STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065292	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Sandalwood, The	3835 Harlan St Wheat Ridge, CO 80033

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on observations, interviews and record review, the facility failed to ensure one (#63) of one resident reviewed for activities of daily living out of 35 sample residents were provided appropriate treatment and services to maintain or improve their abilities. Specifically, the facility failed to: -Provide Resident #63, who had difficulty with communication, with an appropriate communication tool to ensure the resident was able to effectively communicate his needs to staff; and, -Create a person-centered care plan for Resident #63 which addressed his communication deficits. Findings include: I. Facility policy and procedure The Person-Directed Care Plans policy and procedure, reviewed 7/12/22, was provided by the nursing home administrator (NHA) on 4/25/24 at 1:50 p.m. It read in pertinent part, The purpose of long term person-directed care plans is to tell a resident story. Care plans will be developed consistent with the resident's specific conditions, risks, needs, behaviors, preferences, and current standards of practice. Measurable goals and individualized interventions will be identified. II. Resident #63 A. Resident status Resident #63, age 90, was admitted on [DATE], and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included atherosclerosis of coronary artery bypass graft (heart disease), depression, dysphagia (difficulty in swallowing) and cognitive communication deficit (difficulty with communicating including difficulty with understanding, producing language, and nonverbal communication skills such as gestures and facial expressions). (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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/23/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required substantial/maximal assistance with bed mobility, transfers, and upper body dressing. He was dependent on lower body dressing, toilet hygiene, wheelchair mobility and shower/bathing. He used a tube feeding for eating. The assessment documented the resident had a cognitive communication deficit diagnosis. The assessment documented the resident had adequate hearing and his speech clarity was clear with distinct intelligible words. He made himself understood with the ability to express ideas and wants considering both verbal and non-verbal expression. The assessment documented the resident had the ability to understand others with clear comprehension. The assessment documented the resident did not have a restorative nursing program for communication. The care area assessment (CAA) was not triggered for communication to be addressed in the care plan. B. Resident observation and interview Resident #63 was interviewed on 4/22/24 at 11:37 a.m. Resident #63 was seated in his wheelchair in his room. Resident #63 had a book and an iPad on his side table. Resident #63 was alert but did not respond to simple words such as hello or yes/no questions when asked. He did not make any sounds with his voice. -Attempts to communicate with and understand Resident #63 were not successful during the interview and there was nothing observed in the resident's room, such as signage with communication instructions, to indicate how to communicate effectively with the resident. Resident #63 was interviewed again on 4/23/24 at 10:13 a.m. Resident #63 was seated in his wheelchair, his bed was made, his television was on. Resident #63 was able to shake his head slightly to some yes and no questions. Resident #63 pointed to his mattress but it was unclear what he was attempting to communicate. -Attempts to effectively communicate and understand the resident were again unsuccessful during the interview and there was nothing observed in the resident's room, such as signage with communication instructions, to indicate how to communicate effectively with the resident C. Record review -Resident #63's comprehensive care plan, initiated 1/16/22, revealed there was no care plan related to his cognitive communication deficit and no interventions related to ensuring the resident was able to effectively communicate his care needs to staff. -The mood/antidepressant care plan, revised 2/2/23, documented an intervention to encourage the resident to express any feelings of anger, frustration and sadness. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the care plan did not reveal how the resident would be able to communicate and express his feelings. The cognitive care plan, revised 2/2/23, revealed the resident did not have a diagnosis of dementia but displayed episodes and moments of confusion. The interventions included using consistency when conversing/interacting with the resident. -The care plan did not reveal how the resident would be able to communicate with the staff. A 10/12/23 speech-language pathologist (SLP) evaluation revealed Resident #63 was evaluated for treatment of speech, language, voice, communication and/or auditory processing. The resident was referred to SLP due to exacerbation of cognitive impairment, decreased safety awareness, increased need for assistance from others and decreased speech intelligibility. The treatment diagnosis was cognitive communication deficit. The overall treatment goal was to improve the resident's intelligibility of speech. The short term goal of SLP treatment was for the resident to demonstrate adequate vocal hygiene (proper breath support and maintaining adequate hydration) with greater than 75% of opportunities in order to improve vocal quality with communication of his basic wants/needs. The resident's baseline on 10/12/23 revealed he required maximum assistance and education related to the goal was provided. The long term goal of SLP treatment was for the resident to increase his ability to communicate using conversational responses/exchanges during structured communication exchanges with minimal cues in order to communicate his basic wants/needs and in order to participate in meaningful interactions. The resident's baseline on 10/12/23 revealed the resident required moderate cueing. Resident #63 was discharged from SLP services on 11/17/23 after a total of six visits due to the highest practical level achieved. At discharge on 11/17/23, the short term goal of SLP treatment was not met as the resident was 60% accurate (not 75%) and required moderate assistance. At discharge on 11/17/23, the long term goal of SLP treatment was not met and the resident continued to require moderate cueing. The SLP discharge recommendations revealed the resident appeared at baseline and was to continue with long term care and family support for the highest quality of life. -Although the resident continued to require moderate cueing and assistance with communication at discharge from SLP treatment, there was no evidence of continuity of care and follow up with the nursing staff and daily care team to prevent a decline and maintain Resident #63's communication abilities. D. Staff interview (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 4/25/24 at 11:46 a.m. The DOR said the therapy staff did not write care plans but there should have been verbal communication with the nursing staff to update the care plan after the SLP therapy ended. The DOR said she did not know how the caregivers for Resident #63 interacted with him. She said some of the caregivers knew him well and communicated with gestures and the resident could communicate some. The DOR said she would recommend signage or a communication board to be used with Resident #63 and she would let nursing staff know to put something in the care plan to follow through on communication with the resident. The DOR said physical therapy (PT) was currently seeing the resident due to a decline in transfers and they noted a decline in his communication as well. The DOR said the current SLP was out on vacation, but due to Resident #63's decline in communication, she would get an order for a new SLP evaluation so new recommendations for the resident's communication could be put in place from the SLP. The director of nursing (DON) was interviewed on 4/25/24 at 12:01 p.m. The DON said Resident #63 communicated in a low voice whisper. The DON said he would also nod his head and communicate with his daughter through an iPad. The DON said Resident #63 should have a communication care plan so new staff members or agency staff would know how to communicate with him and know his preferences. The DON said Resident #63 nodded in the morning when asked how he was doing. The DON was not sure how he was able to communicate needs such as his pain levels. During the interview with the DON, the DON asked an unnamed certified nurse aide (CNA) who was passing by in the hallway about Resident #63. The CNA said she communicated with the resident by asking him yes or no questions. She said she would show the resident two outfits and he would point to the one he wanted to wear for the day. The CNA said she gave Resident #63 extra time in order to communicate his needs to her. The DON said it would have been important to communicate the CNA's effective ways of communicating with the resident in a care plan so other caregivers would know the communication techniques. The DON said the purpose of a care plan was to understand how to take care of a resident but she did not see a communication care plan for Resident #63. The DON said she would have a discussion and get the resident's care plan updated so staff know how to communicate with and take care of Resident #63.

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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** 47818 Based on observations, record review and interviews, the facility failed to ensure one (#17) of one resident out of 35 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents'choices. Specifically, the facility failed to ensure Resident #17 received a new CPAP (continuous positive airway pressure) mask timely. Finding include: I. Resident #17 A. Resident Status Resident #17, age 89, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included obstructive sleep apnea (intermittent obstruction of the airway during sleep), chronic respiratory failure with hypoxia (decreased oxygen) and dependence on supplemental oxygen. The 3/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He required extensive assistance of one staff member with dressing and personal hygiene. B. Observations and resident interview Resident #17 was interviewed on 4/22/24 at 11:00 a.m. The resident had a reddened area across the bridge of his nose and reddened lines on either side of his nose. Resident #17 said his CPAP mask was not fitting well. The resident said he had recently received a new mask but it was still irritating the bridge of his nose. Resident #17 said the facility was doing nothing to prevent the irritation to his nose. On 4/22/24 at 1:30 p.m., Resident #17 had a reddened area across the bridge of his nose and reddened lines on both sides of his nose. On 4/23/24 at 10:00 a.m., Resident #17 had a reddened area across the bridge of his nose and reddened lines on both sides of his nose. C. Record review The skin breakdown care plan, initiated on 6/25/23 and revised on 4/13/24, revealed Resident #17 was at risk for skin breakdown related to wearing a CPAP at night which placed him at risk around the CPAP mask sites. It indicated Resident #17 would not have areas of redness or skin breakdown through the review date. Pertinent interventions included checking the CPAP mask for correct fit and possibly replacing the mask if needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/29/24 situation, background, assessment, recommendation (SBAR) communication form identified Resident #17 had a skin tear to the bridge of his nose on 3/29/24. The assessment of the skin tear concluded the CPAP mask for Resident #17 might be too tight. The SBAR indicated Resident #17's wife was notified and it was reported to medical provider (MP) #1 on 3/29/24. The 3/29/24 change of condition (COC) assessment indicated Resident #17 had redness to the bridge of his nose from possible tightness of the CPAP mask. The assessment further indicated the resident needed a new CPAP mask for nightly which fit properly because the current one was rubbing the bridge of his nose. The COC indicated the assistant director