STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065283	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Post Acute	5230 E 66th Way Commerce City, CO 80022

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 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** 19262 Based on observations and staff interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public on one of four units. Specifically, the facility failed to provide the necessary housekeeping and maintenance services to maintain resident room [ROOM NUMBER], #307, #316, #318, #303, #302 and #311 in a sanitary and comfortable manner. Findings include: I. Facility policy and procedures The Safe and Homelike Environment policy, revised 12/2023, was provided by the director of nursing (DON) on 7/16/24 at 11:33 a.m. The policy revealed the term environment referred to any environment in the facility that was frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. A homelike environment de-emphasized the institutional character of the facility setting, to the extent possible; and allowed the resident to use personal belongings that supported a homelike environment. A use of the determination of homelike, should include the resident's opinion of the living environment. The term orderly was defined as an uncluttered physical environment that was neat and well kept. The term sanitary included, but was not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment included, but was not limited to, equipment used in the completion of the activities of daily living. The facility would create and maintain, to the extent possible, a homelike environment that de-emphasized the institutional character of the setting. Housekeeping and maintenance services would be provided as necessary to maintain a sanitary, orderly and comfortable environment. Any unresolved environmental concerns would be reported to the nursing home administrator (NHA). Resident areas would have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. II. Resident room observations (continued on next page)

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 9:06 a.m. resident room [ROOM NUMBER] was observed. The observation revealed sheetrock damage on two room walls, chipped paint on one room wall, two small holes on the wall under the sink, debris in the room corners, sheetrock damage around the room sink, two unused metal curtain holders over the window, black discoloration on the room cove base, black marks on the entrance room door, a torn bathroom linoleum floor, one black plunger and one white toilet brush standing upright on the bathroom floor, multiple dead bugs in the bathroom light fixture, black marks on the bathroom door frame and a nonfunctional bathroom exhaust fan. On 7/15/24 at 9:12 a.m. resident room [ROOM NUMBER] was observed. The observation revealed separated linoleum flooring under the room sink, sheet rock damage on the room wall by the sink, six unused metal anchors in the wall by the sink, multiple dead bugs in the bathroom light fixture, a loud squeaking bathroom exhaust fan, black marks on the bathroom door, black marks on the bathroom's metal heater cover, one white toilet brush in a holder standing upright in the bathroom, four large sections of torn linoleum flooring in the bathroom, one white urine collection hat on the floor behind the toilet (not dated, labeled with a resident or bagged in plastic) and chipped paint on the bathroom door frames. On 7/15/24 at 9:19 a.m. resident room [ROOM NUMBER] was observed. The observation revealed debris in the room corners, loose room cove base, chipped paint on the room walls, a missing string pull cord extender for a room wall light, four small holes on the wall by the sink, the room sink drained slowly, unpainted sheetrock patches behind the headboard of the bed by the window, one room floor tile with two chipped areas on the tile, room metal heater cover end cap was loose, black marks on the bathroom metal heater cover, black marks on both bathroom doors, chipped paint on both bathroom door frames, two black plungers and one white toilet brush standing upright on the bathroom floor, one loose bathroom ceiling tile, a loose metal room heater cover, chipped paint on the metal room heater cover, a nonfunctional bathroom ceiling exhaust fan and chipped paint on the entrance door frame. On 7/15/24 at 9:27 a.m. resident room [ROOM NUMBER] was observed. The observation revealed a missing metal room heater cover under the window, chipped paint on one wall by the bathroom, sheetrock damage on the room wall at the footboard by the first bed and debris in the room corners. On 7/15/24 at 9:33 a.m. resident room [ROOM NUMBER] was observed. The observation revealed debris in the room corners, paint chips on one wall by the bathroom, one black plunger and one white toilet brush standing upright on the bathroom floor, one loose ceiling tile, a missing exhaust fan in the bathroom, four missing bathroom wall tiles, chipped paint on the bathroom door frame, cracked bathroom linoleum floor, two white urine collection hats on a shelf in the bathroom (not dated, labeled with a resident name or bagged in plastic), black marks on the bathroom door, chipped paint on the wall by the sink and chipped paint on the wall by the footboard of the bed by the window. On 7/15/24 at 9:46 a.m. resident room [ROOM NUMBER] was observed. The observation revealed debris in the room corners, chipped paint on both bathroom doors, chipped paint on both bathroom door frames, multiple dead bugs in the bathroom light fixture, one black plunger and one white toilet brush standing upright on the bathroom floor, a bathroom sheetrock patch needed painting, three small holes in the wall by bed one, sheetrock damage above the cove base under the room sink, four room sheetrock patches were unpainted by the room sink, one loose ceiling tile over the bed by the window, four unused metal wall anchors in the wall by the window, one ceiling panel with a missing corner and one water damaged ceiling tile. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 9:57 a.m. resident room [ROOM NUMBER] was observed. The observation revealed four missing pieces of the horizontal window blinds, debris in the room corners, chipped paint on the bathroom door frame, chipped paint on the room wall by the bathroom door, multiple dead bugs in bathroom ceiling light fixture, chipped paint on the bathroom doors, one black plunger standing upright on the bathroom floor, two portions of the bathroom metal heater cover were bent outward (sharp to the touch), one male urinal (not dated, labeled with a resident name or bagged in plastic) sitting on the toilet tank lid, one missing bathroom transition strip and chipped paint on the wall to the left of the sink. III. Staff interviews An environmental tour of the facility was conducted with the nursing home administrator (NHA) and the maintenance supervisor (MS) on 7/15/24 at 12:49 p.m. Each of the above residents' rooms were observed with the NHA and the MS for the environmental concerns. The MS said facility staff submitted work orders by calling him, telling him in person or by using the facility's management computerized system. The NHA said the staff had been in-serviced on the use of the facility's management computerized system system. The MS said he reviewed the facility's management computerized system work order requests on a daily basis. The NHA said that staff could place work orders in the facility's computerized healthcare software system. The NHA said the computerized healthcare software system would then generate a work order in the facility's management computerized system. The MS said he did not have any work orders of the observed environmental concerns, submitted in the facility's management computerized system system. The MS said resident rooms were inspected each month. The MS said resident rooms were routinely audited for environmental issues. The NHA said resident rooms and bathrooms were cleaned daily. The NHA and the DON were interviewed together on 7/16/24 at 9:44 a.m. The DON said urine collection hats should be thrown away after they were used. The DON said the urine collection hats should not be stored in resident rooms. The DON said the male urinal should have been stored in a plastic bag. The DON said the urine collection devices could be an infection control issue. The NHA said the plungers and toilet brushes were removed from the resident bathrooms on 7/15/24 (during the survey).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on interviews and record review, the facility failed to take steps to protect one (#19 and #256) of eight residents from physical abuse out of 45 sample residents reviewed for abuse. Specifically, the facility failed to prevent Resident #19 from physical abuse by Resident #256. Findings include: I. Facility policy and procedure The Abuse: Prevention of and Prohibition Against policy, revised 11/29/23, was provided by the director of nursing (DON) on 7/10/24 at 2:28 p.m. It read in pertinent part, Abuse is willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. II. Incident of physical abuse between Resident #256 and Resident #19 on 6/13/24 A. Facility investigation of the altercation on 6/13/24 The witness statement, dated 6/13/24, written by a certified nurse aide (CNA), documented Resident #256 and Resident #19 were sitting at the dining room table. The residents went back and forth talking to each other. They told each other to be quiet. They said do not tell me what to do and I will knock the black out of you. Resident #256 grabbed a hold of Resident #19's hair and would not let go. The 6/13/24 nurse incident note revealed Resident #256 and Resident #19 were sitting at the dining room table. They were talking back and forth telling each other to be quiet. The note documented the residents were saying do not tell me what to do and I will knock the black out of you. The staff went to separate the residents and Resident #256 grabbed Resident #19's hair and did not want to let go. The unit nurse, the therapist and another staff member separated the residents and redirected both residents from one another. The therapist took Resident #256 outside for redirection and distraction. Resident #19 was redirected and removed to an alternate area. The progress note documented no skin changes were noted on either resident. The progress note documented neither resident recalled the event and remained at baseline. The facility's conclusion of the internal investigation was Resident #256 pulled Resident #19's hair. The facility's investigation summary revealed Resident #256 was sent to a higher level of care on 6/13/24 for the safety of self and others and for psychosocial safety and stabilization. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation revealed Resident #256 had four incidents with other residents prior to the incident on 6/13/24. Resident #256 had an incident on 2/23/24, 2/24/24, 4/10/24 and 4/28/24 with other residents The interventions for each incident included to redirect the resident and provide frequent checks. -Resident #256 and Resident #19 had a previous incident on 4/28/24. -Review of Resident #256's comprehensive care plan did not reveal There were not new person-centered interventions after Resident #256 was involved in multiple resident to resident altercations (see care plan below). B. Resident #256 - assailant 1. Resident status Resident #256, age greater than 65, was admitted on [DATE] and discharged on [DATE] to a local hospital. According to the June 2024 computerized physician orders (CPO), diagnoses included vascular dementia, cognitive communication deficit and muscle weakness. The 4/25/24 minimum data set (MDS) assessment revealed the resident's cognitive status was severely impaired with a brief interview for mental status (BIMS) score of three out of 15. The MDS assessment did not identify the resident displayed behaviors during the assessment period. 2. Record review The care plan, dated 2/19/24 and revised 6/20/24, identified the resident had verbal and physical aggression related to her dementia. Resident #256 was agitated when staff attempted to assist her and she responded physically when she became frustrated. Interventions included monitoring the resident and her surroundings to minimize known stressors such as multiple residents too close to the resident (5/23/24) and redirecting as needed(5/10/24). -The care plan did not identify new interventions implemented after the 2/23/24 and 2/24/24 resident to resident altercation incidents. C. Resident #19 - victim 1. Resident status Resident #19, age 82, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included Alzheimer's disease and dementia. The 5/17/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of one out of 15. The MDS assessment identified the resident displayed verbal behaviors toward others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review The care plan, revised 7/15/24, identified the resident had a history of being verbally and physically aggressive if others were in her walking path and she could become aggressive if another resident had an object she wanted. Interventions include offering to take her outside (5/17/24) and redirecting her when she yelled at others (6/20/24). V. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 6/15/24 at 2:12 p.m. He was familiar with Resident #256. LPN #2 said he was not present on 6/13/24 when the altercation took place. He said he was aware Resident #256 and Resident #19 were involved in a resident to resident altercation. He said the residents that resided in the secured unit were confused and often argued among themselves. LPN #2 said he stepped in when arguing occurred, tried to separate the residents when they argued and he tried to distract the residents. The nursing home administrator (NHA) was interviewed on 7/16/24 at 10:57 a.m. The NHA said the 6/13/24 altercation between Resident #265 and Resident #19 was substantiated as physical abuse. He said after the altercation, the facility immediately separated the residents and redirected them. The NHA said the intervention used to prevent the 6/13/24 altercation was to redirect the resident. The NHA said this intervention was not effective.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review, observations and interviews the facility failed to ensure two (#19 and #100) of three residents reviewed for out of 45 sample residents were free from involuntary seclusion. Specifically, the facility failed to ensure Resident #19 and Resident #100 who resided in the secured unit, had the required ongoing documentation of the review and revision to meet the criteria and if the interventions met the needs of the resident. Findings include: I. Facility policy and procedure The Elopement and Unsafe Wandering policy, revised December 2023, was provided by the director of nursing (DON) on 7/16/24 at 5:25 p.m. It read in pertinent part, It is the facility's policy to provide a safe environment for all residents through appropriate assessment, interventions, and adequate supervision to prevent accidents related to unsafe wandering or elopement. Care plan interventions will consider the elements of the evaluation or behavior observations that identified the resident at risk. II. Resident #19 A. Resident status Resident #19, age 82, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease and dementia. The 5/17/24 minimum data set (MDS) assessment revealed the resident's cognitive status was severely impaired with a BIMS score of one out of 15. The resident required substantial assistance with transfers, oral hygiene, toileting, showering and personal hygiene. The resident was completely dependent on staff to wheel her manual wheelchair. The MDS assessment identified that wandering was not exhibited. B. Observations During a continuous observation on 7/15/24, beginning at 12:00 p.m. and ending at 12:32 p.m., the resident was in her wheelchair at a dining table in the secured unit dining room. Her head was down and she was sleeping on and off. She had a stuffed animal cat in her arms. C. Record review (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The elopement care plan, revised 5/23/24, revealed Resident #19 was at risk for elopement secondary to a history of elopement, Alzheimer's disease and poor safety awareness. The resident could exhibit behaviors including exit seeking, unplanned exiting, aimless walking and wandering or none. Interventions included documenting wandering behavior, documenting attempted diversional interventions and monitoring and documenting observed behavior and episodes every shift. -The resident's