STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065278	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Health and Rehabilitation Center	710 3rd St Windsor, CO 80550

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41172 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 grooming and personal hygiene for three (#1, #3 and #5) of three residents reviewed out of 10 sample residents. Specifically, the facility failed to: -Ensure Resident #1, Resident #3 and Resident #5, who were dependent on staff for bathing, received their scheduled showers; and, -Ensure resident #5, who was dependent on staff for ADL care, received assistance with shaving. Findings include: I. Facility policy and procedure The Supporting Activities of Daily Living (ADL) policy, revised March 2018, was received from the regional director of operations (RDO) on 6/10/24 at 4:53 p.m. The policy documented in pertinent part, 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). II. Resident #1 A. Resident status Resident #1, age 65, was admitted on [DATE] and discharged on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included debility, congestive heart failure, peripheral vascular disease (poor circulation to extremities), and surgical incision to the right groin. The 5/24/24 MDS assessment revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. She required maximal, substantial assistance with bathing. B. Record review (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's June 2024 CPO revealed the following physician's order: Wound Care for the right groin incision, daily showers, clothing and bedding changes, ordered 5/23/24. The bathing records from the electronic medical record (EMR) were provided by the director of nursing (DON) on 6/10/24 at 1:00 p.m. -The documentation revealed the resident had not received showers on 5/28/24, 5/29/24, 6/3/24, 6/4/24, 6/5/24, 6/7/24 or 6/8/24 as ordered. The showers on those days were documented with a N or NA. III. Resident #3 A. Resident status Resident #3, age 84, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included debility, congestive heart failure, diabetes mellitus and obesity. The 4/15/24 MDS assessment revealed the resident had mild cognitive impairment with a BIMS score of 13 out of 15. She required maximal, substantial assistance with bathing. B. Resident interview Resident #3 was interviewed on 6/10/24 at 12:34 p.m. Resident #3 said she was supposed to get bed baths during the day shift on Tuesdays and Fridays. She said she was too big to go in the shower or bath and therefore she had to have bed baths. Resident #3 said she frequently did not get a bed bath because the staff told her they were too busy or did not have enough staff. C. Record review The certified nurse aide (CNA) bathing record tasks for the last 30 days (from 5/11/24 through 6/10/24) was reviewed in the EMR on 6/10/24 at 12:45 p.m. The bathing task record documented the resident preferred baths on Tuesdays and Fridays. -There was no documentation in the CNA task record to indicate Resident #3 had received a bed bath from 5/11/24 through 6/10/24. Paper records of baths for Resident #3 from 5/11/24 through 6/10/24 were requested from the DON on 6/10/24 at 1:00 p.m. The records were provided at 1:30 p.m. The paper bathing records documented the following: Resident #3 received a bed bath on 5/16/24 (Thursday), 5/28/24 (Tuesday), 5/31/24 (Friday), 6/4/24 (Tuesday) and 6/10/24 (Monday). -There was no shower documentation for the week of 5/19/24 through 5/25/24. -The resident did not have a bed bath on 6/7/24. The paper shower record documented could not shower due to short staffing. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The paper record documentation provided by the DON indicated Resident #3 received a bed bath, was shaved, and had no skin concerns on 6/17/24 and 6/23/24. -However, the information was provided on 6/10/24 and 6/17/24 and 6/23/24 had not occurred yet. IV. Resident #5 A. Resident status Resident #5, age 84, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included diabetes mellitus, cerebral vascular accident (stroke) and multi drug resistant organism (MDRO). The 4/25/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. She required maximal, substantial assistance with personal hygiene including shaving. B. Observation and interview Resident #5 was observed in her room on 6/10/24 at 11:24 a.m. She had long, thick, white facial hair across her entire upper lip, chin and below her chin. She said she would like to be shaved. C. Record review The resident's bathing records were reviewed in the EMR. The CNA task bath record documented the resident preferred baths on Wednesdays and Saturdays. -There was no documentation in the CNA task record to indicate Resident #5 had received a bed bath from 5/11/24 through 6/10/24. Paper records of baths for Resident #5 from 5/11/24 