STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arvada Care and Rehabilitation Center	6121 W 60th Ave Arvada, CO 80003

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 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 51711 Based on observations and interviews, the facility failed to post, in a form and manner accessible and understandable to residents, information on how to file a complaint with the State Agency. Specifically, the group interview revealed the facility failed to: -Ensure residents knew where the required posting on how to file a complaint with the State Agency was located; -Ensure all required information was included on the posting; and, -Ensure that residents were able to easily access and read the information on the posting. Findings include: I. Observations On 3/10/25 at 8:28 a.m. a posting on how to file a grievance with the State Agency was observed hanging in the facility lobby. The posting was missing the State Agency email address and was hanging behind a potted plant. On 3/10/25 at 3:53 p.m. the required posting with the State Agency information on it was observed a second time in the corner of the lobby. The information on how to file a grievance was posted above the eyeline for a resident in a wheelchair and was written in a small font. II. Resident group interview The resident group interview was conducted on 3/10/25 at 11:10 a.m. with five residents (#8, #23, #24, #26 and #40) who routinely attended monthly resident council meetings and were deemed interviewable by the facility and assessment. All five residents said they did not know how to file a complaint with the State Agency and were not aware the information was posted in the facility. III. Resident interviews (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065321	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Resident #26 was interviewed on 3/10/25 at 3:57 p.m. Resident #26 said the postings on the wall were too small and she was unable to see them from her wheelchair. She recommended blowing up the posting to the same size as the ombudsman advocate posting. Resident #23 was interviewed on 3/10/25 at 4:02 p.m. Resident #23 said that he was able to see the location of the grievance policy posting but was unable to read back the phone number posted on the policy from a seated position in his wheelchair. IV. Staff interviews The social services director (SSD) and the regional social services director (RSSD) were interviewed together on 3/11/25 at 12:28 p.m. The SSD was unsure of the required elements to be included for State Agency information and said she would ask someone. After asking someone, the SSD said the posting was located in the corner of the facility lobby (behind a plant) and the grievance policy also had the information included on it, however both postings were missing the State Agency email address. She said the nursing home administrator (NHA) was made aware of the missing information. She said both documents were in the process of being corrected. The SSD said the information to file a complaint and grievance process was explained to residents at their first care conference meeting after their admission to the facility. The NHA was interviewed on 3/11/25 at 4:07 p.m. The NHA said he and the SSD were responsible for the State Agency grievance postings. He said he was made aware of the need for corrections to the postings, specifically regarding the missing State Agency email address, font size and location, so that residents would be able to easily access and read the information on the posting.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711 Based on record review, observations and interviews, the facility failed to develop and implement a baseline care plan which included the instructions needed to provide effective and person-centered care for four (#9, #24, #201 and #39) of five residents reviewed for baseline care plans out of 32 sample residents. Specifically, the facility failed to ensure pertinent medical information was included on Resident #9, Resident #24, Resident #201 and Resident #39's baseline care plans within 48 hours of admission. Findings include: I. Resident #9 A. Resident status Resident #9, age 78, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included age related osteoporosis with pathological fractures, fracture of lower end of left femur, prosthetic left knee joint, acute respiratory failure, protein calorie malnutrition and end stage renal disease. The 1/17/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. B. Record review Review of Resident #9's baseline care plan, dated 1/14/25, revealed a focus area for skin. The care plan had a blank area that indicated to specify the area of the skin concerns, but it was left blank. Under the activities of daily living (ADL) section, the focus areas and interventions indicated to specify the number of staff needed to transfer the resident, specify what type of assistance the resident required and to specify upper or lower body assistance. -These areas were not personalized to the resident. The baseline care plan did not specify the residents cognitive status or initial discharge goals. II. Resident #24 A. Resident status Resident #24, age less than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included fusion of spine, lumbar region, heart failure, entercolitis due to clostridium difficile (infection of the bowel system), spinal stenosis and need for personal care assistance. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/14/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The MDS assessment revealed that the resident has acute/chronic pain and a surgical wound. B. Record review Review of Resident #24's baseline care plan, dated 2/11/25, revealed the care plan did not include information regarding interventions for the resident's surgical wound care or the location of the wound. The cognition baseline care plan had areas that instructed it to be resident specific, but the area was left blank. The baseline care plan did not address the resident's initial discharge goal. III. Resident #201 A. Resident status Resident #201, age 76, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included fusion of spine, thoracic region, spinal stenosis, encounter for surgical aftercare following surgery on the nervous system, foot drop left foot and need for personal assistance care. The 2/25/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. He