of nursing (ADON) had ordered him a new mask, wound care orders had been requested, the family was notified and medical provider (MP) #1 was notified. -However, review of the resident's medical record did not reveal wound care orders for treatment or monitoring. The 3/29/24 interdisciplinary (IDT) review note, written by the ADON indicated Resident #17's CPAP mask would be checked for the correct fit and determine if the mask needed to be replaced. The 4/15/24 progress note, written by the ADON, indicated a call to the CPAP equipment distributor was made and the company was notified Resident #17 needed to be fitted for a new CPAP mask. The note documented a technician from the CPAP equipment distributor would see Resident #17 at the facility on 4/16/24. The 4/16/23 progress note indicated Resident #17 was fitted for a new CPAP mask and connection tubing by the CPAP equipment distributor. The 4/25/24 incident note, written by the ADON, indicated Resident #17 had a 0.5 centimeter (cm) x 1.5 cm blanchable (temporary obstruction of blood flow) red area to the bridge of his nose from a tightly fitting CPAP mask that had recently been replaced. The incident note indicated Resident #17 reported the new mask was fitting better and orders were placed to monitor the blanchable redness to Resident #17's nose. The 4/26/24 IDT progress note indicated Resident #17 continued to a have reddened blanchable area on his nose despite the intervention of having Resident #17 fitted for a new CPAP mask. The progress note indicated Resident #17 would have a physician's order for skin prep to his nose. -However, a review of Resident #17's electronic medical records (EMR) on 4/26/24 failed to reveal a physician's order for monitoring or treating the reddened area of the nose. D. Staff interviews (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 4/24/24 at 10:00 a.m. LPN #1 said Resident #17 had recently received a new CPAP mask because the old one was too tight and caused a reddened area to the bridge of his nose. LPN #1 reviewed Resident #17's EMR and referred to a 3/29/24 SBAR communication note (see above) noting the first appearance of a reddened area to the bridge of the resident's nose. LPN #1 was unable to locate a physician's order for wound care or to monitor the area. LPN #1 said it took a couple of weeks from the discovery of the reddened area on 3/29/24 for Resident #17 to get fitted for a new mask and skin prep was applied as a barrier between the nose and mask until he received a new CPAP mask. LPN #1 said Resident #17 did not have an order to apply skin prep as a barrier in the EMR. The ADON was interviewed on 4/25/24 at 11:30 a.m. The ADON said he was made aware of the redness to the bridge of Resident #17's nose from a risk management note documented on 3/29/24. The ADON said he checked in with the resident daily about the redness of his nose and his discomfort levels. The ADON said it was not until 4/14/24 that he felt the resident's ill-fitting CPAP mask was an issue that warranted a call to order a new one. The ADON said he did not document the conversations or track the reddened area to the bridge of Resident #17's nose. The ADON said medical provider initiated physician's orders for wound care. He was unaware of why an order was not put into the EMR for Resident #17 and said he would have to look into it. The ADON said addressing the fit of the CPAP mask sooner for Resident #17 could have prevented the continuation of the reddened area on the bridge of his nose. -Clarification from the ADON for for why wound care treatment orders were not initiated (on 4/25/24, see record review above) for Resident #17 was not provided prior to the survey exit on 4/26/24.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on observations, record review and interviews, the facility failed to ensure two (#15 and #10) of two residents reviewed for limited range of motion (ROM) received the appropriate treatment and services to maintain or prevent a further decrease in their ROM out of 35 sample residents. Specifically, the facility failed to: -Ensure Resident #15 was monitored for the use of splints (devices that stabilize a part of your body and hold it in place); and, -Ensure Resident #10 was properly positioned in her wheelchair to ensure her head was in a comfortable position. Findings include: I. Resident #15 A. Resident Status Resident #15, age 75, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included hemiplegia (severe or complete loss of strength) and hemiparesis (weakness or the inability to move on one side of the body) following a cerebral infarction (stroke) affecting the right dominant side, arthritis (painful inflammation and stiffness of the joints) and contracture (shortening and hardening of muscles and tendons often leading to deformity) of the right hand. The 3/26/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance from one staff member for dressing, toileting and set-up assistance with personal hygiene. The assessment indicated Resident #15 had functional limitations in range of motion in her lower and upper extremities on one side. B. Observations and resident interview Resident #15 was interviewed on 4/22/24 at 10:31 a.m., Resident #15 was in her room watching television. There was a sign on the wall providing instructions for the application of a hand and elbow splint to be applied to the resident's right arm. There were two splints located on a nightstand next to Resident #15's bed. Resident #15 said only certain staff knew how to apply her splints correctly. Resident #15 said she occasionally would refuse to allow certain staff members to apply the splints since they did not know how to properly apply them. During a continuous observation on 4/23/24, beginning at 10:00 a.m. and ending at 12:00 p.m. Resident #15 was not wearing her splints. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The occupational therapy (OT) evaluation and treatment plan, with a certification period of 12/12/23 to 2/9/24, revealed Resident #15 would safely wear a resting hand splint and elbow extension splint on her right hand, right wrist, right fingers and right elbow for up to two hours and Resident #15 would tolerate wearing a right elbow splint for eight hours a day to promote range of motion and maintain skin integrity. The OT evaluation indicated goals for Resident #15 included reducing contractures and increasing strength. A review of the April 2024 CPO revealed the following physician orders related to Resident #15's contractures: -Resident #15 was to wear a right elbow extension splint during evening hours to reduce contracture and maintain range of motion ROM), ordered 3/7/24; and, -Resident #15 was to wear a right right hand splint during daytime hours to reduce contracture and maintain range of motion, ordered 3/7/24. -However, the March 2024 medication and treatment administration record (MAR/TAR) and April 2024 MAR/TAR failed to include documentation to indicate Resident #15's splints had been applied per the OT recommendations. -Review of the CNA (certified nurse aide) task documentation failed to reveal documentation indicating the resident's splints were being applied per the OT recommendations. -A review of Resident #15's comprehensive care plan did not reveal a care plan focus for Resident #15's use of splints for her contractures to her right elbow and hand. D. Staff interviews CNA #1 was interviewed on 4/24/24 at 9:30 a.m. CNA #1 said she was unable to find where to chart splint use for Resident #15. CNA #1 said she was unsure what type of splints Resident #15 used. She said she thought Resident #15 might use a right hand splint. CNA #1 said the use of splints and braces were usually located in the CNA task documentation and CNAs charted on the type of splint, duration of splint being on and if a resident declined to wear it. CNA #1 said if documentation for splint use was not found in the CNA task documentation, it might be located on the TAR for the nurses to chart on. Licensed practical nurse (LPN) #1 was interviewed on 4/24/24 at 9:35 a.m. LPN #1 said she was unable to find a physician's order for documenting Resident #15's splint use. LPN #1 said Resident #15 had a right hand splint and right elbow brace to help with her contractures. LPN #1 said Resident #15 was inconsistent with wearing the splints and it depended on the day or who was working because Resident #15's mood would fluctuate and she had a history of being non compliant with the splints. LPN #1 said staff needed to document in the resident's medical record when she refused to wear it. -Despite LPN #1's interview indicating Resident #15 sometimes refused to wear her splints, the medical record failed to reveal any documentation which indicated the resident refused her splints (see record review above). (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of rehabilitation (DOR) was interviewed on 4/25/24 at 9:32 a.m. The DOR said the therapy department was only able to add standard orders to a chart. The DOR said the therapy department was not responsible for updating the resident's plan of care. The DOR said the nursing staff and the resident, if applicable, were provided verbal education from therapy on recommendations for using splints. The DOR said she verbally communicated standing orders to the ADON or the DON and they would add the order to a resident's MAR /TAR for documentation purposes and add the information to a care plan. The DOR said she could not remember if she had spoken to the ADON or the DON about adding the order for splint use for Resident #15 to the MAR/TAR or adding it to the care plan. The DOR said Resident #15 was using an elbow brace and hand splint for her right affected arm to reduce the worsening of contractures. The DOR said Resident #15's contractures could worsen if she did not use the splints consistently. The DOR was unable to locate documentation to reveal the use of splints for Resident #15. 47024 II. Resident #10 A. Resident status Resident #10, age 70, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included muscle spasm, cervicalgia (pain in the neck), major depressive disorder, chronic obstructive pulmonary disease (COPD), anxiety disorder, chronic kidney disease, chronic pain syndrome, hemiplegia and hemiparesis (inability to move one side of the body) affecting the left non-dominant side and diabetes mellitus type II. The 3/26/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was dependent on staff for oral hygiene, toileting, bathing, upper and lower body dressing, rolling left to right, moving from sitting to lying, picking up objects and mobilizing in the wheelchair. B. Observations On 4/22/24 at approximately 11:10 a.m. Resident #10 was sitting in her wheelchair with her head leaning to the right with her chin resting slightly above her collarbone. On 4/23/24 at approximately 1:00 p.m., during the resident council meeting, Resident #10 was in attendance sitting in her wheelchair slumped to the right side with her head pressed against the right side of the headrest and tilted downward. On 4/23/24 at approximately 3:35 p.m. Resident #10 was sitting in the dining room for an activity with her head tilted downward onto her chest. The position of her head made it so the resident was only able to look at the table. On 4/25/24 at approximately 12:24 p.m. Resident #10 was sitting up in her wheelchair with her head tilted to the right with her chin down towards her chest. She was trying to eat her lunch. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at approximately 1:10 p.m. Resident #10 was sitting in her wheelchair with her head tilted to the right with her chin resting on her collarbone. C. Resident interview Resident #10 was interviewed on 4/22/24 at approximately 11:10 a.m. Resident #10 said she had asked for a new head brace for her wheelchair but had not gotten one. She said the head brace that was on her current wheelchair did not hold her head in an upright position which caused her pain. Resident #10 was interviewed again on 4/25/24 at approximately 1:10 p.m. Resident #10 said she felt her head was not in a good position and she needed to be repositioned in her wheelchair. She said her head was still not positioned correctly. D. Record review A review of Resident #10's comprehensive care plan did not reveal the use of the resident's wheelchair headrest or how to properly position the resident in the wheelchair. A daily skilled note dated 11/22/23 at 10:13 a.m. documented the staff looked at the resident's wheelchair headrest due to the resident stating it was broken and not working. The staff had to use towels to keep her head upright. A daily progress note dated 3/13/24 at 2:06 p.m. documented a staff member contacted the resident's medical equipment provider regarding adjustment/replacement of the wheelchair headrest on 2/26/24 and 3/13/24. The progress note documented the facility was awaiting a response for an appointment to be scheduled for the medical equipment provider to come in and adjust the headrest. A daily progress note dated 3/15/24 12:55 p.m. documented a sheepskin was applied to the resident's wheelchair headrest for comfort and skin protection while waiting for a wheelchair headrest replacement. A daily progress note dated 4/1/24 at 1:14 p.m. documented the wheelchair provider assessed the Resident #10's wheelchair, adjusted the headrest and recommended ensuring the resident was seated all the way back in the chair with her hips square and staff needed to be educated on proper alignment of the resident in her wheelchair to maximize her comfort. The Kardex (tool used by staff to provide person centered care), dated 4/25/24, was provided by registered nurse (RN) #1. It documented the resident used a soft neck brace. -The Kardex did not include how to position the resident correctly in her wheelchair. E. Staff interviews The DOR was interviewed on 4/25/24 at approximately 12:55 p.m. The DOR said Resident #10 received her wheelchair about two years ago (2022). She said an outside company adjusted the resident's wheelchair. She said the facility staff tried to adjust the resident's headrest but it did not help. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DOR said the resident continued to say something was wrong with her headrest. The DOR said the wheelchair provider came to the facility on [DATE] and they said placing a different head rest would not make any difference for her. The DOR said the wheelchair company said the facility needed to position the resident better in the wheelchair. The DOR said the wheelchair provider said resident should be all the way back in the chair and to adjust her hips first so her shoulders would follow and be straight. The DOR said the CNAs positioned the resident when they got her out of bed and into the wheelchair in the morning. The DOR said she and the assistant director of nursing (ADON) took pictures of the resident's appropriate positioning to show staff how the resident should be positioned in her wheelchair. She said the pictures were in a notebook at the nurse station. She said the resident had contractures in her neck and the headrest was for support and comfort. RN #1 was interviewed on 4/25/24 at 1:15 p.m. RN #1 said there was not a notebook at the nurses station that explained how to position Resident #10. She said the positioning information should be in the Kardex for the CNAs. She said the Kardex was an extension of the resident's plan of care to help the CNAs know how to provide individualized care to the residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47024 Based on interviews and record review, the facility failed to provide an environment free from accident hazards and risks as possible for three (#60, #52 and #43) of seven residents reviewed for accidents/hazards out of 35 sample residents. Specifically, the facility failed to -Ensure neurological checks were completed per standards of practice after Resident #60 sustained unwitnessed falls; and, -Ensure staff were properly trained to assist Resident #52 and Resident #43 with slide board transfers after the residents sustained falls during transfers. Findings include: I. Facility policy and procedure The Fall Management policy and procedure, revised on 2/1/24, was provided by the nursing home administrator (NHA) on 4/25/24 at 10:11 a.m. It read in pertinent part, A fall is defined as the failure to maintain an appropriate lying, sitting, or standing position, resulting in an individual's sudden, unintentional relocation either to the ground or into contact with another object below the starting point. Neurological evaluations will be implemented with any witnessed incident/fall involving a potential head injury or all unwitnessed incident/fall. II. Failure to complete neurological checks after unwitnessed falls A. Resident #60 1. Resident status Resident #60, age 75, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included severe persistent asthma, chronic respiratory failure with hypoxia (low oxygen), visual loss in both eyes, morbid obesity, chronic pain, anxiety disorder, depression and muscle weakness. The 2/20/24 minimum data set (MDS) assessment documented the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident required supervision for oral and personal hygiene. She required substantial assistance for toileting. She was dependent on staff for showering. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident had two or more falls with no injury during the review period. 2. Record review The fall care plan, initiated on 8/29/23 and revised on 3/18/24, documented the resident was at risk for falls related to weakness, disorientation, history of falls and side effects of medications. The interventions included offering to take the resident to the activities room to work on a quilt, assessing the resident's bed for safety, encouraging the resident to be in common areas while awake and in her wheelchair, ensuring the resident had a safe environment, ensuring the resident was wearing appropriate footwear when ambulating and ensuring the resident's bed was in the low position while she was in bed. a. Fall incident 12/23/23 - unwitnessed A nursing note dated 12/23/23 at 12:41 a.m. documented the resident was found lying on the floor on her left side in front of the bed. The resident said she was sitting on the side of the bed and was unable to stop herself from falling. The note documented neurological checks were initiated. -However a request was made for the neurological checks following the resident's fall on 12/23/23. The director of nursing (DON) said the facility did not have documentation indicating neurological checks were completed after the resident sustained an unwitnessed fall on 12/23/23 (see interview below). b. Fall incident on 2/5/24 - unwitnessed A nurse note dated 2/5/24 at 6:43 a.m. documented an unwitnessed fall. The note documented the fall had occurred on 2/4/25 at 6:40 p.m. The resident was found on the floor and the resident's neurological status was within normal limits. -However a request was made for the neurological checks following the resident's fall on 2/5/24. The DON said the facility did not have documentation indicating neurological checks were completed after the resident sustained an unwitnessed fall on 2/5/24 (see interview below). c. Fall incident on 3/23/24 - unwitnessed A nurse note dated 3/23/24 at 3:58 p.m. documented the resident sustained an unwitnessed fall. The resident was found lying on the floor in front of her bed when staff were responding to her call light. The resident said she was trying to transfer herself to bed and her legs gave way. She said the CNA had told her she would be back to help her into bed. The resident sustained a skin tear to the right upper arm. A nurse note dated 3/24/24 at 5:31 a.m. documented the resident was continuing with neurological checks. -However a request was made for the neurological checks following the resident's fall on 3/24/24. The DON said the facility did not have documentation indicating neurological checks were completed after the resident sustained an unwitnessed fall on 3/24/24 (see interview below). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Staff interviews The DON was interviewed on 4/25/24 at approximately 11:30 a.m. The DON said Resident #60's fall on 3/23/24 was unwitnessed and neurological checks should have been completed. She said if the staff did not do neurological checks after a resident sustained an unwitnessed fall they would not be able to identify if any neurological problems had come up. She said Resident #60's fall on 3/23/24 should have been reviewed in the IDT meeting. She said new interventions should have been put into place. III. Failure to ensure staff were trained properly on resident slide board transfers A. Resident #52 1. Resident status Resident #52, age 68, was admitted to the facility on [DATE]. According to the April 2024 CPO, diagnoses included chronic embolism and thrombosis (blood clots) of the left subclavian vein (a deep vein to the heart), chronic obstructive pulmonary disease (COPD), paraplegia (inability to move lower part of the body), chronic kidney disease, adjustment disorder and depression. The 4/1/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent for eating and oral hygiene, required set-up assistance with upper body dressing, required maximal assistance with putting on footwear, bathing, toileting and toilet hygiene. A. Record review The care plan for falls, initiated on 7/4/23 and revised on 4/3/24, documented the resident was at risk for falls related to impaired sensation to bilateral lower extremities. Interventions included anticipating and meeting the resident needs, applying pillows to aid in positioning the resident when lying in bed, encouraging the resident to use the call light, ensuring the call light was within reach and educating the resident about having a staff member present when attempting to transfer into a car. A nursing note dated 11/1/23 at 12:03 a.m. documented CNA #2 reported the resident had slid from the bed during a slide board transfer from the wheelchair back to bed. An IDT review note dated 11/1/23 at 9:17 a.m. documented staff were re-educated on slide board transfers. -However, a lifts, transfers, gait belts, slide boards and slings educational sign in sheet, dated 10/25/23 and 11/2/23 revealed CNA #2 did not attend the educational training sessions. B. Resident #43 1. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #43, aged over 65, was admitted to the facility on [DATE]. According to the April 2024 CPO, diagnoses included atrial fibrillation (abnormal heart beat), acute respiratory failure, depression, insomnia (inability to sleep), anxiety disorder, and muscle weakness. The 3/27/24 MDS assessment documented the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required set-up assistance with oral hygiene, supervision to roll left and right. The resident required moderate assistance with upper body dressing and transitioning from sitting to lying in bed. The resident required maximal assistance with toileting hygiene, bathing, lower body dressing and putting on footwear. 2. Record review The fall care plan, initiated on 9/23/23 and revised on 11/5/23, documented the resident was at risk for falls related to weakness and side effects of medications. The interventions included: anticipating and meeting the residents needs, encouraging the resident to use the call light, using foam wedges for positioning when lying in bed, utilizing physical therapy to evaluate the resident for a cushion/pillow and make recommendations, and utilizing a pillow for positioning. A nurse note dated 10/5/23 at 4:50 p.m. documented the resident fell during a transfer. The resident said her legs were not strong enough to hold her up and that was why she fell . A nurse note dated 10/5/23 at 4:58 p.m. documented a CNA reported the resident fell on her left knee when she was unable to complete a slide board transfer. -However, a lifts, transfers, gait belts, slide boards and slings educational sign in sheet, dated 10/25/23 and 11/2/23 revealed CNA #3 did not attend the educational training sessions. C. Staff interviews The NHA was interviewed again on 4/24/24 at 2:29 p.m. He said there had been training for the staff on how to safely transfer a resident. He said CNA #2 was working at the time of Resident #52's fall and CNA #2 did not receive the transfer training. He said CNA #2 should have received immediate training on the correct way to complete a slide board transfer after she was involved in Resident #52's fall. The NHA said CNA #3 was working at the time of Resident #43's fall, however, he said CNA #3 did not receive the transfer training. He said CNA #3 should have received immediate training on the correct way to complete a slide board transfer after the CNA was involved in Resident #43's fall.

