter associated urinary tract infection (CAUTI). The hospital paperwork documented the CAUTI was related to poor hygiene and catheter care. The hospital paperwork documented the resident was soaked in urine upon arrival to the emergency department. The resident had a large sacral decubitus ulcer and cellulitis of the scrotum likely associated with poor hygiene. The resident was started on intravenous (IV) antibiotics. The resident was readmitted to the facility on [DATE] and continued on IV Meropenem (an antibiotic medication) until 2/5/24. Additionally, the facility failed to provide consistent catheter care for Resident #11. Cross-referenced to F880 failure to use aseptic technique while replacing a suprapubic catheter and F726 failure to ensure sufficient competent nursing staff. Findings include: I. Professional reference According to the Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for Prevention of Catheter-Associated Urinary Tract Infections, 6/6/19), retrieved on 3/1/24 from https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines-H.pdf, Proper Techniques for Urinary Catheter Maintenance: Following aseptic insertion of the urinary catheter, maintain a closed drainage system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. Consider using urinary catheter systems with preconnected, sealed catheter-tubing junctions. Maintain unobstructed urine flow. Keep the catheter and collecting tube free from kinking. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Empty the collecting bag regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container. Use Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Routine hygiene is appropriate. If obstruction is anticipated, closed continuous irrigation is suggested to prevent obstruction.I. Professional reference According to the Healthcare Infection Control Practices Advisory Committee (HICPAC), Guideline for Prevention of Catheter-Associated Urinary Tract Infections, 6/6/19), retrieved on 3/1/24 from https://www.cdc.gov/infectioncontrol/pdf/guidelines/cauti-guidelines-H.pdf, Proper Techniques for Urinary Catheter Maintenance: Following aseptic insertion of the urinary catheter, maintain a closed drainage system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment. Consider using urinary catheter systems with preconnected, sealed catheter-tubing junctions. Maintain unobstructed urine flow. Keep the catheter and collecting tube free from kinking. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. Empty the collecting bag regularly using a separate, clean collecting container for each patient; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container. Use Standard Precautions, including the use of gloves and gown as appropriate, during any manipulation of the catheter or collecting system. Change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Routine hygiene is appropriate. If obstruction is anticipated, closed continuous irrigation is suggested to prevent obstruction. II. Facility policy and procedure (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The Catheter Care, Urinary policy, revised August 2022, was provided by the corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Empty the collection bag at least every eight hours using a separate, clean collection container for each resident. Avoid splashing, and prevent contact of the drainage spigot with the nonsterile container. III. Resident #15 A. Resident status Resident #15, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included sepsis (infection of the blood), urinary tract infection (UTI), depression, quadriplegia, neurogenic bladder (slow movement of the bladder), neuromuscular dysfunction of bladder and colostomy status. The 2/10/24 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. He was dependent on staff for all activities of daily living (ADLs). The MDS assessment documented the resident had an indwelling catheter, had a UTI within the last 30 days and had septicemia (blood infection). B. Resident interview and observations Resident #15 was interviewed on 2/13/24 at 4:07 p.m. Resident #15 said he had a catheter. He said his catheter was not emptied for an extended period of time in January 2024. He said his catheter backed up and soaked all of his clothes. He said because of this he got a UTI and ended up with sepsis. Resident #15 said he also got a wound on his scrotum because of the moisture from the catheter backing up. He said the staff at the facility did not clean his scrotum well, which also led to the development of the wound. At 5:20 p.m. Resident #15's catheter bag was hanging over the edge of his electric wheelchair. The catheter bag was three-fourths full of urine. The resident did not have a leg anchor to attach the catheter bag to his leg to alleviate the catheter from pulling. Resident #15 said the facility did not provide him with leg anchors which caused a pulling sensation on his bladder. He said it hurt when the catheter bag was pulled. He said he had a midline IV access site on his arm that was no longer in use. Resident #15 said he was on IV antibiotics after being in the hospital in January 2024. Resident #15 was interviewed again on 2/14/24 at 8:59 a.m. Resident #15 said he refused to shower yesterday (2/13/24) because he was in a lot of pain. He said he did refuse care at times because he did not feel the staff knew what they were doing. Resident #15 said he would refuse to go to bed because he was afraid the staff would leave him in bed and he would not have access to his call light for assistance. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Resident #15's call light was not within reach during the interview. His call light was clipped onto his bedside table which was pushed up against his roommate's bed. Resident #15 was unable to get his power wheelchair close enough to the call light to initiate it. Because of his quadriplegia, Resident #15's call light was initiated by him blowing into it. Resident #15 said he preferred to stay in his power wheelchair, so if he needed help he could use his wheelchair to go down the hallway and find staff. Resident #15 said when his clothes were wet it caused him to have spasms that caused him to sweat and caused pain. He said his clothes were soaking wet. Resident #15 had a one inch hole in the tubing of his catheter. Resident #15 said his body was itching and it felt like his skin was burning because his clothes were so wet. C. Record review The urinary care plan, initiated on 1/2/23 and revised on 1/5/23, revealed Resident #15 had a suprapubic catheter due to his diagnosis of a neurogenic bladder. The interventions included: providing the resident with a 24 French suprapubic catheter, positioning the catheter bag and tubing below the level of the bladder, changing the catheter as needed for displacement, infection and obstruction, checking the tubing for kinks when providing care to the resident and each shift, monitoring and documenting signs of pain or discomfort due to the catheter and monitoring and recording and reporting signs or symptoms of a UTI to the physician. The February 2024 CPO revealed Resident #15 had the following physician orders related to his catheter: -Suprapubic catheter size French #24/30 milliliters (ml) balloon. Monitor every shift for placement and functioning. Change as needed if dislodged, leaking or plugged, ordered 10/4/23; -Change suprapubic catheter 24 French, 10 cubic centimeter (CC) bulb attached to gravity drainage bag as needed for being pulled out, leaking or plugged, ordered 6/12/23; -Flush suprapubic catheter with 60 ml of normal saline at bedtime every Friday for patency, ordered 12/22/23; and, -Exchange suprapubic catheter immediately for infection, ordered 2/14/24. The 1/15/24 emergency department encounter note documented in pertinent part, The resident had significant skin breakdown around his abdominal wall and his scrotum and was soaked in urine upon arrival. The 1/15/24 infectious disease hospital note documented in pertinent part, The resident presented to have purulence (pus) around the suprapublic site. The 1/16/24 hospitalist progress note documented in pertinent part, The resident had likely recurrent CAUTI related to poor hygiene and catheter care. The resident had scrotal cellulitis and his urine was growing mixed flora (an unusual growth of multiple types of bacteria). (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The 1/17/24 inpatient hospital pain progress note documented in pertinent part, Resident #15 arrived at the emergency department and was found to be tachycardic (rapid heart rate), tachypneic (rapid breathing), febrile (fever) with an elevated white blood cell and lactate meeting systematic inflammatory response syndrome (SIRS) (an exaggerated defense response from your body to a harmful stressor) criteria. The patient had a large sacral decubitus (open wound) ulcer and cellulitis (infection of the skin) of his scrotum likely associated with poor hygiene. IV antibiotics were initiated. IV. Resident #11 A Resident status Resident #11, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 CPO diagnosis included quadriplegia, neuromuscular neurogenic dysfunction of the bladder (lack of bladder control), overactive bladder, benign prostatic hyperplasia with lower urinary tract infection and diabetes. The 2/14/24 MDS assessment revealed the resident was cognitively intact with a BIMS with a score of 15 out of 15. The resident had impaired functional ability on both sides of the upper (shoulders, elbows, wrists and hands) and lower (hips, knees, ankles and feet) extremities due to quadriplegia and used a motorized wheelchair to get around. The resident needed substantial assistance with personal grooming and was dependent on staff to complete most ADLs. The resident did not reject or refuse care. The resident had an indwelling catheter (suprapubic catheter). B. Resident interview and observation Resident #11 was interviewed on 2/15/24 at 10:02 a.m. Resident #11 said the staff did not check on his catheter regularly to empty his leg drainage bag when it was full. He said he usually had to ask staff to empty the bag unless it was bedtime and staff emptied the bag to change it over to the larger overnight bag. -At the time of the interview, the resident's urine drainage bag was more than two-thirds full and bulging with dark amber urine. Resident #11 was interviewed on 2/15/24 at 1:33 p.m. Resident #11 said staff had not emptied his drainage bag today (2/15/24) and the floor nurse had not checked his suprapubic stoma (insertion site) since yesterday (2/14/24). Resident #11 said he was experiencing some abdominal discomfort. -At the time of the interview, the resident's urine drainage bag was full almost to the section of the bag where the tubing entered the ag. The drainage bag was bulging with amber-colored urine. Resident #11 said the nurses were supposed to irrigate his suprapubic catheter twice a day and he was lucky if they irrigated the catheter once a day. C. Record review The February 2024 CPO revealed the following physician orders related to Resident #11's suprapubic catheter: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-Irrigate the suprapubic catheter twice a day with sterile water at 7:00 a.m. and bedtime, start date 9/11/23; and, -Suprapubic catheter #24 French with a 5 cubic centimeters (cc) bulb, drain to a gravity drainage bag. Monitor placement and patency during and after care every shift (6:00 a.m., 2:00 p.m. and 10:00 p.m.) every shift., start date 5/23/23. Review of Resident #11's December 2023 treatment administration records (TAR) revealed irrigation of the resident's suprapubic catheter was not completed on the following dates: -12/27/23 at 7:00 a.m.; and, -At bedtime on 12/9/23, 12/10/23, 12/17/23, 12/21/23, 12/22/23, 12/23/23, 12/26/23 and 12/31/23. Review of Resident #11's January 2024 treatment TAR revealed irrigation of the resident's suprapubic catheter was not completed on the following dates: -1/18/24 at 7:00 a.m.; and, -At bedtime on 1/21/24, 1/27/24 and 1/28/24. Review of the December 2023 TAR revealed monitoring for placement and patency of Resident #11's suprapubic catheter was not completed on the following dates: -12/27/23 at 6:00 a.m.; and, -12/9/23, 12/10/23, 12/17/23, 12/21/23, 12/22/23, 12/23/23, 12/26/23 and 12/31/23 at 2:00 p.m. Review of the January 2024 TAR revealed monitoring for placement and patency of Resident #11's suprapubic catheter was not completed on the following dates: -1/18/24 at 6:00 a.m.; -1/21/24 and 1/27/24 at 2:00 p.m.; and, -1/21/24 at 10:00 p.m. -A review of the medical record revealed no documentation of why the treatments were not provided. Progress notes revealed the resident had complications with the resident's catheter being dislodged. The condition was discovered on 12/11/23 during the scheduled order for the nurse to monitor the catheter for placement. The comprehensive care plan, revised on 10/13/23, revealed a care focus on managing the resident's suprapubic catheter with the goal of ensuring that the resident remained free from catheter-related trauma. Interventions included providing catheter care every shift, monitoring, documenting and reporting signs and symptoms of urinary tract infection. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-There were no interventions to address the physician's order to irrigate the resident catheter. V. Staff interviews Registered nurse (RN) #1 was interviewed on 2/14/24 at 9:59 a.m. RN #1 said Resident #15 had a catheter. RN #1 said the certified nurse aides (CNA) were responsible for emptying the resident's catheter bag when needed. RN #1 said he observed Resident #15's catheter around 7:30 a.m. on 2/14/24 and did not notice any abnormalities. RN #1 said he did not empty the catheter bag at that time and noted it to have approximately 350 ml of urine in it. CNC #1 was interviewed on 2/14/24 at 10:08 a.m. CNC #1 said she had just visited with Resident #15. CNC #1 said Resident #15 had a hole in his catheter tubing and his clothes were soaked in urine. CNC #1 said the staff were replacing the catheter and providing the resident dry clothing. CNC #1 said Resident #15 needed a shower as it appeared he had not had one in a while. CNC #1 said the care Resident #15 received was not acceptable. CNC #1 said the resident had emotional harm and was in distress when she was in his room that morning. CNC #1 said Resident #15 had been admitted to the hospital in January 2024 with sepsis related to a UTI. RN #1 was interviewed again on 2/14/24 at 2:59 p.m. He said hand hygiene should be performed prior to catheter care. He said it was important to wear gloves. RN #1 said the first step to performing catheter care was assessing the resident's blood pressure and the output of the catheter. RN #1 said he would then gently remove the catheter. RN #1 said he would then dispose of the old catheter, take off his gloves, perform hand hygiene and put new gloves on. RN #1 said he then cleaned the area and lubricated the area. RN #1 said he would then insert the catheter and inflate the balloon based on the physician's orders. RN #1 said he would then gently tug on the catheter to ensure it was patent. RN #1 said he would ensure the catheter was draining. RN #1 said he would then remove his gloves and perform hand hygiene. Cross-reference F880 due the catheter care not being completed in a sanitary manner and F726 for competent nursing staff. CNC #1 was interviewed again on 2/15/24 at 3:27 p.m. She said catheter bags needed to be emptied once a shift or as needed. CNC #1 said the nurse should visually look at the catheter every shift to ensure it was functioning properly. CNC #1 was interviewed again on 2/20/24 at 12:37 p.m. CNC #1 said Resident #15's concerns regarding his care were valid. CNC #1 said she understood why Resident #15 refused care at times. CNC #1 said the facility needed to rebuild rapport with Resident #15 to help reduce his care refusals. 41032