electronic medical record (EMR) did not reveal that the facility identified a certain time of day for wandering and elopement attempts. -The resident's EMR did not reveal that the facility identified a pattern for purposeful wandering. -The facility did not identify wandering and elopement de-escalation behaviors. The 2/9/24 elopement and wandering evaluation revealed the resident scored an 11, which indicated the resident was a high risk for elopement and wandering. The evaluation indicated the resident did not have a history of elopement and did not make statements about a desire to leave the facility. The resident wandered aimlessly with the potential to go outside and had active exit-seeking behavior. The resident wandered to intrude on the privacy or activities of others. The wandering behavior was the same as the prior evaluation. -The resident's EMR revealed there were no elopement attempts between 12/1/23 and 7/16/24. The certified nurse aide (CNA) behavior symptom tracking was reviewed on 7/16/24. It revealed there was no wandering observed between 6/16/24 to 7/16/24. A review of the resident's EMR on 7/16/24 did not reveal there was documentation that wandering was monitored, if interventions were used and if the interventions were effective in January 2024, February 2024, March 2024, April 2024, May 2024, June 2024 and from 7/1/24 to 7/16/24. The 12/13/23 interdisciplinary team (IDT) progress note revealed the resident wandered into another's resident's room. -A review of the resident's EMR revealed there was no documentation that wandering was monitored, if interventions were used and if the interventions were effective after the resident wandered into another resident's room on 12/13/23. -A review of Resident #19 EMR from 12/14/23 to 7/16/24 did not reveal any additional progress notes that the resident had wandering behaviors. III. Resident #100 A. Resident status Resident #100, age 81, was admitted on [DATE], According to the July 2024 CPO, diagnoses included dementia, displaced fracture of left femur, mood disturbance, psychotic disturbance and anxiety. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/25/24 MDS assessment revealed the resident's cognitive status was severely impaired with a BIMS score of zero out of 15. The resident was dependent with eating, oral hygiene, toileting, showering, dressing, and personal hygiene. The resident was completely dependent on staff to wheel his manual wheelchair. The MDS assessment did not identify that wandering was exhibited. B. Observations During a continuous observation on 7/15/24, beginning at 12:00 p.m. and ending at 12:32 p.m., the resident was observed in his wheelchair in the secured unit dining room. The resident was assisted by an unknown staff member to a dining table. At 12:15 p.m. the resident left the table and walked throughout the dining area. At 12:20 p.m. an unidentified staff member asked the resident if he was hungry and redirected the resident to the opposite side of the dining table. The unknown staff member brought the resident's lunch tray to the dining table. The resident ate his lunch until 12:32 p.m. C. Record review The elopement care plan, initiated on 7/11/24 (during the survey), revealed the resident was at risk for elopement and wandering related to impaired safety awareness and cognitive decline. Interventions included documenting wandering behavior and attempted diversional interventions. -The resident's EMR did not reveal that the facility identified a certain time of day for wandering and elopement attempts. -The resident's EMR did not reveal that the facility identified a pattern for purposeful wandering. -The facility did not identify wandering and elopement de-escalation behaviors. The mood and behavior care plan, revised on 7/15/24 (during the survey), revealed the resident had potential for mood or behavior problems related to insomnia, dementia, mental disorder and pain. The resident had periods of confusion, agitation and wandering without intent. Interventions included taking the resident outside, offering food and drinks and redirecting the resident away from the other residents'rooms if necessary. The 6/19/24 elopement and wandering evaluation revealed the resident scored a five, which indicated the resident was a low risk for elopement and wandering. The resident did not have a history of elopement, he did not make statements about a desire to leave the facility, and he did not wander to place the resident at significant risk of harming themselves or others. -The resident's EMR revealed there were no elopement attempts between 6/5/24 and 7/16/24. The CNA behavior symptom tracking was reviewed on 7/16/24. It revealed there was no wandering observed between 6/16/24 to 7/16/24. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The July 2024 CPO revealed the resident had a physician's order that indicated to monitor and document observed wandering behavior. The physician's order indicated to document the following: exit seeking, 2 - unplanned exiting, 3 - aimless walking and wandering, and 4 - none, ordered 6/18/24. The June 2024 MAR revealed the resident had episodes of aimless walking and wandering on 6/19/24, 6/21/24 and 6/23/24. The July 2024 MAR revealed the resident had episodes of aimless walking and wandering on 7/5/24 and 7/6/25 and had episodes of exit-seeking on 7/6/24. -A review of the resident's EMR revealed that there was no documentation of what interventions were used when the resident had episodes of aimless walking and wandering and when the resident had episodes of exit-seeking. IV. Staff interviews The DON, the nursing home administrator (NHA) and the social service resource (SSR) were interviewed together on 7/15/24 at 3:29 p.m. The NHA said the residents had a care plan for wandering to tell the staff what to do if the resident wandered. The DON said if a resident wandered, the staff should intervene and redirect them. The SSR said if a resident wandered staff should offer an activity as a distraction. The DON said the licensed nurses documented in the resident's EMR if they observed wandering. The DON said CNAs documented in the behavior tracking log or would tell the nurse. The DON said she knew the interventions were effective for the residents because if the staff used an intervention that was not effective, they would notify her via text message. The DON said she told the staff verbally to try another intervention. The DON said the effectiveness of the interventions was not monitored or documented. The DON was interviewed again on 7/16/24 at 2:59 p.m. The DON said the nurses and the CNAs monitored the residents for wandering behaviors. The DON said the nurse documented wandering in the MAR and the CNAs documented in the behavior activity tracking log. The DON said she was familiar with Resident #19. The DON said did not know the resident's wandering was not documented and interventions were not documented for their effectiveness. The DON said she was familiar with Resident #100. The DON said she was not aware the resident's interventions were not documented for their effectiveness.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure residents were provided services that meet professional standards. Specifically, the facility failed to ensure narcotic medications were documented on the narcotic log at the time of removal from the locked narcotic drawer on two of four medication carts. Findings include: I. Facility policy and procedure The Controlled Medications Storage and Reconciliation policy, revised January 2024, was provided by the director of nursing (DON) on 7/15/23 at 12:23 a.m. It read in pertinent part, It is the policy of this facility to safeguard access and storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse using separately locked, permanently affixed compartments, with the exception that controlled medications and those medications subject to abuse may be stored with non-controlled medications as part of a single unit package medication distribution system, if the supply of the medication(s) is minimal and a shortage is readily detectable. This facility will maintain a process for monitoring, administration, documentation, reconciliation and destruction of controlled substances. When a controlled medication is administered, the licensed nurse administering the medication immediately enters all of the following information on the accountability record: -Date and time of administration; -Amount administered; and, -Signature of the nurse administering the dose, completed after the medication is actually administered. II. Observations and interviews On 7/11/24 at 11:52 a.m. the medication cart on the [NAME] unit was observed with registered nurse (RN) #2 and licensed practical nurse (LPN) #4. RN #2 compared the narcotic log to the actual narcotic count for Resident #16's hydrocodone five milligrams (mg)/acetaminophen 325 mg pills. -The narcotic log revealed 59 remaining pills, however, the actual count revealed 58 remaining pills. RN #2 said she administered one hydrocodone/acetaminophen pill to Resident #16 on 7/11/24 at 8:11 a.m. and she had forgotten to document the removal of the medication from the locked controlled substance drawer of the medication cart. (continued on next page)

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	065283	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeview Post Acute	5230 E 66th Way Commerce City, CO 80022

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 12:45 p.m., the medication cart on the Golden unit was observed with RN #3. The following discrepancies were found: -Resident #32's lorazepam 0.5 mg narcotic log revealed 11 remaining pills, however, the actual count revealed 10 remaining pills. RN #3 said she administered one lorazepam 0.5 mg pill on 7/11/24 at 7:35 a.m. to Resident #32 and had not yet documented the removal of the medication from the locked controlled substance drawer. She said she was supposed to document the narcotic in the narcotic log when she removed it from the medication card containing the medication. -Resident #109's pregabalin 100 mg narcotic log revealed 20 remaining pills, however, the actual count revealed 19 remaining pills. RN #3 said she administered one pregabalin pill to Resident #109 on 7/11/24 at 8:48 a.m. and had not yet documented the removal of the medication from the locked controlled substance drawer. -Resident #109's oxycodone 20 mg narcotic log revealed 62 remaining pills, however, the actual count revealed 61 remaining pills. RN #3 said she administered one oxycodone pill to Resident #109 on 7/11/24 at 11:08 a.m. and had not yet documented the removal of the medication from the locked controlled substance drawer. -Resident #94's tramadol 50 mg narcotic log revealed 53 remaining pills, however, the actual count revealed 52 remaining pills. RN #3 said she administered one tramadol pill to Resident #94 on 7/11/24 at 11:17 a.m. and had not yet documented the removal of the medication from the locked controlled substance drawer. III. Staff interview The DON was interviewed on 7/11/24 at 2:49 p.m. The DON said she would check