required moderate to maximum assistance with mobility and activities requiring use of the lower body. The MDS assessment revealed that the resident had a surgical wound. B. Record review Review of Resident #201's baseline care plan, dated 2/20/25, revealed the care plan did not include information regarding interventions for the resident's surgical wound care and the location of the wound. The cognition baseline care plan had areas that instructed it to be resident specific, but the area was left blank. The baseline care plan did not address the resident's initial discharge goal. IV. Staff interviews The social services director (SSD) and the regional social services director (RSSD) were interviewed on 3/11/25 at 12:28 p.m. The SSD said she completed the care plans for areas related to preadmission screening and resident review (PASRR), discharge planning, psychosocial review and cognition. She said the MDS coordinator (MDSC) completed the baseline care plan with assistance from the nursing staff. The SSD said the areas she completed were included in the comprehensive care plan. Director of nursing (DON) #1 was interviewed on 3/11/25 at 4:07 p.m. DON #1 said the MDSC completed the baseline care plans. 47151 V. Resident #39 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #39, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included senile degeneration of the brain, chronic obstructive pulmonary disease (COPD), frontal lobe and executive function (cognitive skills that affect decision making), deficit epilepsy (seizure disorder) and obstructive uropathy (urine blockage). The 11/21/24 MDS assessment revealed the resident had severe cognitive impairments with aBIMS score of seven out of 15. The resident was dependent on care for ADLs. The assessment documented the resident used an indwelling catheter. B. Resident observation and interview On 3/5/25 at 12:37 p.m. Resident #39 was in his chair with the catheter bag and tubing secured properly and off the floor. C. Record review A review of Resident #39's CPO revealed a physician's order for catheter care every shift, to change the foley catheter and bag as needed, ordered 9/26/25. A review of Resident #39's baseline care plan documented the following: The resident's cognition care focus area documented he was at risk for impaired cognitive function/dementia or impaired thought processes but failed to document a specific diagnosis. Pertinent interventions included that he needed supervision and assistance with all decision making and resident centered behavior interventions. -However, resident centered behavior and decision making interventions were not documented. The resident's ADL baseline care plan focus area documented he had an ADL self care performance deficit but failed to document a specific diagnosis. The baseline care plan identified ADL interventions of toilet use failed to specify how many staff were needed. Pertinent interventions included the resident needed staff participation with transfers but failed to specify how many staff. -However, the resident's comprehensive ADL care plan documented a pertinent intervention that the resident needed the assistance of two staff with a mechanical lift, initiated 10/7/24. The baseline care plan did not address the resident's catheter care or complication of the catheter care that potentially included urinary tract infections, skin irritation or leakage.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure one (#40) of four residents who required respiratory care received care consistent with professional standards of practice out of 32 sample residents. Specifically, the facility failed to maintain, clean, sanitize and properly store Resident #40's bilevel positive airway pressure (BiPAP) mask and machine. Finings include: I. Facility policy and procedure The Non Invasive Respiratory policy, revised November 2024, was provided by the nursing home administrator (NHA) on 3/10/25 at 6:18 p.m. It read in pertinent part, It is the policy of this facility to provide non-invasive ventilation as per physician's order and current standards of practice. BiPAP is a respiratory therapy intervention that delivers an inhale pressure and an exhale pressure to provide a patent airway. It requires a machine that generates the separate pressures through a tube into a mask that fits over the nose or mouth. Non-invasive ventilation systems vary by manufacturer. Common equipment includes the machine, tubing, mask, headgear/straps, disposable/non-disposable filters, and humidifier chamber. The facility will obtain an order for the use of a BiPAP device and setting from the practitioner. A personal BiPAP device may be brought into the facility for resident's use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. The facility will follow the manufacturer's instructions for the use of the machine. Nursing will assess the skin integrity around the mask site daily to ensure there is no impairment to the skin. Document use of the machine, resident's tolerance, any skin, respiratory or other changes and responses. Follow manufacturer's instructions for the frequency of cleaning/replacing filters and serving the machine. Only the supplier may service the machine. Replace equipment immediately when it is broken or malfunctions, or if visible soiling remains after cleaning. Replace equipment routinely in accordance with manufacturing recommendations. General guidelines: face mask and tubing once every three months; head-gear, non disposable filters and humidifier chamber once every six months. II. Resident #40 A. Resident status Resident #40, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnosis included Parkinson's disease (disease that causes unwanted movements and tremors), asthma, acute respiratory failure, weakness, unspecified dementia, anxiety, insomnia, dependence on supplemental oxygen and other obsessive compulsive disorder. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/12/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed supervision for bathing, set-up assistance with lower body dressing and footwear and was independent with all other activities of daily living (ADL). The MDS assessment documented the resident did not refuse care. The MDS assessment documented the resident used a CPAP (continuous positive airway pressure) device and intermittent oxygen therapy. -However, the resident did not use a CPAP and used a BiPAP (see observations, record review and interviews below). B. Resident interview and observations Resident #40 was interviewed on 3/5/25 at 3:38 p.m. Resident #40 said he used a BiPAP machine but no one cleaned it. He said the mask was ripped and the strap was broken on the side. Resident #40 said he was told he needed to order a new mask himself if he wanted the mask to get to the facility sooner. Resident #40's BiPAP machine was observed on his bedside nightstand. The machine had small, brown stained drops on the outside of the machine. The tube extended down to the floor and was connected to his mask which was under the head of his bed. His floor underneath the bed was dusty with a crumpled Kleenex, a folded sheet of wrinkled paper and another piece of crumpled paper. Resident #40 picked up his BiPAP mask. The mask cushion was torn near the bottom and one of the clips connecting the headgear to the mask was broken on the side. On 3/6/25 at 12:25 p.m. an unidentified certified nurse aide (CNA) delivered Resident #40's lunch tray to him as he sat on his bed. Resident #40's BiPAP tube extended to the floor and the mask was on the floor. Resident #40 was not encouraged or asked to store his mask in a different place. On 3/6/25 at 12:30 p.m. Resident #40s's BiPAP tube extended down to the floor and his BiPAP mask was under clothes under the head of his bed. Underneath Resident #40's bed had not been cleaned since the observations the previous day and the same items were still under his bed (as observed on 3/5/25). On 3/10/25 at 11:45 a.m. Resident #40 was not in his room. Resident #40's bed was observed to have the same items underneath as observed on 3/5/25 and 3/6/25 (see above). A gallon jug of water was on the floor under the head of his bed with his BiPAP mask stored on top of the water jug. C. Record review A review of Resident #40's March 2025 CPO documented the following orders: -Apply BiPAP every night shift, ordered on 12/7/24; -Change distilled water in BiPAP every night shift, ordered on 12/7/24; and, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Clean BiPAP mask, wash with soap and water and let air dry every night shift, ordered on 12/7/24. Resident #40's comprehensive care plan revealed the following: Resident #40 had altered respiratory status and difficulty breathing related to sleep apnea and used a BiPAP, initiated 12/13/24. Pertinent interventions included to apply BiPAP every night shift, clean BiPAP mask and wash with soap and water and let air dry, and change distilled water in BiPAP (initiated 12/16/24). -The care plan failed to document the resident's preference for storing his BiPAP mask on the floor. -However, Resident #40's care plan was updated on 3/10/25 (during the survey) with the intervention that Resident #40 insisted on placing his BiPAP mask on the floor beside his bed. Staff were to offer and encourage the resident to hang his mask on the wall hook next to the head of the bed (HOB), initiated 3/10/25. A review of Resident #40's electronic medical record revealed the following: A provider note written on 1/29/25 at 1:33 p.m documented the resident was moving to long term care (from rehabilitation) in another room in the facility. He remained on a CPAP while sleeping, and to continue with the CPAP, wearing it every night. A physician note on 2/25/25 written at 8:03 p.m. documented the resident was getting a new CPAP mask. -However, Resident #40's physician's orders and care plan documented that the resident used a BiPAP. V. Staff interviews The director of nursing (DON) #1 was interviewed on 3/10/25 at 2:00 p.m. DON #1 said the facility had replaced Resident #40's mask previously. DON #1 said the facility contracted a respiratory services vendor when Resident #40 first arrived at the facility. The DON said when the resident was admitted he said he was unable to use his mask because prior to his admission to the facility a piece to his mask was lost. DON #1 said Resident #40 placed his mask on the floor himself. DON #1 said he had picked up the mask on 3/10/25 and placed it on the bedside dresser next to the resident's bed but he did not notice the mask was torn and the strap was broken at that time. DON #1 said he had since called their contracted respiratory services vendor to come over and replace the mask. The regional clinical resource (RCR) was interviewed on 3/11/25 at approximately 10:00 a.m. The RCR said Resident #40 changed insurance providers during his stay at the facility and said the insurance would only cover the cost of a new BiPAP mask periodically. The RCR said Resident #40 liked to have his BiPAP mask accessible and at his bedside to use it easily. The RCR said she offered to hang Resident #40's mask and he refused. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 3/11/25 at approximately 11:00 a.m. LPN #1 said Resident #40 was very independent and would put on his mask and remove the mask by himself. LPN #1 said she did not clean the BiPAP machine and that task belonged to the night nurse. LPN #1 said she had not noticed the resident's mask on the floor when she administered his medications in the morning. The respiratory services representative (RSR) was interviewed on 3/11/25 at 5:05 pm. The RSR representative said that because Resident #40 owned his own personal oxygen device, he had to get approval through the facility for a replacement mask. The RSR said then either the facility would pay for it, or the resident's insurance company would. He said right now, all of Resident #40's disposable oxygen equipment was paid for through insurance. The RSR said that the director of rehabilitation (DOR) told Resident #40 the prior week, to contact his insurance company to get the process moving. The RSR said he and the DOR were just talking to Resident #40, and the DOR suggested the human resources department might be able to help coordinate with the insurance company to order Resident #40 more supplies. The RSR said to his knowledge, his company had not talked to Resident #40 about the possibility of using their company's equipment, but if Resident #40 chose to do so the RSR said the respiratory services company would be responsible for cleaning and replacing the resident's equipment. The RSR said his company did not clean or replace residents' personal oxygen equipment. -The manufacturing instructions for Resident #40's BiPAP machine was requested on 3/10/25 but not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 51711