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services 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 ensure that residents who require colostomy services receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. for two (#15 and #11) of two residents reviewed for colostomy care out of 29 sample residents. Specifically, the facility failed to ensure Resident #15's and Resident #11's colostomy bags were maintained per physician's guidance and professional standards of practice. Findings include: I. Professional reference The American Cancer Society's Caring for a Urostomy (10/16/19), retrieved on 2/27/24 from https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/urostomy/management.html, read in pertinent part, During the day most people need to empty the pouch about as often as they used the bathroom before they had urostomy surgery or other bladder problems-for many people, this might mean every 2 (two) to 4 (four) hours, or more often if you drink a lot of fluids. Different pouching systems are made to last different lengths of time. Some are changed every day, some every 3 (three) days or so, and some just once a week. It depends on the type of pouch you use. Your pouch should be changed on a schedule that fits your routine. And it's best to have a regular changing schedule so problems don't develop. In other words, don't wait for it to leak to change it. Before changing your pouch, clean your hands well and put all your supplies on a clean surface. Clean pouches decrease the chances of germs (bacteria) getting into your urinary system. Bacteria can multiply quickly even in the tiniest drop of urine. These germs may travel up the ureters and cause a kidney infection. Bacteria can also cause foul-smelling urine. II. Facility policy and procedure The Colostomy/Ileostomy Care policy, revised October 2010, was provided by the corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, The purpose of this procedure is to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. The following information should be recorded in the resident's medical record: the date and time the colostomy/ileostomy care was provided, the name and title of the individual(s) who provided the colostomy/ileostomy care, any breaks in the resident's skin, signs of infection, or excoriation of the skin, how the resident tolerated the procedure, if the resident refused the procedure, the reason(s) why and the intervention taken and the signature and title of the person recording the data. III. Resident #15 (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Resident status Resident #15, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO) diagnoses included sepsis (infection of the blood), urinary tract infection (UTI), depression, quadriplegia (decreased or no movement of all four limbs), neurogenic bowel (decreased bowel movements), neuromuscular dysfunction of bladder (decreased bladder movement) and colostomy status (an opening into the colon from the outside of the body). The 2/10/24 minimum date set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #15 was dependent on staff for all ADLs. The MDS documented the resident had an indwelling catheter, had a UTI within the last 30 days and had septicemia (blood infection). B. Observations and resident interview Resident #15 was interviewed on 2/13/23 at 4:07 p.m. Resident #15 said he had a colostomy. Resident #15 said his colostomy bag was often full of gas and would explode. He said the staff did not assist him with burping his colostomy to release some of the gas that built up inside of it. At 5:20 p.m. Resident #15's colostomy bag was fully inflated. There was a small amount of stool in the bottom of the bag and the rest of the bag was full of gas. Resident #15 said he often had to ask staff to assist him with his colostomy care because he was afraid of it exploding. Resident #15 was interviewed again on 2/14/24 at 8:59 a.m. Resident #15 said he had a lot of gas in his colostomy bag. His colostomy bag was full of gas and fully inflated. C. Record review The colostomy care plan, initiated on 1/5/23, revealed Resident #15 had a colostomy. The interventions included utilize colostomy supplies specific to Resident #15's needs, maintaining intact peristomal skin by using the appropriate pouch, cleaning and prepping the skin, applying skin barrier as order and applying the pouch correctly, keeping the pouch emptied routinely, monitoring for compilations and reporting concerns to the physician and monitoring the color, consistency, odor and amount of stool. The February 2024 CPO revealed Resident #15 had the following physician orders related to his colostomy: Colostomy care once a shift, empty colostomy bag as needed, every shift related to quadriplegia, ordered 1/5/23. -There were no orders for routine maintenance including replacing the colostomy bag per standards of practice. IV. Resident #11 (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Resident status Resident #11, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 CPO diagnosis included quadriplegia, neuromuscular neurogenic dysfunction of the bladder (lack of bladder control), overactive bladder, benign prostatic hyperplasia with lower urinary tract infection and diabetes. The 2/14/24 MDS assessment revealed the resident was cognitively intact with a BIMS with a score of 15 out of 15. The resident had impaired functional ability on both sides of the upper (shoulders, elbows, wrists and hands) and lower (hips, knees, ankles and feet) extremities due to quadriplegia and used a motorized wheelchair to get around. The resident needed substantial assistance with personal grooming and was dependent on staff to complete most ADLs. The resident did not reject or refuse care. The assessment revealed the resident had a colostomy device. B. Resident interview and observation Resident #11 was interviewed on 2/15/24 at 1:33 p.m. Resident #11 said he had a lot of gas in his colostomy. Staff were supposed to check on his colostomy every couple of hours to burp the colostomy bag when it was full of gas to prevent the colostomy from popping open and leaking feces on his person. Resident #11 said staff did not check on the colostomy as they should and the device has popped open and covered him with feces on a number of occasions. Resident #11 said he had to remind staff to assist him with the management of his colostomy or they would not provide the needed care. Resident #11 said he was always worrying that the bag would pop open. -At the time of the interview, the resident ' s colostomy bag contained a medium bowel movement and was extremely extended with gas. C. Record review Resident #11' s February CPO documented the following order: -Check resident's colostomy bag every two hours, start date 1/20/24. - There were no other orders or maintenance instructions for care of the resident ' s colostomy. -The comprehensive care plan, revised on 10/13/23, failed to document a care focus for the care and maintenance of the resident ' s newly placed colostomy (placed on 1/10/24). A progress note dated 1/18/24 documented: Resident is complaining that his colostomy bag keeps leaking. A progress note dated 1/23/24 documented: Resident ' s colostomy was leaking, and the bag was changed and cleaned. V. Staff interviews (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNC #1 was interviewed on 2/14/24 at 10:08 a.m. CNC #1 said after visiting with Resident #15, she did not feel he was receiving good colostomy care. Licensed practical nurse (LPN) #1 was interviewed on 2/15/24 at 3:00 p.m. LPN #1 said colostomy bags needed to be burped to release the gas build up. LPN #1 said colostomy bags should be emptied and changed as needed. LPN #1 said she used her clinical judgment to know when to change a colostomy bag. CNC #1 was interviewed again on 2/15/24 at 3:27 p.m. CNC #1 said colostomy care should include burping the bag as needed, emptying the bag as needed and replacing the bag every few days. CNC #1 said colostomy bags needed to be checked frequently. CNC #1 said the facility had several agency staff members. CNC #1 said the facility also had several residents who had colostomies. CNC #1 said all staff should have received competencies regarding colostomy care. CNC #1 said the staff had not been provided education on how to care for colostomies. CNC #1 was interviewed again on 2/20/24 at 11:50 a.m. CNC #1 said Resident #15's colostomy bag exploded over the weekend. CNC #1 said the resident refused care after it exploded. CNC #1 said the bag should not have gotten to the point where it exploded. CNC #1 said Resident #15 had a lot of gas which caused his colostomy bag to fill with gas quickly. CNC #1 said Resident #15's colostomy bag needed to be monitored closely. CNC #1 said she would contact the resident's physician to ask about a gas reducing pill to help the resident with his increased gas. CNC #1 was interviewed again on 2/20/24 at 12:37 p.m. CNC #1 said Resident #15's concerns regarding his care were valid. CNC #1 said she understood why Resident #15 refused care at times. CNC #1 said the facility needed to rebuild rapport with Resident #15 to help reduce his care refusals. 41032