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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** 47350 Based on interviews and record review, the facility failed to provide timely and effective interventions to prevent weight loss for one (#41) of four residents reviewed for weight loss out of 35 sample residents. Resident #41 was admitted to the facility for long term care on 1/14/23 and readmitted on [DATE] with diagnoses of hyper-[NAME] syndrome (a rare immunodeficiency syndrome), anemia (low blood count) and dementia. Resident #41 had multiple food allergies, including soy protein, brussels sprouts, mushrooms, nuts, pine nuts, shellfish, wheat products and protein hydrolysate. On 10/1/23, Resident #41 weighed 139 pounds (lbs). On 10/15/23, Resident #41 weighed 119.2 lbs, which indicated the resident had lost 19.8 lbs. The registered dietitian (RD) requested the resident to be reweighed on 10/16/23, 10/19/23, 10/24/23 and 10/26/23. The resident was not reweighed until 10/26/23, 10 days after the initial reweigh was requested, where she weighed 116.5 lbs. The resident had lost 16.2% (22.5 lbs) in 25 days, which was considered severe. The facility did not implement a nutritional intervention to address the resident's severe weight loss until 11/7/23 when a nutritional orange juice supplement was added three times a day. The physician had ordered the resident's weight to be obtained weekly beginning 11/11/23 and ending on 1/15/24. During this time the facility failed to follow physician orders and weigh the resident consistently on a weekly basis to closely monitor the resident's weight loss. On 2/8/24, Resident #41 weighed 110.3 lbs. The resident had lost an additional 6.2 lbs from 11/6/23 to 2/8/24. Despite the resident losing an additional 6.2 lbs from 11/6/23 to 2/8/24, the facility did not implement additional nutritional interventions. On 3/15/24, Resident #41 weighed 103 lbs. On 3/19/24, 3/20/24, 3/22/24 and 3/26/24 the RD requested the resident to be reweighed. The facility did not reweigh the resident until 4/1/24 where she weighed 100.5 lbs. The resident sustained a 6.6% (7.3 lbs) weight loss, which was considered severe from 2/8/24 to 3/15/24 in one month. The facility implemented fortified mashed potatoes on 3/31/24, 16 days after the resident sustained a severe weight loss. On 4/1/24 the resident triggered for severe weight loss of 27.7% (38.5 lbs) in six months from 10/1/23 to 4/1/24. The facility did not reassess and implement further nutritional interventions to address the resident's severe weight loss. Due to the facility's failures to closely monitor the resident's weight, obtain timely reweighs and implement timely nutritional interventions, Resident #41 sustained a 27.7% (35.8 lbs) weight loss in six months, which was considered severe. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Findings include: I. Facility policy and procedure The Weight and Height Management policy and procedure, revised on 12/6/18, was provided by the nursing home administrator (NHA) on 4/25/24 at 10:11 a.m. It read in pertinent part, Residents will be weighed a minimum of monthly by nursing, unless otherwise ordered by the physician. Upon admission, residents will be weighed weekly for four weeks unless contraindicated (resident preference, pain, end of life). The registered dietitian (RD) will evaluate weekly admission body mass index (BMI), baseline weights and weight trends to recommend weight frequency. The physician will be notified of significant weight loss. If a weight change as noted above is accurate the direct care nurse or RD should review and evaluate recent acute temporary care plan to identify possible reasons for the weight change. The RD/designee will review weights and make recommendations, based on potential weight gain or loss trends. II. Resident #41 A. Resident status Resident #41, age 77, was admitted on [DATE] readmitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included hyper-[NAME] syndrome, anemia and dementia. The 3/19/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. She was dependent on staff for toileting. She required substantial/maximal assistance with personal hygiene, bed mobility, transfers and required supervision with touch assistance and cueing with eating. The assessment documented the resident was 63 inches (five foot, three inches) tall and weighed 103 lbs. The resident had a weight loss of 5% or more in one month or a weight loss of 10% in six months that was not physician prescribed. B. 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 9/28/23 and revised on 4/3/24, revealed Resident #41 had significant unplanned weight loss. The resident had a history of significant unplanned weight loss. The care plan documented the 3/27/24 nutrition assessment of the resident's current oral intake and the supplement of six ounces (oz) nutritional white grape juice three times a day was determined to be not sufficient to meet the resident's assessed caloric needs. The resident had pneumonia on 3/8/24. The interventions included encouraging high protein foods, monitoring weights, providing a gluten restricted diet, providing her meals in her room without assistance, providing cueing and encouragement, encouraging the resident to eat and drink throughout day, monitoring the amount of food and fluid intake at meals, providing six oz of nutritional white grape juice three times a day and offering four oz of fortified mashed potatoes with gravy at lunch. -The care plan did not document how frequently the resident was to be weighed. The April 2024 CPO revealed an order for weekly weights due to significant weight loss, ordered 11/11/23 and discontinued 1/15/24. The April 2024 CPO revealed an additional order for monthly weights on the first weekend of every month, ordered 1/15/24. -A review of the resident's medical record revealed the resident's weekly weight was not obtained on 11/18/23, 11/25/23, 12/2/23, 12/16/23, 12/23/23, 1/6/24 and 1/13/24. -A review of the resident's electronic medical record (EMR) revealed the resident's weight was not obtained in January 2024. The resident's weights were documented in the resident's EMR as follows: -On 10/1/23, the resident weighed 139 lbs; -On 10/15/23, the resident weighed 119.2 lbs; -On 10/26/23, the resident weighed 116.5 lbs; -On 10/31/23, the resident weighed 116.0 lbs; -On 11/6/23, the resident weighed 116.5 lbs; -On 12/7/23, the resident weighed 115.5 lbs; -On 12/28/23, the resident weighed 114.0 lbs; -On 2/8/24, the resident weighed 110.3 lbs; -On 3/15/24, the resident weighed 103 lbs; and, -On 4/1/24, the resident weighed 100.5 lbs. The resident sustained a 16% (22.5 lbs) weight loss, which was considered severe, from 10/1/23 to 10/26/23 in less than one month. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The resident sustained a 6.6% (7.3 lbs) weight loss, which was considered severe, from 2/8/24 to 3/15/24 in one month. The resident sustained a 11.9% (13.5 lbs) weight loss, which was considered severe, from 12/28/23 to 4/1/24 in three months. The resident sustained a 27.7% (38.5 lbs) weight loss, which was considered severe, from 10/1/23 to 4/1/24 in six months. The April 2024 CPO revealed the following diet and nutritional supplementation orders: -Gluten restricted diet, regular texture, regular/thin consistency, ordered 9/26/23; -Magic cup once a day, ordered 10/4/23 discontinued 11/7/23; and, -HS (bedtime) snack, ordered 9/14/23. The 9/28/23 nutrition assessment documented the resident was independent with eating. Her weight was 140.5 lbs.She was on a gluten restricted diet with multiple food allergies, which included soy protein, brussel sprouts, mushrooms, nuts, pine nuts, shellfish, wheat products and protein hydrolysate. The 9/28/23 nutrition assessment further documented the resident's current oral intake at meals was not sufficient to meet her assessed calories and protein needs. The interventions included encouraging the resident to consume high protein foods, continuing four oz Magic cup ice cream (frozen nutritional supplement) every day and continuing to monitor and follow up as needed. The 10/16/23 nutrition progress note documented the resident weighed 119.2 lbs which was down from her previous weight of 139 lbs. A reweigh was requested. -However, the facility failed to obtain the reweigh when it was requested. The 10/19/23 nutrition progress note documented the resident weighed 119.2 lbs which was down from the previous weight of 139 lbs. A reweigh was requested. -However, the facility again failed to obtain the reweigh when it was requested. The 10/24/23 nutrition progress note documented the resident weighed 119.2 lbs which was down from her previous weight of 139 lbs. A reweigh was requested. -However, the facility again failed to obtain the reweigh when it was requested. The 10/26/23 nutrition progress note documented the resident weighed 119.2 lbs which was down from her previous weight of 139 lbs. A reweigh was requested. -However, Resident #41 was not reweighed until 10/26/23, 10 days after the RD initially requested the resident to be reweighed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-When the reweigh was obtained, Resident #41 weighed 116.5 lbs and had sustained a 16.2% (22.5 lbs) weight loss in 25 days, which was considered severe, from 10/1/23 to 10/26/23. The 11/7/23 nutrition progress note documented the resident's weight loss was due to insufficient oral intake at meals. The resident's preferences were reviewed and the Magic cup was discontinued per the resident's request. The current interventions included weekly weights. The RD reviewed with the resident to eat high protein foods and recommended starting a nutritional orange juice three times a day. The progress note documented the resident fed herself and received assistance and cueing as needed. -The resident sustained a 16.2% (22.5 lbs) weight loss, which was considered severe from 10/1/23 to 10/26/23 in less than one month. The facility did not implement a new nutritional intervention to prevent further weight loss until 11/7/23. The 12/31/23 nutrition progress note documented the resident's weight was down to 114 lbs on 12/28/23. Her average oral intakes at meals were 50% and, along with the current intervention of the nutritional orange juice, were insufficient to meet current caloric and protein needs. Other current interventions included continue with encouraging high protein foods, nutritional juice and the goal of increasing oral meal intakes of equal or more than 50%. The 12/31/23 quarterly nutrition assessment progress note documented the resident had significant unplanned weight loss. The resident was on a gluten restricted diet with multiple food allergies and was able to feed herself in her room with assistance, cueing and encouragement. Her average oral intake was 58% at meals. The progress note documented the Magic cup was not sufficient to meet her assessed caloric and protein needs so six oz of nutritional orange juice three times a day was implemented to help meet nutritional needs. -The Magic cup was discontinued on 11/7/24 when the nutritional orange juice was ordered. -The resident weighed 114 lbs on 12/28/24. The facility did not implement additional nutritional interventions to prevent further severe weight loss, despite the resident's continued downward trend of weight loss. The 1/31/24 nutrition progress note documented the RD requested a weight to be taken in January. -However, there was no weight documented in the resident's weight section of the EMR for January 2024 (see resident's weights above). The 2/1/24 nutrition progress note documented the resident weighed 108.5 lbs. The resident had a decrease of more than five lbs from her previous weight. A reweigh was requested. -Review of the resident's EMR did not reveal when the resident's weight of 108.5 was obtained. The 2/5/24 nutrition progress note documented a reweigh requested. On 2/8/24 the resident weight was documented as 110.3 lbs, which continued to show a downward trend in weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-However, the facility failed to add any additional nutritional interventions to prevent further weight loss. The 2/29/24 nutrition progress note documented Resident #41 ate in her room, was able to feed herself and received assistance and cueing. Her oral intakes at meals were 42% on average. The current nutrition interventions included nutritional orange juice. The 2/29/24 progress note further documented the resident's current oral intake and nutritional orange juice three times a day was not sufficient to meet nutritional needs. Resident #41 requested chocolate milkshakes. -However, review of the resident's EMR did not reveal the chocolate milkshakes were initiated per the residents request. The 2/29/24 nutrition progress note additionally documented Mighty shake (nutritional supplement) and [NAME] Ready Care shakes (nutritional supplement) contained soy and the resident had a soy allergy. The nutritional orange juice three times a day was changed to nutritional white grape juice. -The RD documented the resident's oral intake and nutritional interventions were not sufficient to meet the resident's nutritional needs. However, the RD did not increase nutritional supplementation to help meet the resident nutritional needs after she had sustained further weight loss or explore other nutritional interventions or supplementation that would accommodate Resident #41's multiple food allergies. The 3/19/24 nutrition progress note documented the resident weighed 103 lbs, which was down from her previous weight of 110 lbs on 2/8/24. The RD requested for the resident to be reweighed. -However, the facility failed to obtain the reweigh when it was requested. The 3/20/24 nutrition progress note documented the RD requested the resident to be reweighed. -However, the facility again failed to obtain the reweigh when it was requested. The 3/22/24 nutrition progress note documented the RD requested the resident to be reweighed. -However, the facility again failed to obtain the reweigh when it was requested. The 3/26/24 nutrition progress note documented the RD requested the resident to be reweighed. -However, the facility again failed to obtain the reweigh when it was requested. -However, Resident #41 was not weighed until 4/1/24, 13 days after the RD initially requested the resident to be reweighed. -When the reweigh was obtained, Resident #41 weighed 100.5 lbs and had sustained a 6.6% (7.3 lbs) weight loss in one month, which was considered severe, from 2/18/24 to 3/15/24. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-In the time between when the reweigh was requested and the time it was obtained, from 3/15/24 to 4/1/24, Resident #41 lost an additional 2.4% (2.5 lbs), which was not significant, but continued to demonstrate the continued downward trend of weight loss. The 3/31/24 nutrition quarterly assessment documented Resident #41 had weight loss. The note documented the resident's current oral meal intake and nutritional white grape juice three times a day was not sufficient to meet her assessed nutrition needs.The resident had a history of pneumonia on 3/8/24. The interventions included a goal of consuming 50% or greater for meals, gaining one to two lbs per week and offering four oz fortified mashed potatoes with gravy for lunch. The February 2024 medication and treatment administration record (MAR/TAR) documented Resident #41 was provided with six oz of nutritional white grape juice three times a day for nutritional support on multiple days. -However, the February 2024 MAR/TAR failed to document how much of the nutritional grape juice was consumed by the resident each time it was offered. The March 2024 MAR/TAR documented Resident #41 was provided with six oz of nutritional white grape juice three times a day for nutritional support on multiple days. -However, the March 2024 MAR/TAR failed to document how much of the nutritional grape juice was consumed by the resident each time it was offered. The April 2024 MAR/TAR documented Resident #41 was provided with six oz of nutritional white grape juice three times a day for nutritional support on multiple days. -However, the April 2024 MAR/TAR failed to document how much of the nutritional grape juice was consumed by the resident each time it was offered. A review of the April 2024 CPO and the medical record failed to reveal documentation of an interdisciplinary team (IDT) meeting regarding Resident #41's weight loss. A review of the meal intakes for Resident #41 from 3/25/24 to 4/22/24 revealed the following: -Out of 29 opportunities for breakfast, the resident ate 50% or less 11 times and 25% or less five times; -Out of 29 opportunities for lunch, the resident ate 50% or less nine times, 25% or less three times and the meal was not documented one time; and, -Out of 29 opportunities for dinner, the resident ate 50% or less seven times, 25% or less four times, refused one time and the meal was not documented three times. A review of snack intakes for Resident #41 from 3/27/24 to 4/22/24 documented the resident did not take a snack on 3/27/24, 4/7/24, 4/9/24, 4/12/24 and 4/16/24. -The documentation failed to reveal the type of snack offered and the amount consumed when the resident did accept a snack. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The visual bedside Kardex report (a tool utilized by certified nurse aides (CNA) to provide personalized consistent care) indicated the resident needed to be encouraged to eat meals upright and remain upright for 30 minutes after eating. -It did not indicate Resident #41 needed supervision with touch assistance and cueing for meals. -It did not indicate the resident liked to eat her meals in her room and needed assistance when eating in her room. A review of the feeding assistance documentation for Resident #41 from 3/25/24 to 4/22/24 indicated Resident #42 received set up help only or no set up assistance from staff for meals on multiple occasions. -The feeding assistance documentation revealed Resident #41 received physical assistance with eating only one time during the 3/25/24 to 4/22/24 timeframe. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/24/24 at 1:50 p.m. LPN #1 said a print out was generated monthly on who needed to be monitored for weights. Residents who had trending or significant weight loss would be put on the weekly weight list. She said the RD communicated which residents needed to be weighed weekly with the nursing staff. She said Resident #41 was receiving nutritional juice three times a day with a bedtime snack. She said the resident usually ate in her room. She said she did not think Resident #41 was receiving assistance to eat while she was in her room. She said residents who had weight loss should be receiving supervision for meals. The RD was interviewed on 4/25/24 at 9:00 a.m. The RD said when residents triggered for weight loss they were put on weekly weights. The RD said if there was a change of five pounds or more from their previous weight they were reweighed to ensure the accuracy of the weight. She said she provided a list of residents that needed to be weighed to the assistant director of nursing (ADON). She said if the weights were not completed she would follow up with the ADON to ensure the weights were done. The RD said weights were monitored in addition to how well residents were doing with their supplement and their nutritional interventions. She said when residents' weights became stable they would be taken off of weekly weights and weighed monthly. She said residents who triggered for weight loss were discussed weekly at the IDT meeting. She said she did not know where the IDT discussions were documented. She said residents who needed additional assistance with meals were encouraged to eat in the dining room where staff was able to provide additional assistance and supervision or cueing if required. The RD said meal intakes were monitored for all meals and should be documented for all residents, including the residents who triggered for significant weight loss. The RD said Resident #41 triggered for weight loss on 10/15/23. She said she placed Resident #41 on weekly weights on 11/11/23 and was placed back on monthly weights on 1/15/24, because Resident #41's weight had stabilized. She said she monitored how Resident #41 did with her supplement and nutritional interventions. She said she knew the current order for Resident #41 said monthly weights but she was aware Resident #41 needed to be weighed weekly due to continued weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Despite the RD indicating in her interview that Resident #41 had been put back on monthly weights on 1/15/24, documentation of the resident's weights in the EMR revealed the resident's weight continued to trend downward consistently (see record review above). -Despite the RD indicating in her interview that she was aware the Resident #41 needed to be weighed weekly due to her continued weight loss, the facility did not put the resident back on weekly weights when she continued to lose weight (see record review above). The RD said Resident #41 had multiple food allergies and was on a gluten restricted diet with regular texture and thin liquids. She said she was placed on nutritional grape juice on 11/7/23 She said nutritional juices contained additional calories and protein. She said Resident #41 seemed to like the nutritional grape juice better than the orange juice. She said she had added fortified mashed potatoes, which had additional butter and milk in them, to Resident #41's menu for lunch. She said the staff encouraged Resident #41 to eat in the assisted dining room but since the resident chose to eat in her room, CNAs should be providing additional supervision and cueing. CNA #3 was interviewed on 4/25/24 at 9:35 a.m. CNA #3 said residents that required assistance and supervision should ideally go to the restorative dining room for assistance. She said the Kardex would indicate if a resident needed assistance with their meals. She said Resident #41 ate in her room, however, she said she did not know if the resident required any additional assistance with meals. The NHA was interviewed on 4/25/24 at 9:30 a.m. The NHA said nutritional assessments were conducted on admission, yearly, quarterly and with a change of condition. He said he would try to locate where the nutritional IDT meetings were documented. -However, the nutritional IDT progress notes were not provided by the NHA prior to the survey exit on 4/26/24.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to ensure one (#191) of two residents out of 35 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to ensure consistent communication and documentation with the dialysis center occurred regarding care and services provided for Resident #191. Findings include: I. Facility policy and procedure The Dialysis Care Policy, reviewed 7/12/23, was provided by the nursing home administrator (NHA) on 4/25/24 at 10:11 a.m., It read in pertinent part, Coordination of dialysis care will include communication about code status, change in medications, current vital signs, weight management, required treatments, care concerns and appropriate interventions and fluid restriction management limitations. This information will be sent with the resident to their dialysis appointments. II. Resident #191 A. Resident status Resident #191, age 78, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included congestive heart failure (CHF) and end stage renal disease (ESRD). The 4/26/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He was dependent with toileting, required substantial/maximal assistance with transfers, partial/moderate assistance with bed mobility and set up assistance with eating. B. Record review The nutrition care plan, initiated 4/22/24, documented Resident #191 was at a nutritional risk related to ESRD and dialysis. It indicated the resident received dialysis three days a week. The dialysis care plan, initiated 4/7/24, documented resident Resident #191 had ESRD and required dialysis. Interventions included dialysis as ordered, dietary to evaluate as needed, monitor fistula (a connection between the artery and vein for dialysis access) in left arm and monitor for complications from dialysis. A review of the dialysis treatment record from 4/9/24 to 4/24/24 revealed Resident #191 received dialysis on 4/9/24, 4/11/24, 4/12/24, 4/15/24, 4/17/24, 4/19/24 and 4/22/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hemodialysis communication record forms from 4/9/24 to 4/24/24 revealed there was no hemodialysis communication form in the chart on 4/11/24, 4/12/24, 4/15/24, 4/17/24 and 4/19/24. -A hemodialysis communication form for 4/22/24 revealed the facility pre-dialysis portion of the communication form was filled out, however, the dialysis portion was not completed. -Review of Resident #191's electronic medical record (EMR) failed to reveal documentation to indicate communication between the facility and the dialysis center had occurred on 4/11/24, 4/12/24, 4/15/24, 4/17/24 and 4/19/24. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/24/24 at 11:10 a.m. LPN #1 said each resident that went to dialysis had a book that went with them to and from dialysis. She said the facility filled out the top portion of the form with vital signs, medications given and sometimes the resident's weight. She said the form was sent to dialysis with the resident along with a face sheet and medical orders for scope of treatment (MOST). LPN #1 said the form was important for communication between the facility and the dialysis center to ensure the residents were receiving continuity of care. She said the forms were a permanent part of the resident's medical record and were uploaded in the electronic medical record (EMR) by the medical records department. The dialysis registered nurse (DRN) was interviewed on 4/24/24 at 11:50 a.m. The DRN said the facility usually sent the communication form with residents that received dialysis. She said she thought she saw one for 4/22/24 for Resident #191 but she was unsure if the communication forms had been completed for the previous week. The director of nursing (DON) was interviewed on 4/24/24 at 12:30 p.m. The DON said dialysis forms were completed before dialysis by the facility staff. She said the dialysis center then filled out their portion of the form and sent it back with the resident. The DON said if the communication form did not return from the dialysis center to the facility, the facility should call the dialysis center to obtain the documentation to ensure continuity of care for the resident. She said she was unable to locate the dialysis communication forms on the missing dates for Resident #191 (see record review above). The DON said she had checked with the medical records department and was unable to locate the forms. She said she would check with the dialysis center to see if the forms were left there. -The missing dialysis communication forms were not provided by the facility by the end of the survey on 4/26/24. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 4/24/24 at 1:10 p.m. RN #3 said, in the rehabilitation wing of the facility, the nursing staff sent packets with residents that went to dialysis which included the dialysis communication form. He said the communication form should return in the packet back from the dialysis center. He said he was not usually at the facility when residents came back from dialysis but he said communications forms got put into a dialysis binder and then sent to medical records to be uploaded into the EMR. He said staff were unable to locate Resident #191's communications forms. RN #3 said if forms did not return back from the dialysis center, the facility staff should call the dialysis center to find out where the form was.