through 6/10/24 were requested from the DON on 6/10/24 at 1:00 p.m. The records were provided at 1:30 p.m. The paper bathing records documented the following: -The resident had a shower on 5/1/24 (Wednesday), 5/8/24 (Wednesday), 5/11/24 (Saturday), 5/15/24 (Wednesday), 5/18/24 (Saturday), 5/22/24 (Wednesday), 5/25/24 (Saturday), 5/27/24 (Monday) and 5/29/24 (Wednesday). -The resident did not receive a shower on 5/4/24. -The resident received a shower on 6/5/24, seven days after her last shower on 5/29/24. -The paper bathing records documented Resident #5 was not shaved on 5/29/24 or 6/5/24. V. Interviews (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 6/10/24 at 1:40 p.m. She said when the CNAs documented N in the CNA bathing task record it meant the care was not done. She said NA meant not applicable. She said if a resident refused a bath or shower, the CNA would document RR for the resident refused. The DON said she did not know why the showers were not done daily as ordered by the physician for Resident #1 to prevent infection of her groin incision. She said she was not aware the showers had not been done. The DON said showers were documented in the residents' EMR and on paper. She said she had provided the EMR record (as above) and had no further paper records of showers for Resident #1, #3 or #5. The DON said the orders for Resident #3's baths had been put in the EMR incorrectly and therefore there was no documentation of her bed baths. She said she was not aware the resident had no record of baths the week of 5/19/24 through 5/25/24 or that she had not received a bath due to short staffing. The DON said residents were supposed to be shaved on bath days and as needed. She said did not have any further bathing records for June 2024 for Resident #5 or documentation to indicate why she had not been shaved. She said she would have the resident shaved. The DON was interviewed again on 6/10/24 at 4:18 p.m. The DON said she had provided education to the nursing staff in the past about ensuring showers and baths were given and documented. She said she had no current system for monitoring to ensure showers and baths were given and documented.

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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** 41172 Based on observations, record review and interviews, the facility failed to provide an environment as free of accident hazards as possible and ensure residents received adequate supervision and assistance devices to prevent accidents for four (#4, #7, #8 and #9) of five residents reviewed for accident hazards out of 10 sample residents. Specifically, the facility failed to: -Provide supervision to prevent the elopement of Resident #4; -Investigate how Resident #4, who had a wander prevention device, eloped from the facility in order to prevent a recurrence; -Complete accurate elopement risk assessments for Resident #7 and Resident #8; -Ensure Resident #8 and Resident #9's care plans were updated to include their wander risk and wanderguards; and, -Routinely check the function of wander prevention devices for Resident #7, Resident #8 and Resident #9. Findings include: I. Facility policy and procedure The Wandering and Elopement policy, dated 2/29/24, was received from the regional director of operations (RDO) on 6/10/24 at 4:53 p.m. The policy documented in pertinent part, A Wander/Elopement assessment will be completed on all residents upon admission to the facility. The outcome is shared with the interdisciplinary team (IDT) during the initial care conference, or earlier if the elopement risk is of immediate concern. The elopement risk is assessed quarterly or as needed with change of condition. Nursing staff will address initial elopement risk concerns in the baseline care plan. If the resident is identified as an elopement risk, the following will be maintained: Elopement Resident Identification form, including the current color photo, physical description of the resident, as well as approaches for an individualized plan of care will be in the elopement binder. Implementing and care planning interventions to address safety and decrease risk of elopement. A Physical Restraint Use Consent shall be obtained from the resident's responsible party if an electronic device is utilized. A Physician order will be required for the use of monitoring the device. The order will include checking placement of the device every shift and checking function of the device daily. The care plan will be updated to include that an electronic alarm system is used for resident's safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #4 A. Resident status Resident #4, age 79, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included dementia and diabetes mellitus. The 5/1/24 MDS assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He was independent with transfers and