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure two (#11 and #4) of two residents out of 29 sample residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being. Resident #11 was admitted to the facility for long term care on 5/17/23 for long term care with diagnoses of quadriplegia (decreased or no control of all four limbs), neuromuscular dysfunction of the bladder (decreased movement of the bladder), hypoglycemia (low blood sugar), type I diabetes mellitus, neurogenic bowel (decreased bowel movement) and anxiety. Upon admission, Resident #11 weighed 188 pounds (lbs) and he reported he preferred to eat vegetarian meals. Resident #11 was started on Glucerna (diabetic nutritional supplement) once a day on 7/20/23. On 7/6/23, Resident #11 weighed 182.4 lbs. Resident #11 had lost 5.6 lbs, which was not considered significant. On 12/13/23, Resident #11 weighed 166.8 lbs. Resident #11 lost 10.6 lbs or 6% (percent) of his body weight in one month, which was considered significant. At this time the registered dietitian (RD) completed an assessment and increased Resident #11's Glucerna to twice a day. Resident #11 often refused the Glucerna. Resident #11 lost an additional 7.2 lbs from 12/13/23 to 1/23/24. On 1/25/24 30 cubic centimeters (cc) of liquid protein was ordered two times a day for the resident's skin and protein status. On 2/8/24, Resident #11 weighed 156.4 lbs. Resident #11 lost 25.8 lbs (14.2%) from 8/3/23 to 2/8/24, a period of six months, which was considered significant. The facility failed to implement person centered effective nutritional interventions, meet the resident's dietary preferences to prevent significant weight loss and consistently weigh the resident to monitor his weight. Additionally, the facility failed to offer diabetic education to Resident #4 upon admission and ongoing throughout his stay at the facility. Findings include: I. Facility policy and procedure The Nutrition (Impaired)/Unplanned Weight loss-Clinical protocol, revised September 2017, was provided by corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The physician will help identify medical conditions (cancer, cardiac or renal disease, depression, dental problems) and medications that may be causing weight gain or loss or increasing risk for either gaining or losing weight. The physician and staff will monitor nutritional status, an individual's response to interventions, and possible complications of such interventions (for example, additional weight gain or loss, nausea, or vomiting). The Therapeutic Diets policy, revised October 2017, was provided by CNC #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. The dietitian, nursing staff, and attending physician will regularly review the need for, and resident acceptance of, prescribed therapeutic diets. The dietitian and nursing staff will document significant information relating to the resident's response to his/her therapeutic diet in the resident's medical record. If the resident or the resident's representative declines the recommended therapeutic diet, the interdisciplinary team will collaborate with the resident or representative to identify possible alternatives. II. Resident #11 A. Resident status Resident #11, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included quadriplegia (decreased or no control of all four limbs), neuromuscular dysfunction of the bladder (decreased movement of the bladder), hypoglycemia (low blood sugar), type I diabetes mellitus, neurogenic bowel (decreased bowel movement) and anxiety. The 2/14/24 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. He required substantial assistance with eating, oral hygiene, toileting and personal hygiene. He was dependent on staff for showering. The assessment documented the resident was 76 inches (six foot, four inches) tall and weighed 156 lbs. It indicated the resident had no weight loss or weight gain in the last six months. -However, Resident #11 had sustained a significant weight loss of 25.8 lbs (14.2%) in the last six months. B. Observations and resident interview (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During a continuous observation of the lunch meal service on 2/14/24 beginning at 11:24 a.m. and ending at 1:03 p.m., the following was observed: At approximately 12:20 p.m., an unidentified dietary staff member put a cookie and an individual sized bag of potato chips on Resident #11's meal tray. Resident #11 was interviewed on 2/14/24 at 1:54 p.m. Resident #11 said he preferred not to eat meat. He said he had been a vegetarian for [AGE] years. Resident #11 said he only got a cookie and a bag of chips for lunch. He said the menu item was a sloppy joe and he was unable to eat it due to his preferences. Resident #11 said he had to purchase most of his own food since the facility did not accommodate his preferences. Resident #11 said he had lost weight since he was admitted to the facility. Resident #11 did not feel his nutrition needs were being met. Resident #11 said he preferred to stay in bed until 11:00 a.m. Resident #11 said if he got up before then he was in his wheelchair for several hours which caused him pain (see weight change note below). C. Record review The nutrition care plan, initiated on 5/25/23 and revised on 2/15/24 (during the survey), revealed Resident #11 had potential for alteration in body composition integrity (muscle and fat wasting) and potential for unintended weight changes related to worsening condition secondary to numerous comorbidities including: type one diabetes mellitus, quadriplegia, history of pressure ulcer and depression. The interventions included: monitoring, recording and report to the physician signs and symptoms of malnutrition as needed (5/25/23), obtaining and monitoring lab/diagnostic work as ordered and reporting results to physician to follow up as needed (5/25/23), monitoring need for occupational therapy to screen for adaptive equipment (5/25/23), providing and serving supplements as ordered (2/15/24, added during the survey), providing and serving diet as ordered (5/25/23), offering vegetarian items per resident preferences and obtaining preferences (2/15/24, added during the survey), evaluating the resident by the registered dietitian (RD) as needed (5/25/23) and obtaining weights per facility protocol (5/25/23). Resident #11's weights were documented in the resident's medical record as follows: -On 5/18/23, the resident weighed 188 lbs; -On 6/14/23, the resident weighed 185.5 lbs; -On 7/16/23, the resident weighed 182.4 lbs; -On 7/31/23, the resident weighed 182.6 lbs; -On 8/3/23, the resident weighed 182.2 lbs; -On 8/14/23, the resident weighed 182.4 lbs; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 9/7/23, the resident weighed 175.8 lbs; -On 11/10/23, the resident weighed 177.4 lbs; -On 11/17/23, the resident weighed 177.4 lbs; -On 12/13/23, the resident weighed 166.8 lbs; -On 1/23/24, the resident weighed 159.6 lbs; and, -On 2/8/24, the resident weighed 156.4 lbs. -The resident lost 25.8 lbs (14.2%) from 8/3/23 to 2/8/24 in six months, which was considered significant. The 7/8/21 preadmission screening and resident review (PASRR) documented the resident preferred to eat a vegetarian diet. The PASRR documented vegetarian diet options should be offered to the resident at every meal. The 5/18/23 dietary interview assessment documented Resident #11 had a good appetite. Resident #11 said he preferred to have 2% milk and cranberry juice to drink at breakfast and dinner. The resident did not like to snack between meals. Resident #11 did not like fried eggs and did not eat meat. The resident was on a regular diet and did not have any food allergies. The resident was aware the alternative meals were available upon request. The resident preferred to eat in his room. The resident typically ate breakfast, lunch and dinner. The resident preferred to follow a vegetarian diet and enjoyed cheese sandwiches, quesadillas, fish, eggs, salads and burritos for lunch and dinner. The 12/14/23 interdisciplinary (IDT) weight variance assessment documented by the registered dietitian (RD) revealed the resident weighed 166.8 lbs and had lost 5.6% of his body weight in one month (however, the resident had sustained a 6% weight loss in one month). The resident was currently receiving Glucerna or Boost Glucose Control (diabetic nutritional supplement) once a day and liquid protein. The resident was on a vegetarian diet. The resident previously weighed 177.4 lbs. The resident was receiving Ativian (antianxiety medication) and Morphine (pain medication). The resident was a slow eater; had poor ability to feed himself; complained of the taste of the food, disliked the food, disliked the diet and was a picky eater; and, had variable intake. The resident had a recent illness within the last 30 days, a recent significant change in medications and was on psychotropic medication. The resident had a recent illness. The resident had a decline or had low hemoglobin and/or hematocrit and had a decline or low albumin. The assessment documented the root cause analysis was Resident #11 experienced a 5.6% weight loss in 30 days. The resident's current body mass index (BMI) was 20.3, which was considered within normal limits for his height and age. Resident #11 continued to have good intakes and would consume greater than 75% of his meals. Resident #11 received liquid protein and another supplement to assist with his protein intakes. The assessment documented the weight was questioned. Glucerna was increased to twice a day to assist. The RD documented he would continue to monitor. The new intervention was to increase the supplement to twice a day. The IDT member who participated in the review was the RD. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Despite the 12/14/23 IDT note documenting the resident had a 5.6% weight loss, the resident had sustained a 6% (10.6 lbs) weight loss, which was considered significant, from 11/17/23 to 12/13/23, in one month. The physician order revealed the Glucerna eight ounces was increased to two times a day for weight management on 12/14/23. The resident went to the hospital from 1/7/24 to 1/15/24. According to the hospital records, Resident #11 weighed 165 lbs on 1/7/24. On 1/15/24, while he was still in the hospital, he weighed 165 lbs. -The resident had a 10.6 lbs weight loss prior to his admission to the hospital and he was not weighed until 1/23/24, which was eight days after his readmission, where he sustained an additional 7.2 lbs weight loss. The 1/25/24 IDT weight variance assessment documented by the RD revealed the resident weighed 159.6 lbs. The resident had lost 10% of his body weight in two months. The resident was currently receiving Glucerna or Boost Glucose Control twice a day. The resident was on a vegetarian diet. The resident previously weighed 166.8 lbs. The resident was receiving Ativian (antianxiety medication) and Morphine (pain medication). The resident was a slow eater; had poor ability to feed himself; complained of the taste of the food, disliked the food, disliked the diet and was a picky eater; and, had variable intake. The resident had a recent illness within the last 30 days, a recent significant change in medications and was on psychotropic medication. The resident had a recent illness. The resident had a decline or had low hemoglobin and/or hematocrit and had a decline or low albumin. The assessment documented the root cause analysis was Resident #11 continued to lose weight. The resident had a BMI of 19.4 which was within normal limits for his height and age. Resident #11 was a vegetarian and ordered mostly special meals. The resident said he refused meals, because the facility did not offer vegetarian options. The RD spoke with the dietary manager and they have several vegetarian options including grilled cheese, cheese pizza, bean and cheese burritos, salads, eggs and vegetable burgers. The RD notified the resident of the options and the resident said he was not aware the kitchen had these options. The RD documented the kitchen staff reported to the RD that they had notified the resident of these options previously. The RD encouraged the resident to order meal choices he wanted. The RD recommended starting the liquid protein supplement to assist with the resident's low protein status and continuing the Glucerna. The RD documented he would continue to monitor the resident. The IDT member who participated in the review was the RD. -Despite the IDT note documenting the RD met with Resident #11 regarding his vegetarian diet, the resident was not provided with vegetarian options during the survey (see observations above). The resident had a 10% (17.8 lbs) weight loss, which was considered significant, from 11/17/23 to 1/23/24, in two months. -While some nutritional interventions were implemented to address the resident's significant weight loss of 10% (17.8 lbs) from 11/17/23 to 1/23/24 (a period of two months), the facility failed to monitor the resident's weight more frequently to see if the implemented interventions were effective and the resident continued to lose weight. (continued on next page)

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	065274	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute	3185 W Arkansas Ave Denver, CO 80219

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F 0692

Level of Harm - Actual harm

Residents Affected - Few

Liquid Protein 30 cc two times a day for low protein and skin integrity. Liquid protein 30 milliliters (ml) twice a day, mixed with juice, ordered 1/25/24. The RD said he recommended the liquid protein upon the resident's request (see interview below).

-Despite the addition of the Liquid Protein intervention, the facility again failed to implement more frequent monitoring of the resident's weight to determine if the new intervention was effective, and the resident continued to lose weight.

The February 2024 medication administration record (MAR) revealed Resident #11 consumed an average of 41% of the ordered Glucerna from 2/1/24 to 2/14/24.

The 2/15/24 dietitian note documented the RD met with Resident #11 to review the resident's weight and discuss the menu options. The resident said he had been ordering smaller meals and was no longer ordering off the always available menu like he used to. Resident #11 reported he was a picky eater and had concerns about the food. The RD documented the nutrition services director (NSD) was present during the conversation to assist with the menu discussion. The resident reported he was a very picky eater and did not like the selection of food being offered. The RD documented he reminded the resident of the discussion they had regarding the always available menu options. The resident said he was picky regarding those options as well. The resident said he liked spaghetti with marinara, fish sticks with tarter sauce and yogurt. The RD mentioned to the resident the other options that were offered and the resident said he wanted more variety. The RD documented the current options available were reviewed with Resident #11 which included bean and cheese burritos that were currently on backorder, grilled cheese, quesadillas and Resident #11 said he needed salsa and sour cream, vegetarian burgers, salads, yogurt, fruits, eggs and other vegetables. Resident #11 raised his voice and said he was tired of those options and the facility was forcing him to purchase his own frozen meals to eat. The resident continued to raise his voice and became visibly frustrated. Resident #11 continued to criticize the quality of the food and said the food options did not meet his preferences or cooking techniques. The RD notified the resident that there are menu options the kitchen can provide and the staff can make a more personalized menu to try and assist the resident. The resident became emotional and said I am just done with this. The RD encouraged the resident to suggest additional meals that he would like, so the facility could build a menu that represented his wants and needs. Resident #11 said he would think of options. The RD documented the resident had several organic snacks in his room that he had purchased.

-The resident had a 14.2% (25.8 lbs) weight loss, which was considered significant, from 8/3/23 to 2/8/24, in six months. While interventions were put in place, the interventions were not assessed for their effectiveness. The resident only accepted Glucerna, on average, 41% of the time.

-The facility did not provide the resident with his dietary preferences, which resulted in a decreased oral intake.

Cross-reference F806 for preferences.

The 2/15/24 weight change note documented at 7:41 a.m. revealed the resident had refused his weight that week. The RD documented he would continue to request weekly weights (see RD and resident interview).