Based on observations, record review and interviews, the facility failed to ensure one (#201) of two residents reviewed for pain out of 32 sample residents had an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans and resident preferences.

Specifically, the facility failed to ensure Resident #201's pain was managed appropriately and consistently to meet the resident's stated level of acceptable pain.

Findings include:

I. Facility policy and procedure

The Pain Assessment and Management policy, revised November 2019, was received from the nursing home administrator (NHA) on 3/11/25 at 2:41 p.m. It read in pertinent part, It is the policy of this facility to provide an environment and programs that assist each resident to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. Residents are provided and receive the care and services needed according to established practice guidelines. Resident pain is assessed and managed by an interdisciplinary team who work together to achieve the highest practicable outcome.

The facility assists each resident with pain to maintain or achieve the highest practicable level of well-being and functioning by screening to determine if the resident has been or is experiencing pain, comprehensive evaluation of pain and using pharmacological and/or non-pharmacological interventions to manage the pain and/or try to prevent the pain consistent with the resident's goals.

A resident will be assessed for pain upon admission, quarterly and with any change in condition.

The facility will monitor residents' pain status and treatment effects on a regular basis.

II. Resident #201

A. Resident status

Resident #201, age 76, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included history of fusion of spine, thoracic region, spinal stenosis (a condition where the spinal canal, the bony tunnel that houses the spinal cord and nerve roots, becomes narrowed), encounter for surgical aftercare following surgery on the nervous system, foot drop left foot and need for personal assistance care.