ambulation. Resident #4 required partial to moderate assistance with dressing and personal hygiene, and supervision with toileting. The assessment documented the resident wandered. B. Record review On 4/27/24 the Wander Elopement Risk Evaluation documented the Resident #4 ambulated independently, routinely wandered or paced, wandered or paced in a manner that placed his safety at risk and had a diagnosis of dementia impacting his decision making. The assessment further documented the resident was confused and wandered in halls independently but did not appear to be at risk for exit seeking. On 4/27/24 at 2:06 p.m. a nurse progress note documented the resident had a diagnosis of dementia and ambulated with a walker. A wanderguard was placed. On 5/19/24 at 1:03 p.m. a nurse progress note documented Resident #4 went out the front door without the wanderguard going off. He was redirected back to the building. He walked out when another resident opened the door. His wanderguard was replaced. On 5/22/24 a Special Care Unit Criteria (secure unit) review documented the resident met the criteria for the special unit due to dementia with exit seeking, walking in halls naked, and wandering. On 5/25/24 at 12:57 p.m. a nurse progress note documented the resident was found walking two blocks away from the facility. His wanderguard did not go off when the resident exited. It did go off when the resident came back to the building. There were no injuries. The family was notified and said they would come in and move him to the secure unit that afternoon (5/25/24). -The physician's orders were reviewed. There were no orders for a wanderguard or checking the function of a wanderguard. -There was no documentation the physician was notified of Resident #4's elopement on 5/25/24. A physician's order, dated 5/28/24, documented Resident #4 was to move to the men's secure unit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The elopement risk care plan, initiated 4/27/24, documented the resident's risk for leaving the facility unattended would be minimized through the review date. Interventions included identifying patterns of wandering, intervening as appropriate, distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television and books. The resident used a wanderguard for safety and staff were to check placement of the wanderguard every shift. The care plan indicated Resident #4 was moved to the secure unit on 5/25/24. C. Interviews and observation The nursing home administrator (NHA) was interviewed on 6/10/24 at 1:00 p.m. The NHA said Resident #4 had eloped on a weekend. He said he was informed in a group chat text. He said he did not have an investigation of how the resident eloped with a wanderguard bracelet on. The NHA said he thought maybe the maintenance director checked the doors to make sure they were working the following Monday, but he was not sure. He said he had not interviewed any of the staff and did not know who was involved. The NHA said he was not aware there were no physician's orders for the wanderguard device or documentation the bracelet was checked to ensure it functioned routinely. The NHA said maybe the door was already open and Resident #4 followed someone out. He said he did not know how long the resident had been gone from the facility or who found him. The NHA said he had not reported the elopement to the state agency. The director of nursing (DON) was interviewed on 6/10/24 at 1:07 p.m. She said she was notified Resident #4 eloped via a group text chat on the weekend from social services. She said she thought the NHA investigated the elopement. The DON said she did not know how long the resident was gone or who found him. She said social services could provide more information. The DON said Resident #4 did have a wanderguard but she did not see a physician's order for it or to check the placement and function of the device routinely. The DON said the wanderguard device should be checked every 24 hours for placement and function. She said there was no increased supervision or monitoring of the resident but there should have been prior to his elopement on 5/25/24. The regional vice president (RVP) was interviewed on 6/10/24 at 1:28 p.m . The RVP said an investigation should have been done of the elopement to determine the cause. The RVP said the facility was doing a house sweep (during the survey) of all residents and verifying all residents with wander guards had physician's orders to include routine checks of the wanderguard function and a care plan. She said she would provide a copy of the facility's plan to correct the issue with elopement and lack of investigation as to cause and IDT education. The maintenance director (MTD) was interviewed on 6/10/24 at 1:45 p.m. The MTD said he heard about Resident #4's elopement over the weekend from a group text chat. He said he did not come in to check the function of the doors over the weekend. He said he routinely checked the function of the alarms on doors Monday through Friday and the manager on duty (MOD) checked them on the weekends. He said the MOD did not document the door checks on the weekends but he documented his door checks Monday through Friday. The MTD said the nursing staff had reported concerns with the doors not alarming when a wanderguard device was in range but each time he checked the doors, they worked. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The front door was checked for function with the MTD on 6/10/24 1:45 p.m The MTD put a wanderguard device in his pocket. The alarm sounded and the door locked when the MTD was about eight feet from the door. The door was then placed in the open position. The door alarmed when the MTD approached with the wanderguard device at approximately eight to nine feet. -Copies of the door checks for Monday through Friday were requested twice from the MTD and not received by the end of the survey on 6/10/24. Registered nurse (RN) #3 was interviewed on 6/10/24 at 2:44 p.m. RN #3 said she was on duty on 5/25/24 when Resident #4 eloped. RN #3 said she came out of the bathroom and a couple of certified nurse aides (CNAs) told her a man in a white van came to the door and said he thought one of the facility's residents was seen down the road a couple of blocks away. She said the CNs got in the white van and went with the man. RN #3 said the CNAs walked the resident back to the facility. RN #3 said she did not know how long the resident had been gone or when he had last been seen at the facility. She said she was notified by the CNAs sometime after lunch. RN #3 said she did not recall who the CNAs were who notified her. She said she notified the family but did not notify the physician. RN #3 said she did not see any injuries on Resident #4. RN #3 said she assumed Resident #4's wanderguard did not alarm when he went out of the building but she did not know. RN #3 said she thought social services notified the NHA. The social service assistant (SSA) was interviewed via phone on 6/10/24 at 3:10 P.M. The SSA said she was helping serve lunch on 5/25/24 and she saw CNAs walking with Resident #4 outside. The CNA's said he had been way down the street. The SSA said she assumed the door did not alarm when the resident went out. She said sometimes it did not alarm when a wanderguard went through the door. She said the door had not alarmed in the past when a wanderguard was near it. She said the maintenance director had been notified. The SSA said she did not know who the CNAs were or who notified the NHA of the elopement. She said the resident already had an assessment done that indicated he needed secure unit placement due to his exit seeking. She said the facility had not moved the resident yet because they were waiting for the family to come in and assist with the move. She said the family had requested to be present for the move to decrease the resident's anxiety. CNA #1 was interviewed on 6/10/24 at 3:18 p.m. CNA #1 said she was providing incontinence care on a resident and saw a man walking outside the window. She said she thought it looked like Resident #4. CNA #1 said she finished what she was doing with the other resident, which took about 15 minutes, and then notified the nurse that she thought she saw a man who looked like Resident #4 walking outside. CNA #1 said she went to see who the resident was. CNA #1 said he was not aware of Resident #4's elopement risk. She said he must have been a good walker because she found him a couple of blocks down the street near a school. CNA #1 said she walked him back to the facility. She said she did not know anything about a white van with a man who had seen the resident. III. Other residents with wanderguards On 6/10/24 at 1:07 p.m. the director of nursing (DON) provided a list of residents with wanderguard needs due to risk of elopement. The list included Resident #7, #8 and #9. A. Resident #7 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #7, age less than [AGE] years old, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included vascular dementia and multiple sclerosis (nerves become damaged and communication with the brain and other body parts is lost). The 4/25/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with transfers, ambulation, dressing, personal hygiene and toileting. The assessment documented he used a wander elopement device. 