D. Staff interviews

(continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD and the NSD were interviewed together on 2/15/24 at 11:59 a.m. The RD said Resident #11 preferred to be a vegetarian. The RD said Resident #11 did eat fish. The RD said Resident #11 was a very picky eater. The RD said he would visit with the resident and try to establish the resident's food preferences and help create a menu for Resident #11 that was nutritionally balanced. The RD said Resident #11's lunch of chips and cookies was not a complete meal and did not provide the resident with adequate nutrition. The NSD said the kitchen had been offering Resident #11 alternative items such as a bean burrito, grilled cheese and cheese quesadilla. The NSD and the RD said they understood that Resident #11 was tired of the alternative options. The RD said resident preferences and nutrition interventions should be included in the care plan. The RD said the certified nurse aides (CNA) documented the resident frequently consumed greater than 75% of his meals. The RD said the CNAs should not document the resident was consuming more than 75% of his meals if he was only consuming cookies and chips. The RD said that was not a complete meal. The RD said he had not provided any recent education on accurate meal consumption documentation. The RD said the CNAs should look at the meal as a whole and refer to MyPlate (food pyramid) as a representation of a complete nutritionally balanced meal. The RD said it was important for meal intakes to be documented accurately to help with his nutritional assessments. The RD said Resident #11 triggered as a significant weight loss in December 2023. The RD said he completed an assessment and increased the Glucerna supplement to twice a day to improve oral nutrition intake. The RD said the resident triggered significant as a weight loss again in January 2024. The RD said at that time he spoke with the resident and the resident requested a protein supplement to help with his skin integrity and protein status. The RD said no further nutrition interventions had been implemented to prevent further significant weight loss. The RD said the resident's comprehensive care plan did not include the resident's significant weight loss, dietary preferences or nutrition interventions that were implemented to help prevent further weight loss. The RD said he completed the IDT assessment and did not have collaboration from other members of the team. The RD said he believed the resident's physician was aware of the weight loss but did not have any documentation indicating the physician had been notified of the significant weight loss. The RD said the facility's policy was to weigh a resident upon admission and then be weighed weekly for three to four weeks to create a baseline. The RD said if the resident's weight was stable the resident was then weighed monthly. The RD said he had requested the nursing staff to weigh Resident #11 weekly in December 2023, so he could monitor the weights more closely. The RD said the facility did not obtain weekly weights for Resident #11. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD said he was aware that Resident #11 refused his weekly weight on 2/15/24. The RD said he was not aware that Resident #11 preferred to stay in bed tuntil 11:00 a.m. and the staff attempted to get his weight prior to 11:00 a.m. The RD said Resident #11 had been in and out of the hospital a couple times and the resident recently got a colostomy bag. The RD said he had not reviewed the February 2024 MAR to determine if Resident #11 was accepting the Glucerna. CNC #1 was interviewed on 2/20/24 at 12:37 p.m. CNC #1 said the facility needed to review weight loss as an IDT team weekly. CNC #1 said the provider needed to be notified if a resident had a significant weight loss. CNC #1 said Resident #11's significant weight loss needed to be reviewed with the IDT to discuss nutrition interventions. III. Resident #4 A. Resident status Resident #4, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 CPO, diagnoses included depression, hypoglycemia (low blood sugar) type one diabetes mellitus, gastroparesis (slowed movement of the stomach), visual loss, need for assistance with personal care, schizophrenia (mental illness), cocaine dependence and heart failure. The 12/27/23 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required set-up assistance for eating. He required supervision for oral hygiene, toileting and personal hygiene. He required substantial assistance for showering. The assessment indicated he was on a therapeutic diet. His vision was adequate and he did not have corrective lenses. -However, the resident was blind. B. Resident interview Resident #4 was interviewed on 2/13/24 at 12:59 p.m. Resident #4 said the food was not good. He said the food was often served late. He said it was difficult to manage his diabetes since the meals were frequently late. He said the facility did not follow standardized portion sizes. Resident #4 said he was blind so it made it difficult for him to know how many carbohydrates he was consuming when the portion sizes were different each day. C. Record review (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The nutrition care plan, initiated on 9/20/23, revealed Resident #4 had potential for alteration in body composition integrity (body and fat wasting) and potential for unintended weight changes related to worsening of his condition secondary to numerous comorbidities such as: type one diabetes, schizoaffective disorder, chronic kidney disease, gastroparesis (slow stomach movement), hypertension (high blood pressure), gastro-esophageal reflux disease (GERD), depression and chronic heart failure. The interventions included obtaining and monitoring lab as ordered and reporting abnormalities to the physician, completing an occupational therapy screen as needed, providing a bowl for the resident's food if requested, providing and serving the diet as ordered, providing double portions as requested even if the resident did not eat it all as he was a picky eater, completing a nutritional evaluation as needed and completing weights per facility protocol. The meal preferences care plan, initiated on 9/2023 and revised on 10/30/23, revealed Resident #4 had a history of voicing that staff were not taking his orders correctly or some of the items he ordered were missing on his meal trays. Resident #4 preferred to have his order read back to him after being taken. Resident #4 became verbally aggressive with staff related to his food items being missed, not getting what he ordered or his order being taken incorrectly. Staff needed to take Resident #4's orders and deliver his meals with two staff members present. The interventions included anticipating and meeting the resident's needs, providing positive interaction, following up on grievances as needed, discussing the resident's behavior, intervening as necessary to protect the rights and safety of others, praising the resident for behavior improvement and taking the resident orders and delivering meals with a second staff member present. The diabetic care plan, initiated on 9/20/23, revealed the resident had type one diabetes mellitus that was managed by insulin and diet. Resident #4 could titrate his insulin dosing as requested for carbohydrate counting. Resident #4 was not to exceed 12 units of insulin per physician order and his history of diabetes. The interventions included administering medications as ordered, educating the resident on medications and potential side effects, referring to nephrology as indicated, allowing Resident #4 to adjust his own insulin needs based on blood sugar levels and food consumed and monitoring the resident's blood sugar before each meal and before bedtime. The visual impairment care plan, initiated on 9/20/23, revealed Resident #4 was legally blind. The interventions included announcing oneself when entering the resident's area, answering the call light timely, placing the call light within reach, ensuring there is adequate lighting, involving the resident in auditory activities, keeping the resident environment free of small objects, keeping visual devices clean and assisting as needed for placement, providing medication as ordered, monitoring the resident's eyes for irritation, monitoring for changes in ability to perform activities of daily living and providing a clean and hazard free environment. D. Staff interviews The RD and the NSD were interviewed together on 2/15/24 at 11:59 a.m. The RD said Resident #4 did not want nutrition education. The RD said Resident #4 was non-complaint with his diet and made his own food choices. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD was interviewed again on 2/15/24 at 1:23 p.m. The RD said he was unable to find documentation in Resident #4's medical record that diabetic nutrition education had been offered to the resident. The RD said he attempted to provide Resident #4 diet education on 2/15/24 (during the survey process). The RD said the resident was upset regarding the portion sizes at the facility. The RD said Resident #4 said the portion sizes were never consistent which made it difficult to dose his insulin correctly. Cross-reference F804 failure to follow the correct portion size. The RD was interviewed again on 2/15/24 at 3:59 p.m. The RD said he was contracted through the facility. The RD said he reviewed his billing documentation. The RD said he found documentation that he billed for diabetic education for Resident #4 several months ago but the resident refused. The RD said there was no documentation in the resident's medical record indicating diabetic education had been offered. CNC #1 was interviewed on 2/20/24 at 12:37 p.m. CNC #1 said diabetic education should have been offered to Resident #4 and documented in his medical record if he refused it.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 41032 Based on staff interviews and record reviews, the facility failed to ensure certified nurse aides and licensed nurses were able to demonstrate competency skills and techniques necessary to care for residents' needs. This placed all residents at the facility at risk of receiving inadequate care. Specifically, the facility failed to conduct staff competency evaluations for all certified nurse aides (CNA), licensed practical nurses (LPN) and registered nurses (RN). Cross-reference F677: failure to provide adequate assistance for activities of daily living for a resident who was dependent on staff for all care. Cross-reference F684: failure to provide diabetic care per standards of care. Cross-reference F689: failure to ensure the needs of a resident with substance use disorder. Cross-reference F690: failure to provide catheter care per standards of care. Cross-reference F691: failure to provide colostomy care per standards of care. Cross-reference F692: failure to implement effective interventions to ensure resident nutrition needs were met. Cross-reference F760: failure to ensure medications were administered according to physician orders. Cross-reference F880: failure to follow appropriate infection control practice while performing prescribed procedures for residents with indwelling medical devices and wounds. Findings include: I. Facility policy The Staffing, Sufficient and Competent Nursing policy, revised August 2002, was provided by corporate nurse consultant (CNC) #1 on 2/20/24 at 12:10 p.m. It read in pertinent part: Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with the resident care plans and the facility assessment. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment. 1. 'Competency' is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law. 3. Staff must demonstrate the skills and techniques necessary to care for resident needs including (but not limited to) the following areas: a. Resident rights; b. Behavioral health; c. Psychosocial care; d. Dementia care; e. Person-centered care; f. Communication; g. Basic nursing skills; h. Basic restorative services; i. Skin and wound care; j. Medication management; k. Pain management; l. Infection control; m. Identification of changes in condition; and n. Cultural competency. 4. Licensed nurses and nursing assistants are trained and must demonstrate competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities. 5. Competency requirements and training for nursing staff are established and monitored by nursing leadership with input from the medical director to ensure that: a. programming for staff training results in nursing competency; b. gaps in education are identified and addressed; c. education topics and skills needed are determined based on the resident population; d. tracking or other mechanisms are in place to evaluate the effectiveness of training; and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. training includes critical thinking skills and managing care in a complex environment with multiple interruptions. II. Competency records The competency skill assessment checks and associated training records were requested on 2/19/24 at 1:02 p.m. The facility was not able to provide documentation of competency or training related to areas where the staff lacked competency in performing care tasks and medical procedures for any of the facility's nursing staff including RNs, LPNs or CNAs. III. Staff interviews CNC #1 and the newly hired nursing home administrator (NHA) were interviewed together on 12/20/24 at 1:20 p.m. CNC #1 said the facility had no record of completing any staff competency evaluations for nursing staff (CNAs, LPNs or RNs) although they should have conducted a skill fair session to ensure the nursing staff were competent with all care tasks. CNC #1 said several key members of the facility leadership team were no longer working in the facility and she and the NHA were hiring a new leadership group to manage nursing services. CNC #1 said the facility had several agency nursing staff on contract filling open nursing shifts and the leadership was in the process of assessing the staff's competency to determine which staff would be scheduled for additional shifts until the facility could hire permanent nursing staff.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on record review and staff interviews, the facility failed to ensure residents were free of any significant medication errors for one (#6) of four residents out of 29 sample residents related to anticoagulants and insulin management. Resident #6 had several significant health conditions requiring close monitoring with personal care services including physician services and nursing assessment with medication and treatment administration to ensure the resident's highest optimal health condition possible. Resident #6 was at high risk for the development of life threatening blood clots that could cause blockages in the heart, lungs and other vital organs potentially shutting the organs down. The facility's nursing staff were to administer physician ordered medication (warfarin) in proper dosages as calculated by the resident physician based on results of regularly assessed lab work. Warferain is a medication that prevents blood clots from forming or growing larger and causing blockages in the blood and blood vessels. The facility put Resident #6 health in jeopardy by failing to ensure all medications were ordered and administered according to physician orders. The most significant medication errors occurred when Resident #6 was not given his prescribed dose of warfarin as a result of several errors and omissions in administration. The resident medication was not consistently available for administration and he missed doses of the medication. Additionally, there were errors in the amount (doses) of medication the resident was given due to the nursing staff's failure to follow and/or confirm the written administration orders in the resident's medication administration record (MAR). The facility's failure to administer the resident's warfarin medication as prescribed by the resident's physician put the resident at increased risk of serious problems such as strokes, heart attacks, deep vein thrombosis (DVT-a blood clot in a deep vein of the leg, pelvis, and sometimes arm) and pulmonary embolism (a sudden blockage in the blood vessels that send blood to your lungs). The facility failed to prevent a potentially life-threatening medication error placing Resident #6 at risk of serious harm due to a failure to receive care and treatment per acceptable professional standards of practice. Findings include: I. Immediate jeopardy A. Failure to administer medications as ordered The facility nursing staff failed to provide Resident #6 with all prescribed medication in accurate dosage on several occasions throughout the three months from December 2023 to February 2024. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #6 had missed several medications prescribed over several weeks of care to treat his diagnosed medical conditions and treat symptoms of illness including abnormal blood clotting; inability to regulate glucose levels in the bloodstream; high blood pressure; urinary tract infection; unrelieved pain; anxiety and depression. The resident missed several significant prescribed medications including warfarin; insulin lispro and insulin glargine for diabetes management; lisinopril and metoprolol succinate for blood pressure regulation. In addition, the resident also missed other medications due to those medications being unavailable (see record review below). The facility was not aware of the extent of the errors until it was brought to their attention during a recent survey (from 2/13/24 through 3/8/24). The facility was not able to explain why the nurses had failed to reorder the unavailable medications and why nursing staff were routinely marked in the MAR that the medication was not available without notifying the resident physician and contacting the pharmacy for a STAT (urgent) reorder of the medication. In addition, the facility leadership were unaware that not all of the nurses (facility hired and agency contracted) had access to the emergency medication backup kit by which to access the unavailable medications to give to the residents in the event of pharmacy ordering and delivery delays. A review of the MAR and the resident progress notes revealed the nurses, most of whom were agency nurses and not regular employees of the facility, documented on the MAR that some medications were unavailable but provided no documentation of why the medications were unavailable or what was being done to secure the unavailable medications. Additionally, a note dated 2/13/24 documented by the resident's nurse practitioner (NP) revealed the facility's nursing staff failed to correctly document the physician's orders to decrease Resident #6's warfarin dose from 5 mg to 4 mg but instead added the 4 mg order without discontinuing the 5 mg. As a result, the resident received 9 mg of warfarin on 2/10/24, instead of the newly ordered 4 mg dose of warfarin causing the resident to be overdosed on warfarin. Current facility leadership was unable to provide any other documentation of that situation. B. Facility notice of immediate jeopardy On 3/5/24 at 6:00 p.m., the nursing home administrator (NHA), clinical nurse consultant (CNC) #2 and interim director of nursing (IDON) were notified of the facility's failure to prevent the occurrence of significant medication errors with place Resident #6 at risk of serious harm likely to occur due to a failure to administer the resident warfarin, insulin and blood pressure medications as prescribed resulting in an immediate jeopardy situation. C. The facility's plan to remove immediate jeopardy On 3/6/24 at 3:15 p.m., the NHA, IDON and CNC #1 presented the following plan to address the immediate jeopardy situation. It read in pertinent part: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/5/24 the IDON completed (an) audit of all carts for medication availability. Medications that were identified as unavailable were ordered from (the) pharmacy for same day delivery. Notifications would be made to the provider, resident and/or resident representative if the medication is not available or if there would be a delay in administering the medication. On 3/5/24, the interim DON educated staff to call the IDON immediately if the medication was unavailable. Her direct cell phone number was given to all nurses on shift and posted at both nursing stations to ensure access to her. On 3/6/24, an audit of all residents who were prescribed warfarin and insulin for the past 30 days was conducted to determine if the deficient practice has impacted other residents. Residents who were not administered (warfarin or insulin) medications due to the medication not being available would have a risk management assessment completed, and the (physician) provider was to be notified for additional orders, as indicated. Actions to Prevent Occurrence/Recurrence: All nurses would be educated by 3/15/24 on how to access the (pharmacy name/e-kit name) system and all facility staff nurses would be provided access to retrieve medications from this e-kit device when a medication was not available. All agency nurses were to refer to the agency (staff information) binder located at each nursing station for the protocol for retrieving medications from the e-kit (e-kit name). The binder will contain information on how the agency nurse can obtain login and access to the (name of the e-kits), and then how to obtain the medications. On 3/6/24, the Unavailable Medications policy was reviewed by the DON (director of nursing) to ensure the facility was following the policy. A nursing in-service was initiated on 3/6/2024 to review this policy with staff. All nurses will be educated before their next shift. Beginning 3/6/24 The IDON completed corrective action and one-to-one education on above listed topics with all licensed nurse(s) identified as being deficient in their practice resulting in this citation. The DON or designee will educate all newly hired licensed nurses on medication administration and reconciliation guidelines and review the unavailable medication policy on day one of orientation before licensed nurses work on the floor. To ensure transcription accuracy, the night shift nurse will run an order listing report for that day and double-check all new orders for accuracy. The DON or designee will monitor compliance by having the night nurse sign the order listing report indicating the review was completed and placing it in the DON mailbox daily. The audits will continue until compliance can be maintained for three consecutive months. Beginning on 3/6/24, the IDON or designee will review the missing medications report daily to ensure medications that are marked as unavailable have proper follow-up. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westwood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3185 W Arkansas Ave Denver, CO 80219	