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on interviews and record review, the facility failed to implement policies and procedures that ensured potential irregularities identified by the consulting pharmacist (CP) and documented in monthly drug regimen reviews (MRRs) as recommendations, would be timely reviewed and acted upon by the medical provider, medical director, and the director of nursing (DON). This failure affected four of four residents (#51, #60, #15, #64) whose records were reviewed. In an interview, the CP responsible for the facility's MRRs stated she emailed the residents' MRRs to the DON monthly. There had been no response to the MRR recommendations for four months, beginning in January 2024. She further stated she had repeatedly notified the medical director, the DON, and the nursing home administrator (NHA) that she was not receiving any response from the facility to her recommendations. A review on 4/25/24 of an executive summary report by the pharmaceutical company revealed multiple MRR recommendations in January 2024 (163), February 2024 (143), March 2024 (131), and April 2024 (138) that had not been returned to the CP to show they had been reviewed and responded to by the medical provider. Further, on 4/24/24 at 2:00 p.m., the DON provided MMRs for Residents #51, #15, #60, and #64 that were not reviewed and signed by the medical provider until 4/25/24, during the survey. These included: -MRRs for Resident #51, dated 3/20/24, 3/22/24, and 4/10/24, which included recommendations to address two medications with anticoagulation properties, an antipsychotic medication without a clinically appropriate indication for use, and an antidepressant. -MRRs for Resident #15, dated 11/10/23, 12/14/23, 1/15/24, 3/22/24, and 4/9/24 which included recommendations to address gradual dose reduction (GDR) of an antipsychotic and antidepressant, lab studies, and pain medication. -MRRs for Resident #60, dated 11/10/23, 12/14/23, 2/15/23, and 3/21/24, which included recommendations addressing GDRs of antidepressants and inquiries about two medications with anticoagulation properties. -MRR for Resident #64, dated 3/22/24, which identified the resident's anticoagulant lacked the diagnosis listed in the resident's diagnosis list. The facility's failure to implement policies and procedures that ensured timely review and response to MRR recommendations created a situation of immediate jeopardy for serious resident harm - potential adverse consequences due to the lack of timely oversight of the residents' medication therapies. Findings include: I. Immediate jeopardy (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A. Findings of immediate jeopardy The facility failed to implement policies and procedures that ensured potential irregularities identified by the consulting pharmacist (CP) and documented in monthly drug regimen reviews (MRRs) as recommendations would be timely reviewed and acted upon by the medical provider, medical director, and the director of nursing (DON). In an interview, the CP responsible for the facility's MRRs stated she emailed the residents' MRRs to the DON monthly. There had been no response to the MRR recommendations for four months, beginning in January 2024. She further stated she had repeatedly notified the medical director, the DON, and the NHA that she was not receiving any response from the facility to her recommendations. A review on 4/25/24 of an executive summary report prepared by the pharmaceutical company revealed multiple MRR recommendations in January 2024 (163), February 2024 (143), March 2024 (131), and April 2024 (138) that had not been returned to the CP to show they had been reviewed and responded to by the medical provider. Further, on 4/24/24 at 2:00 p.m., the DON provided MMRs for Residents #51, #15, #60, and #64 that were not reviewed and signed by the medical provider until 4/25/24, during the survey. These included: -MRRs for Resident #51, dated 3/20/24, 3/22/24, and 4/10/24, which included recommendations to address two medications with anticoagulation properties, an antipsychotic medication without a clinically appropriate indication for use, and an antidepressant. -MRRs for Resident #15, dated 11/10/23, 12/14/23, 1/15/24, 3/22/24, and 4/9/24 which included recommendations to address gradual dose reduction (GDR) of an antipsychotic and antidepressant, lab studies, and pain medication. -MRRs for Resident #60, dated 11/10/23, 12/14/23, 2/15/23, and 3/21/24, which included recommendations addressing GDRs of antidepressants and inquiries about two medications with anticoagulation properties. -MRR for Resident #64, dated 3/22/24, which identified the resident's anticoagulant lacked the diagnosis listed in the resident's diagnosis list. The facility's failure to implement policies and procedures that ensured timely review and response to MRR recommendations created a situation of immediate jeopardy for serious resident harm - potential adverse consequences due to the lack of timely oversight of the residents' medication therapies. B. Facility notice of immediate jeopardy On 4/25/24 at 3:15 p.m., the NHA was notified of the facility's failure to implement policies and procedures that ensured potential irregularities identified in monthly drug regimen reviews (MRRs) would be timely reviewed and acted upon by the medical provider, medical director, and the DON created a situation of immediate jeopardy for serious harm if immediate action was not taken. C. Plan to remove immediate jeopardy (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/25/24 at 5:47 p.m., the NHA implemented an interim plan to ensure the safety of all residents until a formal final plan could be submitted on 4/26/24. It read, in part, that immediately following the discovery of missing follow-up of MRRs for residents, the MRRs for Residents # 51, #15, #60, and #64 were reviewed and given to residents' providers for review and follow-up on recommendations. Based on physician review, appropriate changes were made to residents' medication regimens as needed. Education was completed with DON and Assistant DON regarding follow-up with MRRs on 4/25/24. On 4/26/24 at 1:05 p.m. the facility submitted its final plan to remove immediate jeopardy. The plan read: Immediately following discovery of missing follow up of Medication Regimen Reviews for residents. 1. MRRs for Residents #51, #15, #60, and #64 were reviewed and given to residents' providers for review and follow up on recommendation. Based on physician review, appropriate changes were made to residents' medication regimen[s] as needed. 2. Family and physician notification for Resident #51, #15, #60 and #64 was completed on 4/25/24. 3. Education completed with DON and assistant director of nursing (ADON) regarding follow up with MRRs on 4/25/24. Identification of Others: Prior to the notification of Immediate Jeopardy on 4/25/24, DON/designee began reviewing January 2024 to present MRRs with resident's provider on 4/23/24 to assure recommendations were reviewed by the provider. This included all residents with recommendations. All recommendations will be reviewed and completed by residents' providers by 4/29/24. Systemic Measures: 1. Beginning 4/25/24 the DON/designee will begin reporting to the NHA and vice president (VP) of Clinical Services to ensure monthly MRR follow up has been completed. Review tool to be completed to document completing of review. 2. Beginning 4/25/24 the pharmacy consultant will email monthly reports to the attending physician, the Medical Director, DON, NHA, VP of Clinical Services, and Director of Operations for review and follow up. In addition, hard copies will be provided to providers during regular visits to the community. 3. Facility pharmacy consultant will complete an Interim Medication Regimen Review (IMRR) on all new residents admitted to the facility twice per week to ensure new admissions are reviewed that would discharge from the facility prior to when monthly MRRs are completed. Monitoring 1. MRRs will be reviewed monthly by DON/designee to ensure recommendations have been reviewed/completed by the provider. Findings will be reported to the QAPI (quality assurance performance improvement) meeting held monthly for further review and recommendation. (continued on next page)

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	065292	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Sandalwood, The	3835 Harlan St Wheat Ridge, CO 80033

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	D. Removal of immediate jeopardy On 4/26/24 at 1:05 p.m., the NHA was notified that the facility's plan to remove immediate jeopardy was accepted based on the facility's actions in implementing the measures above. However, the deficient practice remained at an F level, the potential for more than minimal harm that is widespread. II. Facility policy and procedures A. The NHA provided the facility's Drug Regimen Review Policy, dated 7/10/23, on 4/25/24 at 5:28 p.m. It read in pertinent part: -Drug regimen review (DRR) consists of reviewing and analyzing prescribed medication therapy and medication use, including nursing documentation of medication ordering and administration. -The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. -Findings and recommendations are reported to the Administrator, director of nursing (DON), the primary physician, and the medical director, where appropriate. -The consultant pharmacist documents the date each review is completed on the appropriate form and briefly notes the findings. -Facility responsibility: To establish policies and procedures that address response timeframes for monthly DRR. -The consultant pharmacist (CP) documents potential or actual mediation therapy problems and communicates them to the primary physician and the DON. A written report is provided to the physician within seven working days. The physician's response is documented in the consultant pharmacist review record or elsewhere in the resident's medical record. -The physician response is provided to the consultant pharmacist for review and then filed by the facility. -The facility maintains copies of signed reports on file for at least one year. B. Procedures for implementation of the facility's policies and procedures - pharmacist, DON, and medical provider expectations 1. The CP was interviewed on 4/24/24 at 2:29 p.m. and again at 4:59 p.m. about the procedures for facility access to MRR recommendations. The CP said she sends the MRR recommendations through the facility's computer portal to the DON directly. She said the DON was shown how to use the portal to access pharmacy recommendations by the pharmaceutical provider's account manager and by her in February 2024. 2. The DON was interviewed on 4/25/24 at 12:44 p.m. about the procedures for accessing and distributing MRR recommendations to medical providers for review and response. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The DON said the CP reviewed the residents' medications monthly, created a report with medication recommendations, and sent the report through the facility computer portal. The DON said the pharmacist sent an email once she had completed her recommendations. The DON then retrieved the recommendations from the computer portal. She said it was her responsibility to print the report with the CP's recommendations and to distribute it to the appropriate medical provider. The DON said after the medical provider reviewed and responded to the recommendations, she was responsible for returning the MRR with responses to the CP. She said she printed a copy of the report which she kept in a binder in her office. 3. A medical provider was interviewed on 4/25/24 at 4:36 p.m. about the system for review and response to MRR recommendations. The provider said the process when receiving MRR recommendations was to review the resident's history, recommendations for GDRs, indications for psychotropic medications, and to pay special attention to anyone who was on long-term psychotropic medication. He said the medical provider who was on site making rounds was responsible for checking for MRR reports that were left in the provider mailbox. He said the medical providers check the box on Mondays and Fridays and they usually received MRRs monthly. He said medical providers also included physician assistants and nurse practitioners who made rounds and who were responsible for checking for MRRs. The recommendations were responded to while the medical provider was on site unless it was a more complex recommendation. In that case, the MRR report was put back in the mailbox. If it was a critical recommendation, it was returned to the DON. III. Interview with the CP and review of a summary report by the pharmaceutical company of the number of MRRs sent to the facility in 2024, revealed the facility's policy and procedures failed to ensure potential irregularities identified in MRRs as recommendations would be timely reviewed and acted upon by the medical provider, medical director, and the DON. A. CP interview The CP was interviewed on 4/24/24 at 2:29 p.m. and 4:59 p.m. She said it had been a struggle, a delay, in getting responses to MMR recommendations back from the facility. She said she had not received responses from the facility to her medication recommendations for four months. She said most of the recommendations from December 2023 had yet to be returned and, that she had not received any of the more recent, January 2024 to April 2024, recommendations back that confirmed the medical provider had reviewed and responded to the recommendations in the MRR. She stated review and responses to the recommendations in the MRR were not only for compliance with regulatory requirements but also to ensure the safety of the residents, the efficacy of the medications, preventing falls, death, and bleeding, as well as recognizing and reducing polypharmacy. B. Review of MRR summary report. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review on 4/25/24 of an executive summary report by the pharmaceutical company revealed multiple MRR recommendations in January 2024 (163), February 2024 (143), March 2024 (131), and April 2024 (138) that had not been returned to the CP to show they had been reviewed and responded to by the medical provider. III. A review of MRRs for Residents #51, #15, #60, and #64 provided by the DON on 4/24/24 at 2:00 p.m., confirmed the facility's policy and procedures failed to ensure potential irregularities and recommendations identified in MRRs would be timely reviewed and acted upon by the medical provider, medical director, and the DON. A. Resident #51 1. Resident status Resident #51, age 86, was admitted on [DATE]. According to the April computerized physician orders (CPO), the resident's diagnoses included right hemiarthroplasty for a right hip fracture, and Alzheimer's disease and dementia without behavioral, psychotic, or mood disturbance. The 3/22/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of three out of 15. He required substantial/maximal assistance with toileting, bed mobility, transfers, and supervision with eating and personal hygiene. The MDS documented the resident did not have physical or verbal behaviors or psychosis symptoms including hallucinations or delusions. A comprehensive review of Resident #51's behavioral monitoring from 3/22/24 to 4/25/24 revealed the resident did not have verbal or physical behaviors. A review of the resident's care plans revealed in part, plans for mood, antipsychotic medication, anticoagulant medication, and falls. The mood care plan, initiated on 3/22/24 and revised on 4/5/24, indicated Resident #51 had a history of depression and was currently taking an antidepressant and displayed minimal to no signs/symptoms of a depressed mood. Interventions included to administer psychiatric medications as ordered, monitor signs/symptoms of depression, notification of social work or physician of a decline, and psychiatric services as needed. The antipsychotic medication care plan, initiated on 3/18/24, indicated Resident #51 currently was prescribed an antipsychotic medication for dementia. Interventions included to administer medications as ordered, monitor for adverse side effects, monitor for changes in mood or behavior, monitor for falls, and psychiatric evaluation and services as needed. The anticoagulant care plan, initiated on 3/18/24, indicated Resident #51 was on an anticoagulant for a diagnosis of deep vein thrombosis (blood clot) prophylaxis. Interventions included to administer medications as ordered, monitor signs and symptoms of bleeding, monitor labs as ordered. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Recommended adding monthly fasting blood glucose levels or a quarterly HgA1c while Resident #51 was on a Risperdal. The 4/10/24 MRR documented one recommendation. -Recommended that Alzheimer's was not an appropriate indication for Risperdal without behaviors and to update the diagnosis and order directions. b. Lack of documentation to show review and response to the MRR recommendation by the medical provider, the medical director, and the DON. A comprehensive review of Resident #51's electronic medical record (EMR) and MRRs above on 4/24/24, revealed no documentation that the above recommendations had been reviewed and acted upon by the medical provider, the medical director, and DON prior to 4/25/24, during the survey. 47818 B. Resident #15 1. Resident Status Resident #15, age 75, was admitted on [DATE]. According to the April 2024 CPO, diagnoses included dementia with behavioral disturbances, bipolar disorder (mental illness causing shifts in mood, energy, activity levels, and concentration), personality disorder (thoughts, feelings, and behaviors different from an established societal norm), anxiety, arthritis, history of falls, contractures (permanent tightening of the muscles and tendons causing joints to shorten and stiffen) of right foot ankle and hand and chronic kidney disease. The 3/26/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance from one staff member for dressing, toileting, and setup with personal hygiene. Section E of the MDS indicated Resident #15 had not exhibited behavioral symptoms of hitting, kicking, pushing, grabbing, threatening others, screaming at others, or cursing at others. A review of the resident's care plan revealed the resident had a care plan for antipsychotic medication, initiated on 9/21/23 and revised on 10/13/23. It read Resident #15 was taking an antipsychotic medication for a diagnosis of bipolar disorder to assist with symptom management. Although a review of the psychotropic medication review on 12/19/24 revealed no documentation of behaviors for either of the resident's diagnoses to support and clarify the rationale for the use of the antipsychotic or the antidepressant, a review of January, February, March, and April 2024 MAR revealed orders with a start date of 9/21/23 for: -Risperdal (an antipsychotic) oral tablet 0.5 MG by mouth at bedtime for vascular dementia with behaviors. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Effexor (an antidepressant) oral capsule extended release (ER) 24 hour 150 mg (Venlafaxine HCl). Give 150 mg by mouth one time a day for MDD (major depressive disorder). 2. MRR review a. MRRs 11/10/23, 12/14/23, 1/15/24, 3/22/24, and 4/9/24 - with recommendations The 11/10/23 MRR identified Resident #15 was receiving multiple medications that had the potential of affecting electrolytes and renal clearance. Recommendations included obtaining the following labs: comprehensive metabolic panel (CMP) (The 14 tests included in a CMP are: alkaline phosphatase(ALP), alanine aminotransferase (ALT), aspartate aminotransferase (AST), bilirubin, blood urea nitrogen (BUN), creatinine, sodium, potassium, carbon dioxide, chloride, albumin, total protein, glucose, and calcium) a complete blood count (CBC) (a CBC is used to identify conditions including anemia, infection and leukemia), an A1C (measures blood sugar), and a lipid panel. The 12/14/23, MRR inquired if a gradual dose reduction (GDR) for the medication Effexor had been attempted for Resident #15 or was a GDR likely to worsen or destabilize the resident's condition, had a GDR been tried in the past and failed and if so on what date, or was there another response the physician would like to provide. The 1/15/24 MRR inquired if a GDR for the Risperdal had been attempted for Resident #15 or was a GDR likely to worsen or destabilize the resident's condition, had a GDR been tried in the past and failed and if so on what date, or was there another response the physician would like to provide. The 3/22/24 MRR inquired if a GDR for venlafaxine (Effexor) 150 mg (started on 9/21/23; no GDR on file) and Risperdal 0.75 mg (started 10/5/23; no GDR on file) could be attempted or would a GDR likely to worsen or destabilize the residents condition, had a GDR been tried in the past and failed and if so on what date, or was there another response the physician would like to provide. The MRR also asked for a monthly fasting blood glucose check or quarterly HbA1C (blood test used to diagnose type 2 diabetes) related to the use of an antipsychotic medication. The 4/9/24 MRR indicated that combining methocarbamol (muscle relaxant) and oxycodone (narcotic pain medication), per the April medication administration record ordered on 4/5/24 for muscle spasm and severe pain, increased risks of central nervous system (CNS) depression, psychomotor impairment, and respiratory depression and recommended monitoring adverse effects and the following labs were needed: CMP, CBC, a1c and a lipid panel. b. Lack of documentation to show review and response to the MRR recommendation by the medical provider, the medical director, or the DON. A comprehensive review of Resident #15's electronic medical record (EMR) on 4/25/24 and MRRs above revealed no documentation that the above recommendations had been reviewed and acted upon by the medical provider, the medical director, and the DON prior to 4/25/24, during the survey. 47024 C. Resident #60 (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Resident status Resident #60, age 75, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the April 2024 CPO, diagnoses included severe persistent asthma, chronic respiratory failure with hypoxia (low oxygen), visual loss in both eyes, morbid obesity, chronic pain, anxiety disorder, depression, and muscle weakness. The 8/23/23 minimum data set (MDS) assessment documented the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. The resident required extensive assistance from one person with dressing, bathing, locomotion while in the wheelchair, and extensive assistance from one to two people for bed mobility, toileting, and transfers. A review of the resident's care plan revealed plans for antidepressant medication and bleeding. The care plan for antidepressant medication documented the resident was prescribed antidepressant medication for a diagnosis of depression and anxiety. Interventions included to administer medications as ordered, monitor for adverse effects of usage, monitor for changes in mood or behavior, monitor for falls and psychiatric evaluation and services as needed or scheduled. The care plan for bleeding documented that the resident was at risk for bleeding due to taking an anticoagulant medication for coronary artery disease. Interventions included to administer medications as ordered, and monitor for discolored urine, black tarry stools, sudden severe headache, and nausea and vomiting. 2. MRR review a. MRRs dated 11/10/23, 12/14/23, 2/15/24 and 3/21/24 - with recommendations The MRR for 11/10/23 documented Resident #60 was receiving aspirin 81 mg and Plavix 75 mg. The pharmacist documented a recommendation for discontinuation of one of these medications as well as a GDR for Sertraline, an antidepressant medication. The MRR for 12/14/23 recommended a GDR of Duloxetine, an antidepressant medication The MRR for 2/15/24 documented inquiries for regarding Sertraline and Duloxetine, as well as aspirin and Plavix. The MRR for 3/21/24 recommended a GDR for Sertraline and Duloxetine. b. Lack of documentation to show review and response to the MRR recommendation by the medical provider, the medical director, or the DON. A comprehensive review of Resident #60's electronic medical record (EMR) and MRRs above on 4/24/24 revealed no documentation that the above recommendations had been reviewed and acted upon by the medical provider, the medical director, and DON prior to 4/25/24, during the survey. D. Resident #64 (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Resident status Resident #64, over age 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the April CPO diagnoses included a history of falling, long-term use of anticoagulant, fracture of the neck of the right femur, atrial fibrillation, chronic congestive heart failure, peripheral vascular disease (narrow blood vessels in the limbs) and myocardial infarction (heart attack). According to the 2/19/24 MDS assessment, the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. The resident required supervision for oral hygiene, rolling from side to side, and moving from sitting to lying in bed. The resident required partial assistance with upper body dressing, bed-to-chair transfers, toilet transfers, and maximal assistance for toileting hygiene and lower body dressing. The care plan for bleeding documented that the resident was at risk for bleeding due to taking an anticoagulant. Interventions included to administer medication as ordered, monitor for discolored urine black tarry stools, severe headache, nausea, and vomiting, monitor labs, and notify the provider with any concerns. The order detail dated 2/19/24 at 4:10 p.m. documented an order summary of Apixaban, an anticoagulant, one tablet by mouth every day and evening shift for status post hip surgery. 2. MRR review a. A 3/22/24 MMR documented the anticoagulant Eliquis (Apixaban) did not have the correct diagnosis listed in the resident's diagnosis list. b. Lack of documentation to show review and response to the MRR recommendation by the medical provider, the medical director, or the DON. A comprehensive review of Resident #64's electronic medical record (EMR) and MRR above on 4/24/24 revealed no documentation that the inquiry about the diagnosis for Eliquis had been reviewed and acted upon by the medical provider, the medical director, or the DON prior to 4/25/24, during the survey. IV. Facility failure to timely address the facility's known failure to ensure medical providers, the medical director, and the DON reviewed the monthly MRRs and responded to recommendations timely The NHA, interviewed on 4/25/24 at 4:33 p.m., said he was not aware until 4/24/24 (during the survey) that after receiving MRR recommendations from the CP, the recommendations were processed and provided to medical providers. A medical provider, interviewed on 4/25/24 at 4:36 p.m., said he was not aware MRRs had not been given to him by the DON since January 2024. -However, interviews with the CP revealed leadership had been informed multiple times of the facility's failure to review and respond to MRR recommendations timely. Further, the DON, who was directly involved in implementing the facility's policies and procedures to ensure timely review and response to MRR recommendations, was aware. Yet, there was no evidence steps were taken to correct the problem until 4/25/24, during the survey, when the NHA was notified the failure created a situation of immediate jeopardy with the potential for serious harm. (continued on next page)