2. Record review On 4/24/24 the Wonder Elopement Risk Evaluation documented the resident was not at risk for elopement. -However, the resident had a wanderguard device. On 4/25/24 at 12:41 p.m. the social services summary documented the resident had a wanderguard. The care plan, initiated 8/24/22, documented the resident was at risk of elopement related to cognitive status, mobility status and assessment indicating risk for wandering and elopement. He had a wanderguard. The wanderguard was to be checked for proper function daily and placement every shift. On 5/31/24 at 4:15 p.m. the provider documented the resident displayed impaired thought production and problem solving. He had moderate deficits in memory complex attention concentration, word finding and orientation. He had dementia with behavioral disturbance including defecating in the hallways, sexually inappropriateness and poor impulse control. On 6/5/24 at 10:40 a.m. social services documented the resident was going to his wife's funeral with his family. The family was advised that the resident needed constant supervision during the time out of the facility. The June 2024 CPO was reviewed. The resident had a physician's order dated 6/7/24 for a wanderguard, check the placement visually daily. -However, there were no physician's orders to check the function of the device. B. Resident #8 1. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included loss of cognitive function and awareness and mental disorder due to physiological condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 5/7/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of six out of 15. He required limited assistance with bed mobility, transfers, dressing, toileting and personal hygiene. -The assessment documented he did not use a wander/elopement alarm. 2. Record review The June 2024 CPO was reviewed. The resident had an order dated 5/15/24 to apply a wanderguard to prevent the resident from going out of the facility unassisted. Monitor the presence of the wanderguard every shift. -The order did not include checking the function of the wanderguard device. -The nursing progress notes were reviewed for May 2024 and June 2024. There was no documentation as to why the wanderguard was ordered on 5/15/24. -The care plan was reviewed. There was no care plan for elopement or wandering. C. Resident #9 1. Resident status Resident #9, age 84, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia and obesity. The 6/5/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of five out of 15. He required substantial to maximal assistance with transfers, toileting, dressing, and personal hygiene. The assessment documented he used a wander/elopement alarm daily. 2. Record review The June 2024 CPO was reviewed. On 6/10/24 (during the survey) a physician's order was written for a wanderguard device for Resident #9. The Wander Elopement assessment dated [DATE] documented the resident was at low risk for wandering or elopement. -However the assessment inaccurately documented the resident did not have dementia or a condition impacting decision making. -The care plan was reviewed. There was no care plan for wandering or elopement. On 6/10/24, during the survey, a wandering elopement care plan was initiated. The care plan documented risk for wandering and elopement was identified. The resident would not leave the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility unattended. The resident's safety would be maintained. Interventions included clearly identifying the resident's room and bathroom, providing care in a calm and reassuring manner, providing clear, simple instructions and Providing reorientation to surroundings and the environment. D. DON interview The DON was interviewed again on 6/10/24 at 3:08 p.m. The DON said Resident #7, #8 and #9 all required wander guards due to their risk of elopement. She said she was not aware the function of the wander guards was not being checked routinely. IV. Facility follow up On 6/10/24 at 2:35 p.m. (during the survey) the RVP provided an action plan titled Elopement Actions items. The plan documented in pertinent part, Wanderguard audit: -An audit will be completed on 6/10/24 to ensure all residents are accounted for and to check if they have a Wanderguard in place, where it is located, and if it is functional; and, -Once the Wanderguard is confirmed, an audit will be conducted to ensure all appropriate orders and care plans are in place. Completed 6/10/24 for Resident #7, #8, #9. Admission Process to identify Wandering/Elopement Risk -Ensure you have a solid process for new admissions deemed to be at risk to be kept safe in the event WanderGuards are not accessible; -Referrals to be reviewed for risk of wandering/elopement prior to facility acceptance; -Residents identified of risk prior per Elopement to admission staff education to be completed on specific resident to ensure education on wandering/elopement and processes in place for: -15 minutes checks first 24 hours after admission; -Interventions to engage residents in purposeful activities; -IDT to review new admissions the next day to review orders, diagnosis, assessments at the clinical meeting; -Comprehensive, accurate assessment of each resident's needs to be completed no later than 14 days after the admission and at least every three months thereafter, unless there is a significant change in the resident's physical or mental condition; -If significant change resident to be placed on 15-minute checks; and, -If identified as exit seeking to be placed on one and one with IDT review for changes/updates to care plan (continued on next page)