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A meeting has been scheduled for the DON and ADON on 3/11/24 at 10:00 a.m. to meet with the pharmacy consultant to review medication availability and ordering medications timely to ensure the medication ordering and delivery process is in place. The Administrator implemented a QAPI PIP (quality assurance and performance improvement, performance improvement plan) as a means to gather and process information from the audit. Findings will be reported at the monthly QAA (quality assessment and assurance) meeting for a minimum of three months. D. Removal of immediate jeopardy On 3/6/24 at 3:15 p.m., the NHA was notified, based on the review of the facility's plan for removal of immediate jeopardy was accepted and the level of deficient practice remained at a D scope and severity, isolated no actual harm with potential for more than minimal harm. II. Professional reference According to [NAME] Nursing Drug Handbook 2020, Kizior, R. J. and [NAME], K.J., St. Louis Missouri 2020, page (pp). 1287 read in pertinent part: Medication safety is a high priority for the health care professional. Prevention of medication errors and improved safety for the patient are important, especially in today's healthcare environment when today's patient is older, sometimes sicker, and drug therapy regimens can be more sophisticated and complex. According to [NAME]'s Drug Guide 2024, Warfarin, retrieved on 3/4/24 from https://www.drugguide.com/ddo/view/[NAME]-Drug-Guide/51797/all/warfarin#1, Administer medication at the same time each day. Medication requires 3-5 days to reach effective levels; Notify the physician of missed doses. Inform the patient that the anticoagulant effect may persist for 2-5 days following discontinuation. Lab Test Considerations: Monitor prothrombin time (PT) (a blood test that measures how long it takes the blood to clot), international normalized ratio (INR) (a calculation based on the PT results used to monitor people who are being treated with the anticoagulant medication Warfarin), and other clotting factors frequently during therapy; monitor more frequently in patients with renal impairment. Therapeutic PT ranges 1.3-1.5 times greater than control; however, the INR, a standardized system that provides a common basis for communicating and interpreting PT results, is usually referenced. Normal INR (not on anticoagulants) is 0. 8-1.2. An INR of 2.5-3.5 is recommended for patients at very high risk of embolization (for example, patients with mitral valve replacement and ventricular hypertrophy). Lower levels are acceptable when risk is lower. According to [NAME]'s Drug Guide 2024, Insulin Lispro, retrieved on 3/4/24 from https://www.drugguide. com/ddo/view/[NAME]-Drug-Guide/51852/all/insulin%20lispro, Insulin lispro and Insulin glargine are high alert medication: This medication bears a heightened risk of causing significant patient harm when it is used in error. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to Health Match What Can Happen If You Stop Taking Your High Blood Pressure Medication? (5/2/22), retrieved on 3/4/24 from https://healthmatch.io/high-blood-pressure/what-happens-when-you-stop-high-blood-pressure-medication#will-you-ever-be-able-to-stop-taking-your-medication, It's important not to stop taking your pills, even for a few days, without consulting your doctor. Not taking your medication can cause your blood pressure to go out of control. This can cause a large number of problems, including Permanent damage to your arteries; and or an increased risk of aneurysm, which most often form in the aorta, but can develop anywhere. III. Facility policies and procedures The Administration Medication policy, revised April 2019, was received on 2/20/24 at 12:10 p.m., from CNC #1. It read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. -Medications are administered in accordance with prescriber orders, including any required time frame. -Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The Medications Ordering and Receiving from the Pharmacy Provider: Medication Shortage policy, dated 2007, was received on 2/20/24 at 12:10 p.m. from CNC #1. It read in pertinent part, The facility nurse must make every effort to ensure that a medication ordered for the resident is available to meet their needs. Nursing staff shall if the shortage will impact the patient's immediate need of the ordered product: a. Notify the attending physician of the situation, and explain the circumstances, expected availability and optional therapy(ies) that are available. b. Obtain a new order and cancel/discontinue the order for the non-available medication. c. Notify the pharmacy of the replacement order. The Unavailable Medication policy revised February 2023, was provided by the IDON on 3/7/24 at 1:34 p.m. and revealed in pertinent part, Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable. Determine the reason for unavailability, the length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring the resident while the medication is on hold. If a resident misses a scheduled dose of medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report and monitoring the resident for adverse reactions to the omission of the medication. The Emergency Medications policy revised April 2021, was provided by the IDON on 3/7/24 at 1:34 p.m. and revealed in pertinent part, The emergency medication kit will include medications and biologicals that are essential in providing emergency treatment. The contents of each emergency medication kit will be clearly listed. A physician's order is required to administer emergency medications and biologicals. IV. Resident #6 A. Resident status Resident #6, under the age of 65, was admitted on [DATE]. According to the March 2024, computerized physician's orders (CPO), diagnoses included chronic diastolic (congestive) heart failure, diabetes, mood disorder, chronic obstructive pulmonary disease (COPD), gout, hypertension, history of pulmonary embolism, atrial fibrillation and asthma. According to the 12/19/23 minimum data set (MDS) assessment, the resident had intact cognition as evidenced by a brief interview for mental status (BIMS) score of 15 of 15. The resident took antipsychotic, antidepressant, anticoagulant, diuretic, opioid, antiplatelet and hypoglycemic medications daily. B. Resident and resident representative interview Resident #6 was interviewed on 2/13/24 at 2:18 p.m. Resident #6 said he took a lot of prescribed medication and over the counter vitamins and minerals. The resident said on numerous occasions he noticed a few of his medications were missing because he counted them every time he received them. The resident said he asked the nurse every time about the missing medication and the nurse would either say which one was missing or nothing was missing. Resident #6 said he continued to notice missing medication every day from admission (12/17/23) up through the beginning of February 2024. The resident said he believed the problem stemmed from staff not ordering the medication on time and therefore they ran out for weeks at a time. Resident #6's representative was interviewed on 2/15/24 at 1:16 p.m. The resident's representative said from admission the resident was not getting all of his prescribed medications which was very concerning. The resident's representative said she was concerned that the staff did not know what they were doing. The resident representative said she asked to meet with the DON but never heard back from the DON. C. Record review (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #6's medical record, the March 2024 CPO and MAR reviewed the following medication orders and inaccurate medication administration: Warfarin Warfarin sodium tablet 6 mg, give one tablet by mouth at 6:00 p.m., to prevent blood clots, start date 12/16/23 and discontinued 1/6/24. -However, the medication was not administered on 12/25/23, 12/26/23, and 12/28/23 due to not being available. A physician's note dated 12/27/23 read in part: Patient INR (blood work to test warfarin level) came back at 6. 0; however, he missed doses of the medication, will continue medication at normal range and recheck INR tomorrow. The patient takes warfarin for a history of deep vein thrombosis, pulmonary embolism and atrial fibrillation (irregular and often very rapid heart rhythm that can lead to blood clots in your heart). A physician's note dated 1/2/24 read in part: INR with a value of 1.8, value for the patient should be 2.0 to 3.0. Will recheck INR tomorrow after the patient (resumes) receiving full doses before increasing. A physician's note dated 1/3/24 read in part: Patient states that he has had issues with staff not giving him his warfarin doses, there is no issue with the patient's compliance. I do not intend to change his warfarin dosing at this time due to missed doses. Continue warfarin 6 mg every evening. INR monitored weekly, ordered one-time STAT (right away) to establish a baseline. A physician's note dated 1/4/24 read in part: Patient's INR still pending to follow the decision whether to increase or not. Review of the system is otherwise negative. An NP provider exam note dated 1/5/24 read in part: The 1/3/24 INR result was 20.05, reordered STAT as this was not consistent with the patient's condition during the visit. I do not intend to change his coumadin (warfarin) dosing at this time; the lab is likely inaccurate INR. Warfarin sodium tablet 7 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 1/6/24 and discontinued 1/9/24. An NP provider exam note dated 1/9/24 read in part: INRs done by laboratory continue to have likely inaccurate results. The most recent result (1/5/24) was 0.0. The INR result before that (1/4/24) was 1.68. The patient bought his own INR test kit and used it while in the room with me. The value on the patient's home kit was 2.2 on 1/9/24. I do not intend to change his coumadin dosing at this time due to past missed doses (of warfarin). Warfarin sodium tablet 6 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 1/9/24 and discontinued 1/18/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An NP provider exam note dated 1/18/24 read in part: Reason for appointment: INR monitoring. Lab results: INR 25.73 ppm. 1/10/24: Unchanged order for warfarin sodium oral tablet, give 6 mg by mouth one time a day for blood clots. INR was 3.1 on 1/18/24, plan to reduce the dose slightly to 5 mg once a day. Warfarin sodium tablet 5 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 1/18/24 and hold from 1/29/24 to 1/31/24. -However, the 1/31/24 dose was not held. Warfarin sodium tablet 2.5 mg, give one tablet by mouth one time for prevention of blood clots until 2/1/24 at 11:59 p.m., give a total of 7.5 mg at 4:00 p.m., start date 2/1/24. Warfarin sodium tablet 2.5 mg, give one tablet by mouth one time only for INR result of 1.56, for one day, start date 2/2/24. Warfarin sodium tablet 2.5 mg, give one tablet by mouth one time only for INR result of 1.56, for one day and also administer scheduled 5 mg dose (total dose 7.5 mg), start date 2/4/24. Warfarin sodium tablet 5 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 1/18/24. Hold this dose from 2/7/24 to 2/9/24. Discontinue 1/12/24. -The 2/9/24 dose was signed as administered and not held. Warfarin sodium tablet 5 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 1/18/24. Hold this dose from 2/7/24 to 2/9/24. Discontinued on 2/12/24. -However, the 2/9/24 dose was not held and was given at the same time as the warfarin sodium tablet 4 mg dose that was ordered to start on 2/7/24 (see order below). -Additionally, this order was given at the same time as the order below without an order to administer both doses at the same time (see below). -The resident was given a total of 9 mg of warfarin on 2/10/24 and 2/11/24 without an order to give the resident that high of a dose. Warfarin sodium tablet 4 mg, give one tablet by mouth at 4:00 p.m., to prevent blood clots, start date 2/7/23. Hold this dose from 2/12/24 to 2/15/24. -However, the 2/14/24 dose was not held. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An NP provider exam note dated 2/13/24 read in part: Last INR was 3.7, now only on 4 mg, medication is on hold today and tomorrow. Recheck INR on 2/14/24. There was a triage note in my box stating the patient was to receive 9 mg of warfarin on 2/10/2024, his INR was 2.38 at that time. On 2/12/2024 his INR was reported at 3.7. After reviewing the order history, it would appear that orders relayed to nursing to decrease warfarin dosing from 5 mg to 4 mg were misentered resulting in a total of 9 mg dosing. His usual dosing was meant to be reduced from 5mg to 4mg due to excessive INRs. Clearly, the patient was overdosed however the 4 mg dosing may still be correct and I intend to keep it at this level until verified through trial. Insulin and blood pressure medications Insulin glargine inject subcutaneous solution by pen injector 300 units per milliliter (ml), inject 86 units subcutaneously one time a day for diabetes, start date 12/16/23. Insulin lispro subcutaneous solution pen-injector 200 unit/ml, inject subcutaneously before meals for diabetes, as per sliding scale: if 150-200=4 units; 201-250=8 units; 251-300=10 units; 301-350 =12 units for > 351 give 14 units and call the physician provider, start date 12/18/23, discontinued 1/15/24. -The insulin lispro 7:30 a.m. dose was missed: 12/21/23, 12/24/23, 12/25/23 and 12/31/23; and, -The insulin lispro 11:00 a.m. dose was missed: 12/21/23, 12/24/23, 12/25/23 and 12/31/23. Lisinopril tablet 10 mg, give one tablet by mouth at bedtime for hypertension (high blood pressure), start date 12/16/23 and discontinued 1/18/24. Lisinopril tablet 10 mg, give two tablets by mouth at bedtime for hypertension, start date 1/18/24. -The lisinopril 7:00 p.m. dose was missed: 12/21/23, 12/23/23, 12/31/23, 1/3/24, 1/7/24, 1/8/24, 1/14/24, 1/15/24 and 1/16/24. Metoprolol succinate extended release, give two tablets by mouth two times a day for hypertension, start date 12/16/23. -The metoprolol succinate 7:00 a.m. dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/23/23, 12/24/23, 12/25/23, 12/27/23, 12/28/23, 12/31/23 and 1/7/24; and, -The metoprolol succinate 7:00 p.m. dose was missed: 12/22/23, 12/25/23 and 1/3/24. Other medications Macrodantin (Nitrofurantoin Macrocrystal) (antibiotic) capsule 100 mg, give one capsule by mouth in the morning, prophylactically, for chronic urinary tract infection, start date 12/19/23. -The macrodantin (antibiotic) 8:00 a.m., dose was missed: 12/21/23, 12/23/23 and 12/31/23. Spironolactone tablet 50 mg, give one tablet by mouth one time a day for (a diuretic) for hypertension, start date 12/16/23. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The spironolactone 9:00 a.m., dose was missed: 12/21/23, 12/24/23, 12/25/23, 12/27/23 and 12/31/23. Allopurinol 100 milligrams (mg), give one tablet by mouth one time a day for uric acid reducer, start date 12/16/23. -The allopurinol 7:00 a.m., dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/24/23, 12/25/23, 12/29/23, 12/30/23, 12/31/23, 1/2/24, 1/3/24, 1/4/23, 1/7/24, 1/8/24, 1/10/24 to 1/12/24, 1/14/24 and 1/15/24. Aspirin tablet, give 81 mg by mouth one time a day for inflammation, start date 12/16/23. -The aspirin 7:00 a.m. dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/24/23, 12/25/23 and 12/31/23. Gabapentin capsule 300 mg, give two capsules by mouth in the morning and three capsules at bedtime for neuralgia (nerve pain), start date 12/16/23. -The gabapentin 8:00 a.m. dose was missed: 12/21/23, 12/24/23, 12/27/23, 12/28/23, 12/31/23, 1/25/24 and 1/26/24; -The gabapentin 8:00 p.m. dose was missed: 12/25/23, 1/3/24 and 1/30/24. Morphine sulfate tablet extended release 15 mg give one tablet by mouth two times a day for pain, start date 12/16/23. -The morphine sulfate 7:00 a.m., dose was missed: 12/21/23, 12/24/23, 12/31/23, 13/24, 1/24/24 and 1/25/24; and, -The morphine sulfate 5:00 p.m., dose was missed: 12/30/23, 1/2/24, 1/24/24 and 1/27/24. Pregabalin capsule 150 mg, give one capsule by mouth two times a day for muscle pain, start date 12/16/23. -The pregabalin 7:00 a.m. dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/24/23, 12/27/23, 12/28/23, 12/29/23, 12/31/23, 1/2/24, 1/10/24, 1/25/24 and 1/26/24; and, The pregabalin 7:00 p.m. dose was missed: 12/25/23, 12/28/23, 1/3/24, 1/24/24 to 1/26/24. Trazodone HCl tablet 50 mg, give two tablets by mouth at bedtime for insomnia, start date 12/16/23. -The trazodone 7:00 p.m. dose was missed: 12/25/23, 1/3/24, 1/14/24, 1/15/24 and 1/24/24. Wellbutrin tablet extended release 300 mg, give one tablet by mouth one time a day for depression, start date 12/16/23. -The wellbutrin 7:00 a.m. dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/24/23, 12/29/23, 12/30/23 and 12/31/23. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Ziprasidone HCl (antidepressant) capsule 20 mg, give one capsule by mouth two times a day for mental disorder, start date 12/16/23. The ziprasidone 7:00 a.m. dose was missed: 12/19/23, 12/21/23, 12/22/23, 12/24/23, 12/25/23, 12/27/23, 12/31/23, 1/30/24 and 1/31/24; and, -The ziprasidone 7:00 p.m. dose was missed: 12/24/23, 12/25/23, 12/26/23, 12/28/23, 1/3/24, 1/9/24, 1/28/24, 1/30/24 and 1/31/24. -The majority of the above-missed doses had linked documentation explaining that the medication was not unavailable for administration but a few missed medication doses lacked any documentation to explain why the medication was not given to the resident. V. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 2/15/24 at 10:12 a.m. LPN #2 said the discrepancy with missed medication was the result of poor documentation, failure to administer medications as prescribed and a lack of communication with the resident's physician to get new prescriptions and discontinue unneeded medications. LPN #5 was interviewed on 2/15/24 at 11:32 a.m. LPN #5 said the omission of medication administration as observed in the resident's MAR was the result of not getting the medication timely from the pharmacy. LPN #6 was interviewed on 2/15/24 at 12:02 p.m. LPN #6 said Resident #6 was not always in his room and she could not find him so he often did not get his prescribed medications. LPN #6 said the issue with the observed missing medication administration in the MAR was the result of the nurse not documenting why the medication was not given. The pharmacy consultant (PC) was interviewed on 2/20/24 at 1:28 p.m. The PC checked the resident medication record and order history and said per the pharmacy records there were no medication reorder requests for Resident #6 and the reason for all of his missed medications was likely a reordering issue on the part of the facility. CNC #1 was interviewed on 2/20/24 at 4:00 p.m. CNC #1 said the assistant director of nursing (ADON) was supposed to complete daily audits to check each resident's medication supply and ensure that the medication administration nurses were recording prescribed medication timely. The ADON position was currently vacant. CNC #1 said the facility had an emergency backup medication supply in a locked unit. Not all nurses had access to get medications from the backup medication system. The previous nursing leadership team failed to resolve the issue. CNC #1 said the facility was resolving the issue so that all medication administration nurses would be assigned a code so they could access the backup medication system in the event of a resident's prescribed medication being unavailable. Additionally, they were retraining all nurses on the process of reordering resident medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNC #1 provided a list of medications available in the facility emergency medication kit warfarin was available in the e-kit in 1mg, 2 mg, and 5 mg doses and metoprolol 25 mg was available in the e-kit. Agency licensed practical nurse (ALPN) #1 was interviewed on 3/5/24 at 11:30 a.m. ALPN #1 said if she needed to get into the emergency medication kit (e-kit) she would find the DON or ask other nurses if they knew how to get in the e-kit. She said she was not trained by the facility on how to retrieve medications from the e-kit. ALPN #2 was interviewed on 3/5/24 at 11:32 a.m. ALPN #2 said she was agency staff and was not at the facility consistently but she was supposed to have codes and passwords to get into the e-kit. ALPN #2 said she was not given any codes or passwords to access the e-kit, nor was she told how to get into the e-kit. ALPN #3 was interviewed on 3/5/24 at 11:34 a.m. ALPN #3 said it was her first day working at the facility and no facility staff educated her on how to use the e-kit to retrieve medications. The IDON was interviewed on 3/5/24 at 12:45 p.m. The IDON said the facility hired 92-94 percent agency nursing staff and that the facility only had two facility hired nurse employees. The IDON said the week before this interview she had verbally trained the two facility hired nurses on the proper procedure to get medications from the e-kit. She said she would need to call the pharmacy to ask if anticoagulants were in the emergency kit but did not think that warfarin was included in the e-kit because there are various doses of the medication (see interview above with CNC #1 and below with the IDON for more information about the e-kit contents). The IDON said it was the DON's job to review medications each morning but the DON position was currently vacant and the facility was in the process of hiring a new DON, so the reviews of missing medications had not been done recently. The IDON said she did not know why Resident #6's medications were not reviewed in December 2023 and January 2024, so that medication errors could have been found and corrected. The assistant director of nursing (ADON) was interviewed on 3/5/24 at 3:45 p.m. The ADON said she was new to the position and she did not have any documentation of what medications were in the e-kit. She said she did not know where a list of what was inside the e-kits would be in the facility. The ADON showed the e-kit and showed there was no current list on the kit to describe what the contents were and she did not know what was inside the emergency medication kits. The IDON was interviewed again on 3/6/24 at 2:00 p.m. The IDON said she did not know why the agency nursing were only documented medications as missing and unavailable without providing further documentation details. She said when a medication was unavailable to give to a resident its cause should have been reviewed by the DON by the following day and the resident's physician shoul [TRUNCATED]