the policy to see when the narcotics were supposed to be documented. The DON said staff were provided recent education regarding documentation of controlled substances. She said more education was indicated and would be provided to staff regarding the timely documentation of narcotics on the narcotic count log. IV. Facility follow-up On 7/17/24 at 4:42 p.m. (after the survey) the DON provided a staff education document entitled Medication Administration and dated 7/10/24. The document contained an excerpt from the Controlled Medications Storage and Reconciliation policy which emphasized immediate documentation on the narcotic sign-out sheet when retrieving a medication dose from the controlled storage. The in-service record was signed by 18 staff members. On 7/17/24 at 4:42 p.m. the DON provided an additional document entitled Employee 1:1 (one-to-one) Education which included specific education that was provided to two individuals with emphasis on the staff members ensuring the narcotic count was up to date at all times during their shift and ensuring narcotics were signed out immediately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored in two of four medication carts and one of two medication storage rooms. Specifically, the facility failed to ensure: -Medications were labeled with the date it was opened; -Discontinued medications were removed from the medication cart in a timely manner; -Medications were properly disposed in a disposal receptacle; and, -Resident medication was stored in the proper location. Findings include: I. Facility policy and procedure The Storage of Medication Policy, revised [DATE], was provided by the director of nursing (DON) on [DATE] at 2:56 p.m. The policy read in pertinent part, Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to keep their integrity and to support safe, effective drug administration. Eye medications are stored separately from ear medications and inhalers. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal. Medications awaiting destruction that can not be disposed of immediately should be recorded on a log to include the name of the individual storing the medication, resident name, the prescription number, if applicable, the quantity of the medication, the strength of the medication and the date of disposition. II. Observations and interviews On [DATE] at 12:08 p.m. the Golden unit medication cart was observed with registered nurse (RN) #3. -An opened Albuterol (inhaler) 90 micrograms (mcg) box was not labeled with the date opened for use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 said the inhaler should have been labeled with the date when it was opened. On [DATE] at 12:45 p.m. the Golden unit medication cart was again observed with RN #3. Two boxes of Haloperidol two milligrams per milliliter (mg/ml) were in the bottom drawer of the medication cart. -The medications were labeled with a resident's name who no longer resided at the facility RN #3 said the resident had been discharged approximately one week earlier and the resident's Haloperidol medications should have been given to the DON after discharge for proper disposal. On [DATE] at 2:00 p.m. the Montrose medication storage room was observed with licensed practical nurse (LPN) #5. -The medication refrigerator contained an open vial of tuberculin purified protein, five tuberculin units per 0.1 ml which was not labeled with the date the vial was opened. LPN #5 said she opened and used the medication earlier that day ([DATE]) and had forgotten to write the date opened on the vial. On [DATE] at 8:06 a.m. a white medication tablet and a beige medication tablet were observed on the floor near the Sterling unit medication room. LPN #1 took the pills to the DON to have them identified. On [DATE] at 8:13 a.m. one yellow round medication tablet was observed on the floor near the [NAME] nurses station. RN #1 took the pill to the DON to have it identified. RN #1 said medications should not be on the floor. RN #1 said the medication should have been seen on the floor and the nurse should have immediately disposed of the medication. RN #1 said nurses should stay with residents to ensure medications were swallowed. On [DATE] at 1:59 p.m., a certified nurse aide with medication authority (CNA-Med), and RN #1 administered artificial tears to Resident #31. After RN #1 administered the artificial tears to Resident #31, the resident retrieved an opened box of artificial tears from a drawer in his room and gave the box to RN #1. RN #1 said he did not know where Resident #31 got the artificial tears that he retrieved from the drawer in his room. RN #1 said Resident #31 should not have artificial tears in his room because there was not a physician's order for the resident to administer his own artificial tears. III. Staff interviews (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on [DATE] at 2:49 p.m. The DON said the Haloperidol found in the Golden medication cart was for a resident who was deceased on [DATE]. The DON said staff were instructed to give her all discontinued medications and she should receive discontinued medications as soon as possible after a resident had expired. The DON said staff should date medications upon opening. The DON was interviewed again on [DATE] at 9:40 a.m. The DON said the Albuterol inhaler should have been labeled with the date it was opened. The pharmacist consultant (PC) was interviewed on [DATE] at 3:33 p.m. The PC said one of the medications found on the floor of the Sterling unit was an Apixiban (blood thinner) 2.5 mg tablet. The PC