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	065278	A. Building B. Wing	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Pointe Health and Rehabilitation Center	710 3rd St Windsor, CO 80550

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After admission, facility will follow Elopements and Wandering Residents Policy. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering -Residents will be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team; -The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan; - Interventions to increase staff awareness of the resident's risk, modify the resident's behavior, or to minimize risks associated with hazards will be added to the resident's care plan and communicated to appropriate staff; -Adequate supervision will be provided to help prevent accidents or elopements; -Charge nurses and unit managers will monitor the implementation of interventions, response to interventions, and document accordingly; and, -The effectiveness of interventions will be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. Wandering/Elopement Binders -Ensure information for all residents identified to be at risk are placed in an elopement binder at every nurse's station and front desk in the lobby to include a current photo, their room number, and face sheet, and Elopements and Wandering Residents Policy. Maintenance Assessment of WanderGuard and Egress Doors -If not already in place, ensure Maintenance is assessing every egress door accessible to a resident for either the WanderGuard or alarming functionality daily; -The Maintenance Director tested all WanderGuard doors, and egress exit doors to ensure they were functioning properly and alarmed when opened. All exit doors are currently functioning properly as of 6/10/25; -Maintenance Director to assess every egress door accessible to residents Monday - Friday; and, -Manager on Duty to assess every egress door accessible to residents Saturday - Sunday. All Staff Education in Wandering/Elopement Conduct All Staff education on Elopement. Education should include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-What makes a resident at risk; -Actions to take if a resident is exit-seeking; -The locations of your elopement binders; -The process for a missing resident (refer to the Disaster Plan); and, -If a resident does not come out for meals, is not available for medications, is not in usual activities, validate their location; What to do if a door alarm sounds: -Do not just deactivate the alarm; -Look for the resident outside; -Refer to the elopement book to ensure all residents who are at risk are accounted for; and, -Staff training has been initiated 6/10/24 and is ongoing till all staff has received training. All Staff Meeting meeting to be conducted in June and Wandering/Elopement Education to be reviewed. RDO (regional director of operations) completed education with NHA and DON on 6/10/24 regarding expectation for notifying the RDO and Nurse Quality Mentor (NQM) immediately for an elopement event. In case of an elopement event, the RDO, NQM will give guidance on investigation steps and documentation. Conduct Quarterly Elopement Drills Maintenance is responsible for conducting the drills. Facility to use as validation of staff education. Can include setting off a door alarm and seeing if staff respond appropriately on every shift. Elopement drill to be conducted by 6/30/24.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41172 Based on observations, record review and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: -Ensure staff performed hand hygiene with blood glucose checks; and, -Ensure glucometers were cleaned and disinfected with appropriate disinfectant contact time between uses. Findings include: I. Facility policy and procedure The Handwashing Hand Hygiene policy, revised August 2019, was received from the regional director of operations (RDO) on 6/10/24 at 4:53 p.m. The policy documented in pertinent part, Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: Before and after direct contact with residents, before performing any non-surgical invasive procedures, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after contact with objects (such as medical equipment) in the immediate vicinity of the resident and aAfter removing gloves. The Cleaning and Disinfecting of Resident Care Equipment Items and Equipment policy, revised September 2022, was received from the regional director of operations (RDO) on 6/10/24 at 4:53 p.m. The policy documented in pertinent part, Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin (such as respiratory therapy equipment). Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. Semi-critical items are sterilized or disinfected in a central processing location and stored appropriately until use. II. Manufacturer's instructions for Sani-Cloth Germicidal Disposable Wipes The directions on the side of the purple top Sani-Cloth Germicidal Disposable Wipes container used by the facility for disinfecting glucometers read in pertinent part, Disinfects after two minutes. Ensure the surface remains visibly wet for at least two minutes for complete disinfection. III. Observations and interviews On 6/10/24 at 11:01 a.m. licensed practical nurse (LPN) #1 was observed as she checked the blood glucose level of Resident #3. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	After obtaining Resident #3's blood glucose level, LPN #1 wiped the glucometer with a purple top Sani-Cloth Germicidal Disposable wipe. LPN #1 wiped the front and back of the glucometer with the wipe. The surfaces of the glucometer remained wet for approximately nine seconds. -LPN #1 failed to allow the surfaces of the glucometer to remain wet for the two minutes recommended on the container label as the appropriate amount of time for proper disinfection. LPN #1 said she did not know what the dwell time for the wipes was. She said she had just been given the wipe this morning (6/10/24) and she had previously been cleaning the glucometers with an alcohol wipe. On 6/10/24 at 11:24 a.m. LPN #2 was observed as she checked the blood glucose level of Resident #5. At the medication cart down the hall from the resident's room, LPN #2 donned a pair of gloves. -LPN #2 did not perform hand hygiene before applying the gloves. LPN #2 took a glucometer, a test strip, an alcohol pad and two lancets to Resident #5's room. She placed the supplies on the resident's bedside table. She checked the resident's blood glucose level and then pulled the test strip, with blood on it, out of the glucometer. The test strip with blood on it fell on the floor. LPN #2 attempted for several seconds to pick up the test strip off the floor but said it was sticking. She retrieved the test strip off the floor, grabbed the glucometer and headed back to her medication cart, wearing the same gloves she had on to obtain the resident's blood glucose level and pick up the used test strip from the floor. -After returning to her medication cart, LPN #2 proceeded to open a container of purple top Sani-Cloth Germicidal Disposable wipes, without removing her gloves or performing hand hygiene. -The lid to the disposable wipes came off and, without removing her soiled gloves or performing hand hygiene, LPN #2 reached into the canister and pulled out several wipes. -LPN #2 proceeded to clean the front and back of the glucometer with the same soiled gloves and placed the glucometer on a paper towel to dry. The glucometer surfaces remained wet for approximately 10 seconds. -LPN #2 removed her gloves but did not perform hand hygiene. LPN #2 said the glucometer dried quickly. LPN #2 said she did not know what the dwell time was on the Sani-Cloth wipes. She said she had just been given the purple top Sani-Cloth Germicidal Disposable wipes this morning (6/10/24). LPN #2 said she had been using Sani-Hand Cloth wipes to clean the glucometers. She said it was better than nothing. On 6/10/24 at 11:38 p.m. registered nurse (RN) #1 was observed as he checked the blood glucose level of Resident #2. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 went to the resident's room. He said the resident's glucometer was in his room. RN #1 said he did not know why Resident #2's glucometer was kept in his room and other residents' glucometers were kept in the medication cart. RN #1 applied gloves and checked the resident's blood glucose level. -RN #1 did not perform hand hygiene before donning gloves. -RN #1 did not disinfect Resident #2's glucometer after use. RN #1 removed his gloves and went back to his medication cart. -He did not perform hand hygiene after removing his gloves. RN #1 said he had been using the Sani-Hand wipes and not the purple top Sani-Cloth Germicidal Disposable wipes to clean the glucometers. IV. Director of nursing (DON) interview The DON was interviewed on 6/10/24 at 12:57 p.m. The DON said nurses should complete hand hygiene before and after donning gloves to check residents' blood glucose levels. The DON said the glucometers should be disinfected after each use. She said the nurses used to have the purple top Sani-Cloth disinfectant wipes to clean the glucometers. She said she did not know what happened to them but she said she gave the nurses new canisters of the wipes to use this morning (6/10/24). She said she had not provided education on the dwell time or contact time for the Sani-Cloth Germicidal Disposable wipes.