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46022 Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the residents nutritional needs. Specifically, the facility failed to: -Follow correct portion sizes to ensure adequate nutrition was provided to the residents; and, -Follow recipe modifications for the texture modified diets. Findings include: I. Facility policy and procedure The Kitchen Weights and Measures policy, revised April 2007, was provided by corporate nurse consultant (CNC) #1 on 2/15/24 at 10:00 a.m. It read in pertinent part, Food services staff will be trained in proper use of cooking and serving measurements to maintain portion control. Staff will be trained in the appropriate measurement and type of serving utensil to use for each food. Signs or posters explaining coded measurement indicators (color-coded) on utensils will be prominently displayed for reference. The Therapeutic Diets policy, revised October 2017, was provided by CNC #1 on 2/19/24 at 4:30 p.m. It read in pertinent part, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example: diabetic/calorie controlled diet, low sodium diet, cardiac diet; and, altered consistency diet. If a mechanically altered diet is ordered, the provider will specify the texture modification. II. Correct portion sizes A. Observations and record review During a continuous observation during the lunch meal on 2/14/24, beginning at 11:24 a.m. and ending at 1:03 p.m., cook #1 utilized the following scoop sizes: A 2.67 ounce (oz) scoop (0.33 cup) for the cole slaw for the regular diet and the carbohydrate controlled diets. A 2.67 oz scoop (0.33 cup) for the pasta salad for the mechanically altered diets. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The residents on a regular diet received one cookie. -The 2.67 oz scoop (0.33 cup), was 1.33 oz less than the 4 oz specified on the menu extension sheet for the cole slaw for the regular and carbohydrate controlled diets. -The 2.67 oz scoop (0.33 cup), was 1.33 oz less than the 4 oz specified on the menu extension sheet for the pasta salad for the mechanically altered diets. -The menu extension sheet specified the residents on a regular diet were supposed to receive two cookies. During the same continuous observation of the lunch meal on 2/14/24, the following was additionally observed: At 12:28 p.m., cook #1 placed a couple scoops of meat into the food processor. Cook #1 added approximately 0.5 cups of hot water and one scoop of powdered thickener to the food processor. Cook #1 used a spatula to put the pureed meat into a bowl. At 12:31 p.m., cook #1 put four scoops of zucchini that was sitting in water into the blender. The scoops of zucchini had a lot of water in them. Cook #1 blended the zucchini with one scoop of powdered thickener. She poured the pureed zucchini into a bowl. -Cook #1 did not use a measuring device to ensure she provided the residents on the pureed diet the correct portion size. The recipe sheet for the pureed sandwich sloppy joe on a bun specified to puree the bread and the meat separately. The residents on a pureed diet were supposed to receive one #8 scoop and two #20 scoops of bread. The recipe specified to add broth or gravy to the items if they needed thinning. -Cook #1 did not puree the bread. -The residents on a pureed diet did not receive the bread. -Cook #1 added water instead of gravy or sauce to the meat when pureeing it. The menu extension sheets indicated the residents on a pureed diet were supposed to receive a pureed cookie, a pureed sloppy joe with a bun, pureed pasta salad, pureed vegetable of the day, whole milk and a beverage of choice. -Cook #1 did not provide the residents on a pureed diet a bun, pasta salad, cookie or milk. III. Follow recipe modifications for mechanically altered diets. A. Observations and record review During a continuous observation of the lunch meal on 2/14/24, beginning at 11:24 a.m. and ending at 1:03 p.m, cook #1 served the residents on a mechanically altered diet the regular textured meat on the sloppy joes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The menu extension sheet specified for residents on a mechanically altered diet to receive one #8 scoop of pureed meat and two #20 scoops of the pureed bun. IV. Staff interviews The nutrition services director (NSD) was interviewed on 2/14/24 at 4:16 p.m. The NSD said the cooks utilized the menu extension sheet to serve the correct portion sizes and texture. The NSD said cook #1 did not use the correct portion size for the cole slaw for the regular and carbohydrate controlled diet. The NSD said the menu extensions needed to be followed for mechanically altered residents. The NSD said if residents were not served the correct texture of food it put them at risk for choking. The NSD said the residents on a regular diet were supposed to get two cookies and only received one. The NSD said cook #1 needed to use broth or gravy to thin the meat. The NSD said adding water decreased the nutritional value of the food item. The NSD said cook #1 should have used scoops to ensure the residents on a pureed diet received the correct portion size. The NSD said the cooks needed to ensure all menu items that were listed on the meal extension sheets were served to the residents to meet their nutritional needs. The registered dietitian (RD) was interviewed on 2/15/24 at 11:59 a.m. The RD said the residents who were on a pureed diet did not receive adequate nutrition for lunch on 2/14/24. The RD said cook #1 needed to serve all components of the meal to the residents. The RD said cook #1 needed to utilize scoops to ensure the correct portion sizes were served to the residents. The RD said cook #1 did not serve the correct diet texture to the residents on a mechanically altered diet on 2/14/24. The RD said this put the residents at risk for choking. The RD said the menu extensions were not accurate and he would need to look at them to ensure each diet reflected what each diet type was to receive and the correct texture.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46022 Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures. Specifically, the facility failed to ensure resident food was palatable in taste, texture and appearance. Findings include: I. Facility policy and procedure The Food and Nutrition Services policy, revised October 2017, was provided by corporate nurse consultant (CNC) #1 on 1/19/24 at 4:30 p.m. It read in pertinent part, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. II. Observations A test tray for a regular diet was evaluated by three surveyors immediately after the last resident had been served their room tray for lunch on 2/14/24 at 1:05 p.m. The test tray consisted of a sloppy joe sandwich, a bag of potato chips and coleslaw. -The individual bag of potato chips was set directly on top of the sloppy joe sandwich. -The cole slaw was 48.4 degrees fahrenheit (F). The cole slaw was bland and soggy. -The sloppy joe sandwich was greasy. III. Record review The 10/11/23 food committee notes documented the residents said the food orders were not always being taken and they wanted more strawberry yogurt and jelly. The residents wanted more soups and sandwiches for dinner. The 11/9/23 food committee notes documented the residents requested the menu to be posted. The residents wanted more ice cream flavors. The 1/11/24 food committee notes documented the residents wanted deep fried breakfast burritos, hash browns, ham, chile rellenos, clam chowder, gumbo, crispy bacon, fried chicken, tacos, shrimp alfredo and beef stroganoff. IV. Resident interviews (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was interviewed on 2/13/24 at 12:59 p.m. Resident #4 said the food was not good. Resident #4 said the food was often served late. Resident #15 was interviewed on 2/13/24 at 4:07 p.m. He said the food was often served cold. He said the food was bland. Resident #15 said there were some days the food tasted so bad he was unable to eat it. Resident #1 was interviewed on 2/14/23 at 10:33 a.m. Resident #1 said the food was not good because it was served cold when it should have been hot. The resident said he was not going to eat his lunch because it did not look good to him. Resident #19 and Resident #11 were interviewed together on 2/14/24 at 1:54 p.m. Resident #11 said the food was not good. He said he was a vegetarian and ordered vegetables frequently. Resident #11 said the vegetables were over cooked and turned into mush. He said the food was not presented in a tasteful manner. Resident #11 said it often looked like someone had taken a bite out of his food. Resident #19 said both he and Resident #11 ordered a cheese quesadilla the other day that was curled up on the edges and hard. Resident #11 and Resident #19 said the food was cold and tasteless. Resident #11 and Resident #19 said they often ordered their own food because the food provided by the facility was so bad. Resident #11 and Resident #19 said the food was often dry. Resident #12 was interviewed on 2/14/24 at 4:47 p.m. Resident #12 said the food was not good. She said cold foods were often served at room temperature and hot foods were served cold. She said the kitchen often ran out of food. Resident #12 said she often had to ask for her meals to be heated. Resident #20 was interviewed on 2/15/23 at 1:45 p.m. Resident #20 said the food in the facility was usually cold by the time it was served and it did not taste good cold. V. Resident group interview Five residents (#3, #12, #26, #29 and #27), who were identified as interviewable by the facility and assessment, were interviewed on 2/15/24 at 10:34 a.m. All of the residents interviewed said the following: -Thefood was not good; -The food was often cold; -The food was tasteless; and, -The food was often not cooked correctly. Resident #26 said she found the food committee to be a waste of her time as she had raised concerns and they were never addressed. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 and Resident #12 said they voiced their food concerns in the resident council and food committee. They said they did not feel their concerns were being addressed. VI. Staff interviews The nutrition services director (NSD) and CNC #1 were interviewed together on 2/14/24 at 4:16 p.m. The NSD said she had tried the coleslaw that was served for lunch (2/14/24) and said it was bland. The NSD said cook #1 was new to the department and she would provide her with education. The NSD said the coleslaw needed to be kept under 41 degrees fahrenheit for serving. The NSD said the facility had a food committee meeting once a month. CNC #1 said serving the potato chip bag on top of the sloppy joe did not make the meal look appetizing. CNC #1 said the food should be the correct temperature, tasty and look good when served to the residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to provide each resident with a nourishing, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for one (#11) of three residents out of 29 sample residents. Specifically, the facility failed to ensure Resident #11's requests and preferences for a vegetarian diet were served to him. Findings include: I. Facility policy and procedure The Resident Food Preferences policy, Revised July 2017, was provided by corporate nurse consultant (CNC) #1 on 2/19/24 at 4:30 p.m. It read in pertinent part, Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Upon the resident's admission (or within 24 hours after his/her admission the dietitian or nursing staff will identify the resident's food preferences. Nursing staff will document the resident's food and eating preferences in the care plan. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. II. Resident #11 A. Resident status Resident #11, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2024 computerized physician orders (CPO), diagnoses included quadriplegia (decreased or no control of all four limbs), neuromuscular dysfunction of the bladder (decreased movement of the bladder), hypoglycemia (low blood sugar), type one diabetes mellitus, neurogenic bowel (decreased bowel movement) and anxiety. The 2/14/24 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. B. Resident interview and observation During a continuous observation of the lunch line service on 2/14/24, beginning at 11:24 a.m. and ending at 1:03 p.m., the following was observed: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 12:20 p.m. an unidentified dietary staff member put a cookie and an individual sized bag of potato chips on Resident #11's meal tray. Resident #11 was interviewed on 2/14/24 at 1:54 p.m. Resident #11 said he preferred not to eat meat. He said he had been a vegetarian for [AGE] years. Resident #11 said he only got a cookie and a bag of chips for lunch. He said the menu item for lunch was a sloppy joe and he was unable to eat that due to his preferences. Resident #11 said he had to purchase most of his own food since the facility did not accommodate his preference. Resident #11 said he had lost weight since he was admitted to the facility. Resident #11 said there was an alternative menu that had a grilled cheese, cheese quesadilla and a bean burrito. Resident #11 said he was tired of these options. Cross reference: F692 for nutrition. C. Record review The nutrition care plan, initiated on 5/25/23 and revised on 2/15/24 (during the survey), revealed Resident #11 had potential for alteration in body composition integrity (muscle and fat wasting) and potential for unintended weight changes related to worsening condition secondary to numerous comorbidities including: type one diabetes mellitus, quadriplegia, history of pressure ulcer and depression. The interventions included: monitoring, recording and reporting to the physician signs and symptoms of malnutrition as needed (5/25/23), obtaining and monitoring lab/diagnostic work as ordered and reporting results to physician to follow up as needed (5/25/23), monitoring need for occupational therapy to screen for adaptive equipment (5/25/23), providing and serving supplements as ordered (2/15/24, added during the survey), providing and serving diet as ordered (5/25/23), offering vegetarian items per resident preferences and obtaining preferences (2/15/24, added during the survey), evaluating the resident by the registered dietitian (RD) as needed (5/25/23) and obtaining weights per facility protocol (5/25/23). III. Resident group interview Five residents (#3, #12, #26, #29 and #27), who were identified as interviewable by the facility and assessment, were interviewed on 2/15/24 at 10:34 a.m. All of the residents interviewed said the following: -Their meal orders were not always taken; -They often were served food they did not order; and, -They would like their orders to be taken everyday and wanted the kitchen staff to follow what was written on the meal tickets. Resident #27 said he ate in his room. He said he requested double portions for all meals. Resident #27 said he often did not get double portions and was hungry afterwards. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12 said she ordered a side of coleslaw with her meal yesterday (2/14/24) and did not get it. IV. Staff interviews The nutrition services director (NSD) was interviewed on 2/14/24 at 4:16 p.m. The NSD said the certified nurse aides (CNA) were responsible for taking the residents' orders. The NSD said food preferences, such as Resident #11's, should be on the resident's care plan. The NSD said she did not update the residents' care plans. The NSD said if she thought something needed to be on the care plan she would notify the RD. The NSD said the kitchen provided whatever Resident #11 wrote on his meal ticket. The NSD and the RD were interviewed together on 12/15/23 at 11:59 a.m. The RD said Resident #11 preferred to be a vegetarian. The RD said Resident #11 did eat fish. The RD said Resident #11 purchased a lot of his own food. The RD said Resident #11 was a picky eater. The RD said he would visit with the resident and try to establish the resident's food preferences and help create a menu for Resident #11 that was nutritionally balanced. The RD said resident preferences should be included in the care plan. The RD said Resident #11's lunch of chips and cookies was not a complete meal and did not provide the resident with adequate nutrition. The NSD said the kitchen had been offering Resident #11 the alternative items such as a bean burrito, grilled cheese and cheese quesadilla. The NSD and the RD said they understood that Resident #11 was tired of the alternative options.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43135 Based on record review and interviews, the facility failed to develop and implement appropriate quality assurance and performance improvement (QAPI) plans of action to correct identified quality deficiencies, potentially affecting all the residents in the facility. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to medication errors. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program policy, revised February 2020, was provided by the interim director of nursing (IDON) on 3/7/24 at 2:40 p.m. It revealed in pertinent part, The objectives of the QAPI Program are to: Provide a means to measure current and potential indicators for outcomes of care and quality of life. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Reinforce and build upon effective systems and processes related to the delivery of quality care and services. Establish systems through which to monitor and evaluate corrective actions. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: A. Tracking and measuring performance; B. Establishing goals and thresholds for performance measurement; C. Identifying and prioritizing quality deficiencies; D. Systematically analyzing underlying causes of systemic quality deficiencies; E. Developing and implementing corrective action or performance improvement activities; and F. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. II. Respeat deficiencies The facility ' s recertification survey on 9/28/23 included F760 (residents are free of significant medication errors) cited at actual harm scope and severity, isolated. III. Significant medication errors Cross-reference F760 failure to prevent significant medication errors. During the 3/5/24 survey, the facility was cited for significant medication errors which rose to the scope and severity of immediate jeopardy. The facility failed to ensure medications were available from the pharmacy and ensure medications were given according to the physician's orders. IV. Staff interviews The nursing home administrator (NHA) and IDON were interviewed on 3/8/24 at 1:30 p.m. They said the QAPI committee met monthly. They said from September 2023 through today 3/8/24 the facility had several NHAs. They said the committee evaluated the root cause of problems, reviewed plans and made sure the right departments took care of the needed problems. They said from September 2023 up until recently, notes for the QAPI meetings were requested from former NHAs but the facility was never provided with any notes from the QAPI meetings. The IDON said she was unaware that the same citation that was given this week was cited in September 2023. She said she was unaware if the committee discussed the F760 from September 2023. The NHA and IDON said the upcoming QAPI meeting would discuss the issues with medication errors to ensure it was resolved. V. Facility follow-up The IDON provided the following plan on 3/6/24 at 3:15 p.m. to address significant medication errors in upcoming QAPI meetings. The Administrator implemented a QAPI PIP (quality assurance and performance improvement, performance improvement plan) as a means to gather and process information from the audit. Findings will be reported at the monthly QAA meeting for a minimum of 3 months.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 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: -Follow aseptic technique when replacing Resident #15's suprapubic catheter; and -Follow aseptic technique when performing Resident #18's wound care. Findings include: I. Suprapubic Catheter insertion procedure for Resident #15 A. Professional references According to [NAME], B.C. 2001, (8/16/21) Nursing Standards, How to Change a Suprapubic Catheter Effectively, retrieved on 2/27/24 from https://journals.rcni.com/nursing-standard/how-to-series/how-to-change-a-suprapubic-catheter-effectively-ns.2021.e11766/abs, A suprapubic catheter is inserted through the lower abdominal wall, above the pubic bone and below the navel, and into the bladder. A suprapubic catheter change is an aseptic procedure that was undertaken to reduce the risk of infection at the catheter site and in the tract, which has direct access to the bladder. According to Alsolami, F. and Tayyib, N., 9/24/23 International Journal of Urological Nursing: Nurse's knowledge and practice towards prevention of catheter-associated urinary tract infection: A systematic review, retrieved on 2/27/24 from, https://onlinelibrary.[NAME].com/doi/full/10.1111/ijun.12380 Catheter-associated urinary tract infection (CAUTI) is a common complication associated with indwelling urinary catheters, frequently used in healthcare settings. Nurses play a critical role in preventing CAUTI, as they are often responsible for inserting, maintaining and removing urinary catheters. Therefore, it is important to comprehensively assess nurses' level of knowledge about CAUTIs and the variables that influence their application of best practices and recommendations for preventing these infections. Complications from catheter-associated urinary tract infections (CAUTIs) can extend hospital stays, cause patient discomfort, and raise medical expenses and death.1 Meanwhile, catheterization of the urinary tract is a routine hospital operation with a high risk of hospital-acquired urinary tract infections (UTIs). It is responsible for over 70% of all UTIs. Similarly, an indwelling urinary catheter (IUC) is the leading risk factor for CAUTIs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065274	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Post Acute	3185 W Arkansas Ave Denver, CO 80219