The 2/25/25 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. He was able to self-propel in his manual wheelchair and required moderate to maximum assistance with mobility and activities requiring use of the lower body.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS assessment documented the resident had pain almost constantly which affected his sleep and his day-to-day activity almost constantly. The resident received both scheduled and as needed (PRN) pain medications and non-pharmacological pain interventions. The pain evaluation related to change of condition dated 2/20/25 indicated Resident #201's acceptable pain rating upon the completion of the assessment was a 3 on a numeric pain scale of 1-10. B. Resident observations On 3/10/25 at 8:28 a.m. Resident #201 was in the facility lobby on the phone with his resident representative. He said he needed pain medications and if he did not get the pain medication, there was going to be a problem. A facility staff member was notified of Resident #201's need for pain medications. The facility staff member transported Resident #201 back to his room. On 3/10/25 at 9:19 a.m. Resident #201 complained of throbbing pain in left leg and knee. He said the pain had been occurring since his fall a few days after he was admitted to the facility. Resident #201 was taking deep labored breaths to manage the pain until an additional pain medication dose was available. On 3/10/25 at 9:23 a.m. Resident #201 stopped registered nurse (RN) #1, who was en route to administer pain medication to another resident. Resident #201 told RN #1 I don't know how much more of this I can take. I am always in pain. RN #1 returned shortly and gave Resident #201 5 milligrams (mg) of oxycodone (pain medication) by mouth. -Resident #201 did not receive pain medication until almost one hour after he complained of pain while talking on the phone with his representative. On 3/10/25 at 3:10 p.m. Resident #201 was with occupational therapist (OT) #1. Resident #201 told OT #1 he was very tender and he was tapping on both knees. He told OT #1 of having to wait for his pain medication that morning (3/10/25). Resident #201 said his pain was not being controlled. He told OT #1 that after he got off the phone with his representative (on 3/10/25) , his representative called the director of nursing (DON) to get the pain issue resolved. C. Resident interview Resident #201 was interviewed on 3/5/25 at 2:37 p.m. Resident #201said he was always in pain. Resident #201 said he had sustained a fall in the first few days he was admitted to the facility due to delirium from his surgery. He said his pain was somewhat managed, but since his fall (on 2/20/25) he said he had had a shooting, throbbing pain in his left knee where he had a history of a knee replacement. Resident #201 said he was concerned his knee was worsening and he had not been able to follow up with an orthopedic surgeon due to his back surgery and being in the facility. Resident #201 was interviewed a second time on 3/10/25 at 9:11 a.m. Resident #201 said he had spoken to a nurse practitioner (NP) and she was going to order him an extra dose of Oxycodone, however, he said he had not received it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Arvada Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6121 W 60th Ave Arvada, CO 80003	

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During the interview, RN #1 passed by and overheard the conversation and said the NP was putting a physician's order in and she would bring the medication to him shortly.

Resident #201 was interviewed a third time on 3/11/25 at 9:33 a.m. Resident #201 said he was still experiencing pain in his knee and it was now wrapping around to the inside of his left knee. He was unsure if he was involved in developing or revising pain management strategies following his fall as he was told by a nurse he had experienced delirium. Resident #201 said he reported his pain to the NP and someone else was supposed to be scheduling appointments for him for his knee. He said he usually received pain medications scheduled but if he needed something more for pain it took a while to get more medication. Resident #201 said he was unaware of non-pharmacological interventions being used to help his pain.

D. Resident representative interview

Resident #201's representative was interviewed on 3/11/25 at 9:17 a.m. The representative said Resident #201 called her complaining of pain (on 3/10/25) and was in a bad mood. She said he had not had a history of pain in the past. The representative said since Resident #201's admission to the facility, he had complained of pain daily. She said she asked Resident #201 if he had been given pain medication and he said he had taken tramadol. She said Resident #201 had told her that he wanted to end it all. The representative said she asked Resident #201 if she could call someone to help. She said she texted DON #1 and advised him of the resident's pain issues. She said DON #1 reviewed Resident #201's pain medications and documented that Resident #201 was taking trazodone, gabapentin oxycodone and Tylenol.

E. Record review

Resident #201's admission pain assessment, dated 2/19/25, documented the resident experienced pain almost constantly and it was a moderate verbal descriptor out of a mild, moderate or severe description scale.

The 2/23/25 pain care plan identified Resident #201 had expressed acute back pain related to recent surgery, neuropathy, deforming dorsopathies (a group of spinal disorders characterized by abnormal curvature of the spine, leading to structural deformities and functional limitations), and spinal stenosis. He said his goal was not to have any interruption in normal activities due to pain. Interventions included anticipating the resident's need for pain relief and responding immediately to any complaint of pain.