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F 0756 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A. Interview with the CP The CP was interviewed on 4/24/24 at 2:29 p.m. and 4:59 p.m. She said the facility leadership was aware of the problem with MRR reviews and responses. She said she brought it up every month, stating she had informed the medical director, as well as another physician who was very involved and who attended the psychotropic/GDR meetings that she was not receiving any MRR recommendations back from the facility. She also said she informed the DON and the NHA, in person, during each psychotropic/GDR meeting of this, and the DON told her they were working on it. She said she sent an email on 4/10/24, again asking about responses to MRR recommendations and noting the importance of having the recommendations completed. She stated the review and response to the recommendations in the MRR were not only for compliance with regulatory requirements but also to ensure the safety of the residents. B. Interview with the DON The DON was interviewed on 4/24/24 at 12:44 p.m. The DON said after a medical provider had reviewed and responded to the recommendations in the MRR, she sent the MRR report back to the CP through the portal. She also printed a copy of the report and placed it in a binder in her office. The DON said there was not a binder for 2024 because one had not been started. On 4/24/24 at approximately 2:00 p.m., the DON delivered the pharmacy recommendation binder for July 2023 to December 2023. The DON, NHA, and infection preventionist agreed the facility did not have a binder for pharmacy recommendations in 2024. V. Facility follow-up after survey exit 4/26/24. The NHA emailed information on 4/29/24 at 4:12 p.m., addressing Residents #51, #15, #60, and #64, and a letter from the pharmaceutical company explaining the number of MRRs sent to the facility in 2024. A. Regarding the pharmaceutical company letter (undated) explaining the number of MRRs sent to the facility in 2024. The letter read th[TRUNCATED]

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on observations, record review and interviews, the facility failed to ensure one (#5) of one resident reviewed for ancillary services, such as dental services, out of 35 sample residents received routine and 24-hour emergency dental care. Specifically, the facility failed to provide Resident #5 with timely dental care when she sustained a broken tooth. Findings include: A. Resident status Resident #5, under age 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included heart failure, arthrodesis (joint fusion to relieve arthritis pain) and chronic pain. The 3/12/24 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. She was independent with all activities of daily living (ADL). B. Resident interview Resident #5 was interviewed on 04/22/24 at 2:29 p.m. Resident #5 said a piece of her tooth fell out last month (March 2024) while she was brushing her teeth and she needed to see a dentist. Resident #5 said her tooth was painful at times and she tried not to chew her food on the left side of her mouth where the broken tooth was located. Resident #5 said she had informed multiple staff members about her tooth and her need to see a dentist. Resident #5 was interviewed again on 4/25/24 at 9:00 a.m. Resident #5 said the social services coordinator (SSC) told her she was not seen by the dentist at the facility on 4/23/24 because the dental team did not want to see residents while a state survey was in process and left the building (see record review and interviews below). C. Record review The ancillary care plan, initiated 3/25/22 and revised 6/24/22, revealed Resident #5 was being seen by in house dental services. It documented the facility would ensure Resident #5's dental needs would be met. Pertinent interventions included facility staff scheduling appointments for ancillary providers as requested/needed/ordered. A 3/17/24 progress note documented at 1:18 a.m., revealed Resident #5 informed nursing staff a piece of her tooth fell out while brushing her teeth. Nursing staff documented a message had been left for Resident #5's family member and the SSC. (continued on next page)

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	065292	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center at Sandalwood, The	3835 Harlan St Wheat Ridge, CO 80033

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/17/24 progress note documented at 4:01 p.m., revealed Resident #5 informed registered nurse (RN) #2 she needed some teeth pulled. RN #2 documented Resident #5 needed antibiotics and a scheduled blood thinner (eliquis) to be held prior to being seen by the dentist. RN #2 documented a message had been left for the SSC with instructions to provide a healthcare provider with the dental procedure date so orders could be placed addressing the above mentioned medications. A 3/18/24 progress note documented Resident #5 was seen by a medical assistant regarding an upcoming dental procedure and Resident #5 needed preventive antibiotics and her eliquis held for three days prior to getting some teeth pulled. The progress noted revealed Resident #5 needed several teeth pulled and had a history of blood clots. A 4/22/24 progress note documented Resident #5 had a dental appointment on 4/23/24 and orders had been received from a nurse practitioner (NP) for eliquis to be held and for antibiotics to be started prior to the dental procedure. A 4/23/24 progress note written by RN #2 documented Resident #5 was not seen by the dentist (on 4/23/24) because she was not on the dental list to be seen. RN #2 documented the information regarding Resident #5 not being seen by the dentist because she was not on the list was given to the SSC. The SSC informed RN #2 Resident #5 would be on the list to be seen by the dentist when the dental team was back in the facility. D. Interviews The SCC was interviewed on 4/25/24 at 10:00 a.m. The SCC said residents were on a rotating schedule with a mobile dental team who came to the facility for residents' routine dental visits. The SCC said the dental team could be accommodating to residents for immediate dental needs such as a resident voicing mouth discomfort or pain or if nursing staff recognized something that needed immediate attention. The SCC said there was paperwork indicating a resident needed emergent services she had to to the dental team for residents to be seen immediately. The SCC said she was first made aware of Resident #5 having mouth pain on 3/17/24 and was told again on 4/23/24 so she put Resident #5 on the list to be seen by the dentist that same day. The SCC said she did not know if the dental team was contacted in March 2024 to schedule Resident #5 for emergency services. The SCC said she was unable to locate paperwork which indicated Resident #5 had been scheduled to see the dentist related to her broken tooth in March 2024. The SCC said the team's dental assistant told her they did not want to be in the facility (on 4/23/24) when a state survey was ongoing and had left the facility. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The vice president of operations (VPO) for the dental team company was interviewed on 4/26/24 at 11:00 a. m. The VPO said it was her understanding the facility had asked the dental team to leave the building during the survey process and the VPO was currently working with the facility's administration team to get clarification. The VPO said Resident #5 was not on the list to be seen on 4/23/24 and the dental team was not notified in March 2024 that Resident #5 needed to be seen for emergency dental services. The VPO said if the facility had requested Resident #5 be seen for emergency dental services, the dental team would have received paperwork from the facility requesting emergency dental services. The VPO said she would begin the process to have Resident #5 seen by the dentist as soon as possible for her broken tooth.

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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. 43950 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to medication regimen review (MRR) by not providing physicians with the pharmacist recommendations so the physicians could respond to the recommendations timely which rose to the level of immediate jeopardy and created a situation that a serious adverse outcome was likely. Findings include: I. Facility policy The Quality Management Plan/QAPI program (Quality Assurance and Performance Improvement) policy and procedure, revised 11/15/2018, was provided by the nursing home administrator (NHA) on 4/26/24 at 12:50 p. m. It read in pertinent part, Our quality assurance and performance improvement (QAPI) program objective is to evaluate the availability, appropriateness, effectiveness, and effectiveness, and efficiency of resident care, and is a continuous program of evaluating medical, nursing care, social services, activities, dietary, housekeeping, maintenance, infection control, and pharmacy services. Quality Assurance encompasses all departments within our communities that provide care and services to our residents and impact clinical care, quality of life, residents' choice, and transitions of care. This includes care and services provided to our Rehab and Long-Term Care residents by each department in our organization. Procedure 1. Quality Assurance Performance Improvement (QAPI) meetings are scheduled a minimum of monthly but occur more frequently as decided by the NHA and include the medical director(s), nursing home administrator, director of nursing, pharmacist, department managers and frontline staff or residents as appropriate. The nursing home administrator ensures that the meeting is routinely scheduled, an agenda specific to that community is established and data and information is recorded. 2. Topics of discussion may include, but are not limited to, skin and wounds, infection prevention and control, accidents/incidents, admissions/hospitalization s, (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	concerns/complaints, self-reported occurrences, pharmacy, survey follow-up, QAPI PIPs (performance improvement plans), weights, quality measures, medical records, and other areas identified through data collection, meetings, and events/incidents. Committee members are assigned to address and monitor specific topics based on their areas of expertise or their functions. 3. Reports are submitted in writing and discussions at the meetings include any recommendations from the committee and the Medical Director. 4. Other committees are established as needed to identify and address areas of concern and report to the Quality Assurance Performance Improvement committee as directed. 5. Projects and ongoing programs are measured at routine intervals and may be analyzed using Root Cause Analysis, Plan-Do-Study-Act (PDSA) and Fishbone Analysis as needed to ensure that the interventions are appropriate to the problem. Monitoring may consist of monthly data collection and new interventions may be recommended to achieve the desired goals of the particular topic. 6. Quality Assurance Performance Improvement is an ongoing, living, and ever-changing program that adapts itself to the unique needs of each community. Through the various sources of data and their facility assessment, each community identifies its personal focuses/issues and addresses them by creating unique goals and interventions. Monitoring occurs until goals are achieved or surpassed, then may be periodically reviewed to ensure sustained compliance. II. Cross-reference citations Cross-reference F756: The facility failed to provide the physicians with the pharmacist recommendations from the MRR so the physicians could respond to those recommendations. The facility's failure to follow up and act on the pharmacist recommendations put residents in a situation where a serious outcome was likely to occur and created an immediate jeopardy situation. III. Staff interviews Medical provider (MP) #1 was interviewed on 4/25/24 at 4:35 p.m. MP #1 said the medical director was out of the country and was not available for an interview. MP #1said, during the psychiatric pharmacology review meetings, residents' medication histories, gradual dose reductions (GDR) of psychotropic medications and indications for residents' medications were reviewed. He said it was important to minimize or stop unnecessary medications if possible. He said the MRR forms from the pharmacist were put in a box at the nurses station and the providers, including nurse practitioners and physician assistants, would check the box when they were at the facility. He said the turnaround time for completing MRR forms was as soon as possible. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MR #1 said the providers could either agree or disagree with the pharmacist's recommendations. He said if a provider disagreed with the recommendations, they would usually include a note as to why. He said after the recommendations were completed it was put back in the box for the director of nursing (DON) to process and send back to the pharmacist, unless it was a time critical recommendation and then it would be taken to the DON immediately. MP #1 said he was not aware that MRRs had not been given by the DON to the medical providers and the consultant pharmacist (CP) had been without a response from the providers since January 2024. He said it was important to follow up on the recommendations to ensure each residents' drug regimen was appropriate and to prevent adverse outcomes related to medications from occurring for the residents. The NHA was interviewed on 4/26/24 at 12:22 p.m. The NHA said the facility had a QAPI committee which met monthly and consisted of the required members and department heads. He said the committee last met on 4/16/24 and the pharmacist had attended via phone. He said the committee identified concerns through daily reviews, tracking and trending, key indicators and trends against benchmarks. He said the QAPI committee did analysis of concerns and determined what actions needed to be taken. The NHA said the QAPI committee did a performance improvement plan (PIP) at least yearly. He said the committee currently was addressing falls, weight loss, pressure ulcers, employee turnover and recruitment, survey review, activities, maintenance and life safety concerns. He said the committee had the infection preventionist (IP) addressing antibiotic stewardship and vaccination rates. The NHA said the committee was addressing skin tears through incidents or risk management, medication errors, rehospitalization s, quality measures, team reports, pharmacy updates and physician updates. The NHA said some of the topics discussed at the QAPI committee meetings came from risk meetings and morning interdisciplinary team (IDT) meetings. The NHA said the QAPI committee had not identified concerns from the MRR. He said the pharmacist's recommendation had not been provided to the physicians so that the physicians could respond in a timely manner.