said medications should be disposed of properly and nurses should stay with residents to verify residents swallowed medications or did not drop medications on the floor. The PC said the yellow medication found on the floor on the [NAME] unit was Aspirin 81 mg. The DON was interviewed a third time on [DATE] at 3:46 p.m. The DON said the white tablet found on the floor near the Sterling unit medication was an acetaminophen 325 mg tablet. The DON said staff should stay with residents to ensure all medications were swallowed and medications should be disposed of properly and not found on the floor. IV. Facility follow-up On [DATE] at 4:42 p.m. the DON provided a staff education document titled Medication Administration. The education contained 23 staff signatures and was dated [DATE] (during the survey). The education included a Medication Reminders/Tips Sheet and documented the following in pertinent part, -Residents must be observed taking medications; -Proper disposal if medication is dropped; -Notify nurse on duty if medication seen at bedside or on the floor; and, -Physician order is needed for self-administration of medication.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services for one (#54) of one resident reviewed for hospice care services out of 45 sample residents. Specifically, the facility failed to: -Establish a communication process, including how the communication would be documented between the facility and the hospice provider for Resident #54; and, -Ensure hospice agency staff notes were easily accessible to the facility staff and have consistent documentation of hospice care visits in Resident #54's record. Findings include: I. Facility policy and procedure The End of Life Care, Hospice and Palliative Care policy, revised December 2023, was provided by the director of nursing (DON) on 7/11/24 at 9:13 a.m. It revealed in pertinent part, Hospice services will be offered as appropriate and as ordered by the physician. The services will be integrated into the overall individualized, interdisciplinary care plan. Collaboration with hospice will include processes for orienting staff to facility policies and procedures which may include documentation and record keeping requirements. II. Resident #54 A. Resident status Resident #54, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included dementia, anxiety and depression. The 6/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview of mental status (BIMS) score of zero out of 15. The assessment revealed the resident received hospice services. B. Record review The hospice care plan, revised 3/5/24, revealed the resident had a terminal prognosis related to senile degeneration of the brain. Interventions included working cooperatively with the hospice team to ensure the resident's needs were met. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The care plan did not define the services to be provided under hospice care by either the hospice provider or the facility. A review of Resident #54's electronic medical record (EMR) revealed no documentation of visits from the hospice provider from 7/1/24 to 7/16/24 (see interview below). A request for Resident #54's hospice binder was made on 7/15/24 at 2:12 p.m. -Licensed practical nurse (LPN) #2 said he was unable to locate the hospice binder for Resident #54. A second request for the binder was made on 7/16/24 at 9:48 a.m. -LPN #2 was again unable to locate the hospice binder. III. Interviews and observations LPN # 2 was interviewed on 7/15/24 at 2:12 p.m. LPN #2 said he knew the hospice staff made visits based on a binder kept in the nurse's station. LPN #2 said Resident #54 receive hospice services. LPN #2 looked for the binder that included documentation from the hospice services provider during the interview. LPN #2 was unable to locate the binder that included the communication between the facility and the hospice company. LPN #2 was interviewed again on 7/16/24 at 9:48 a.m. He said he knew when hospice staff made visits based on the resident's electronic medical record. LPN #2 showed where the visits were located in the EMR. LPN #2 was unable to show the visits made for the past week (7/9/24 to 7/16/24). He said using the EMR to document visits was a new process. The director of nursing (DON) was interviewed on 7/16/24 at 2:59 p.m. The DON said the social services director (SSD) was the designated hospice coordinator for the facility. The DON said the facility did not have a SSD at that time. The DON said she was the hospice coordinator until the SSD positon was filled. She said the staff knew the frequency of the hospice team visits based on what the hospice company communicated to the DON and the resident's care plan. The DON said after the hospice staff completed a visit with the resident the hospice staff checked in with the unit nurse or the DON. The DON said the unit staff knew what the visit was about based on a verbal report. The DON said the facility had a binder at the nurse's station for hospice staff to document when they visited. The DON said hospice staff did not always use the binder. The DON said Resident #54's binder was not up to date because the DON had access to the hospice EMR so she could check to see what the visit was about if hospice did not give a verbal report. The DON said the unit nursing staff did not have access to the hospice's EMR. The DON said she was unaware she was responsible for establishing a communication process to ensure the resident's needs were addressed and met 24 hours per day and the communication process was documented.