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 - Few	Several barriers to preventing CAUTIs include age, gender, work experience, professional qualification, in-service training, lack of adherence to guidelines, time, equipment, staff availability, and working unit were identified. The review also identified facilitators for preventing CAUTIs, including ongoing/in-service education and self-instructed modules. These educational interventions have improved nurses' knowledge and adherence to prevention guidelines, in addition to applying the competency outcomes and performance assessment-based training programs for nurses to prevent CAUTIs. Therefore, to avoid UTIs, nurses should be well-trained in properly caring for catheters and how to use them. B. Facility policy The Suprapubic Catheter Care policy, revised October 2010, was provided by corporate nurse consultant (CNC) #1 on 2/20/24 at 12:10 p.m. It read in pertinent part,: The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. Steps in procedure: 1. Place the clean equipment on the bedside stand or overbed the table. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly . -Note hand hygiene was step two after the staff was instructed to handle the catheter care supplies. The Catheter Care, Urinary policy, revised August 2022, was provided by CNC #1 on 2/20/24 at 12:10 p.m. It read in pertinent part, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Follow aseptic technique when inserting a urinary catheter. Maintain a closed drainage system when possible. The Handwashing Hand Hygiene policy, revised October 2023, was provided by CNC #2 on 2/20/24 at 12:13 p.m. It read in penitent part, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. - Hand hygiene is indicated immediately before touching a resident, before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device), after contact with blood, body fluids, or contaminated surfaces, after touching a resident, after touching the resident's environment,before moving from work on a soiled body site to a clean body site on the same resident and immediately after glove removal. D. Observation (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Westwood Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3185 W Arkansas Ave Denver, CO 80219	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/24 at 11:10 a.m., registered nurse (RN) #1 was observed changing Resident #15's suprapubic catheter. RN #1 entered the resident's room with gloved hands holding a catheter change kit. The resident was already in bed and lying flat. RN #1 explained the procedure to the resident and uncovered the resident exposing the suprapubic catheter site. Without glove removal, hand hygiene, or setting up a clean or sterile field, RN #1 pulled open the lid of the new sterile catheter kit with the same gloved hands he had just uncovered and positioned the resident with and set the new catheter kit directly on top of the resident bedding. RN #1 reached his dirty gloved hands into the new/sterile catheter kit and removed the new prefilled syringe meant to inflate the new catheter after insertion. RN #1 was about to place the new sterile syringe on the catheter balloon port to remove the saline inside so the old catheter could be removed when he realized the syringe was already full of saline. RN #1 stared at the syringe for a few minutes and placed it back into the new sterile catheter kit. RN #1 reached for the resident's used irrigation syringe and attempted to place it onto the catheter's balloon port, but in his attempts to fit the syringe onto the balloon catheter, he realized it was too big to fit and would not pull any fluid out of the balloon port. RN #1 left the resident's room and returned with the same gloves on and a new empty syringe. RN #1 opened the syringe, placed it on the old catheter's balloon port, extracted the saline holding the old catheter in place and gently slipped the old catheter out of the resident's suprapubic catheter insertion site. RN #1 coiled the removed old catheter in his right gloved hand until the trash can was brought to him for disposal. RN #1 then used his right gloved hand to adjust his own surgical mask and proceeded to the next step of replacing Resident #15's suprapubic catheter without changing his gloves or performing hand hygiene. RN #1 picked up the new catheter, tore off the protective wrapping from the tip of the catheter and used his other hand to pick up and tear open a small packet of lubricant. RN #1 dripped some lubricant on the tip of the catheter and then, without cleaning or lubricating the suprapubic stoma site, inserted the new catheter. RN#1 grabbed the new prefilled saline syringe, uncapped it, attached it to the new catheter balloon port and inflated the balloon to make sure the new catheter would stay in place. RN #1 gave the newly placed catheter a light tug to make sure it was in place and ended the procedure. Cross-reference F726 competent nursing staff E. Interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed on 2/11/24 at 12:33 p.m. RN #1 said hand hygiene should be performed prior to performing a supra pubic catheter change and gloves should be worn during the procedure. RN #1 said after the old catheter was removed the nurse should remove the used gloves and perform hand hygiene before inserting the new catheter. RN #1 said the suprapubic stoma site should be cleaned and lubricated just before the insertion of the new catheter. Once the new catheter was in place, the nurse should inflate the catheter balloon to hold the new catheter in place. Once the procedure was completed the nurse was to clean up the supplies. CNC #1 was interviewed on 2/20/24 at 12:37 p.m. CNC #1 said RN #1 did not perform hand hygiene properly when he replaced Resident #15's suprapubic catheter. 47351 II. Wound care procedure for Resident #18 A. Facility policy The Wound Care Policy was received on 2/20/24 at 12:10 p.m. from CNC #1. It read in pertinent part: Use disposable cloth (paper towel is adequate) to establish a clean field on the resident's bedside table. Place all items to be used during the procedure on the clean field. Arrange all the supplies so they can be easily reached. Wash and dry hands thoroughly. Place disposable cloth next to the resident under the wound to serve as a barrier to protect the bed linens and other body sites. Put on exam gloves and loosen tape and remove dressing. Pull the gloves over the removed dressing and discard in the appropriate receptacle. Wash and dry your hands thoroughly. Use sterile gloves when physically touching the wound or holding a moist surface over the wound. Apply treatments as necessary. Dress wound. [NAME] tape with initials, time, and date and apply dressing. B. Observation On 2/14/24 at 11:45 a.m., the wound care nurse (WCN) entered the Resident #18's room with wound care supplies, including tape. -The WCN did not wash her hands before entering the resident's room and setting up the supplies to perform wound care. -The WCN set up the wound care supplies on the resident's nightstand without first cleaning the surface that was cluttered with an open drink, candy, stacks of paper, and painting supplies. The resident transferred herself from her wheelchair to the bed and lowered her pants to expose her sacral (tailbone area) wound. -Without performeng hand hygiene, the WCN put on exam gloves and proceeded to remove the resident's soiled dressing from the sacral wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Without performing hand hygiene and changing her gloves, the WCN proceeded to open the clean dressing supplies with the same exam gloves on her hands she had used to remove the soiled wound dressing from the resident's wound. -The WCN next handled the opened clean wound dressing supplies and moved the supplies, setting them directly on the resident's bed without a secondary clean field barrier. -The WCN nurse removed her used exam gloves and put on another pair of exam gloves but did not perform hand hygiene between the glove change. The WCN proceeded to clean Resident #18's sacral wound with saline and walked to the wastebasket to throw away the soiled wound care materials. -The WCN removed her used gloves and, without performing hand hygiene, put on another pair of gloves and packed the resident's wound, using her hands, with dry Kerlix (gauze). The WCN covered the wound with a large butterfly shaped dressing and reinforced the dressing with tape. C. Staff interviews The WCN was interviewed on 2/14/24 at 1:00 p.m. The WCN said she was new to the facility and her start date was 2/12/24. The WCN said she did not have wound care certification but would be working toward obtaining wound care certification in the near future. The wound care nurse said that regular glove changes during wound care was the key to infection control. The WCN said preserving a clean work station for dressing materials was also important. CNC #1 was interviewed on 2/20/24 at 1:30 p.m. CNC #1 said nurses performing wound care should wash their hands prior to starting wound care. She said nurses should set up a clean field for supplies, wash their hands and put on clean gloves after removing the old dressing and disposing of it, prior to cleansing the wound and prior to applying a new dressing to prevent the potential spread of infection. CNC #1 said the facility would ensure that the WCN obtained wound care certification.