-The care plan failed to include Resident #201's pain related to his left knee.

Review of Resident #201's March 2025 CPO revealed the following physician's orders for pain management:

Pain level assessment every shift (day and night). His acceptable level of pain was 3 out of 10 on the numeric scale (0-10). Non-pharmacological interventions included repositioning, dim light/quiet environment, relaxation, distraction, music and massage.

-The physician's order failed to specify the resident's pain locations.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lidocan external patch 5% (Lidocaine) apply to left lower extremity topically one time a day for knee pain, ordered 2/27/25. Neurontin oral tablet 600 mg (Gabapentin) give one tablet by mouth three times a day for neuropathy pain, ordered 2/19/25. Robaxin 750 mg oral tablet (Methocarbamol) give one tablet by mouth three times a day for muscle spasms, ordered 2/19/25. Roxicodone oral tablet 5 mg (Oxycodone HCI) give one tablet by mouth four times a day as needed for severe pain 6-10 out of 10, ordered 2/19/25 and discontinued on 2/27/25. Roxicodone oral tablet 5 mg (Oxycodone HCI) give one tablet by mouth three times a day for pain, ordered 2/27/25 and discontinued 3/3/25. Roxicodone oral tablet 5 mg (Oxycodone HCl) give one tablet by mouth four times a day for pain, ordered 3/3/25. Roxicodone oral tablet 5 mg (Oxycodone HCl) give one tablet by mouth every eight hours as needed for severe pain 8-10, ordered 2/27/25. Valium Oral tablet 5 mg (Diazepam) give one tablet by mouth every eight hours as needed for muscle spasms, ordered 2/19/25. Acetaminophen oral tablet 325 mg give two tablets by mouth every six hours for chronic pain while awake. Two tablets = 650 mg each dose NTE (not to exceed) 3 grams in 24 hours, ordered 2/19/25 and discontinued 2/19/25. Tylenol oral tablet 325 mg (Acetaminophen) give two tablets by mouth every six hours for pain while awake, ordered 2/20/25. An oxycodone administration note, documented in the NP/PA (physician's assistant) progress notes from 3/10/25 at 11:32 a.m., revealed Resident #201's pain was not well managed. The NP would add 5 mg oxycodone PRN (as needed) every four hours, in addition to the 5 mg scheduled oxycodone. Review of Resident #201's February 2025 medication administration record (MAR) revealed the resident's pain was greater than his stated acceptable pain level of 3 on the dates of 2/23/25, 2/25/25, 2/26/25 and 2/27/25. Review of Resident #201's March 2025 MAR revealed the resident's pain was greater than his stated acceptable pain level of 3 on the dates of 3/1/25, 3/2/25, 3/5/25, 3/6/25, 3/7/25, 3/8/25, and 3/10/25. -However, there was no follow-up note indicating further intervention was attempted or that a physician was notified of the resident's unacceptable pain levels. III. Staff interviews (continued on next page)

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F 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Licensed practical nurse (LPN) #1 was interviewed on 3/11/25 at 2:04 p.m. LPN #1 said residents' medications were reviewed quarterly or if a change of condition occurred.

DON #1 was interviewed on 3/11/25 at 4:07 p.m. DON #1 said he received a text message from Resident #201's representative (on 3/10/25) and said the resident forgot when he received pain medications. He said the resident was provided pain medications and that he had multiple pain medications.

DON #1 said pain assessments occurred each shift for residents and he was made aware of residents' pain status if it was out of the normal or the provider was not responding. He said he did not routinely audit residents' pain assessments.

DON #1 said pain assessments should be done upon admission and readmission, quarterly, every shift and with changes in condition. He said a pain assessment should have been completed for Resident #201 following the resident's fall on 2/20/25.

IV. Facility follow-up

On 3/13/25 at 11:50 a.m. (after survey exit) DON #2 provided an email which included a follow-up summary documented by the facility's medical director (MD) regarding Resident #201's pain regimen. The MD's summary documented the following in pertinent part:

Resident #201 used very few PRN (as needed) doses of oxycodone upon admission to the facility on [DATE], further, the NP noted delirium on her initial assessment of the resident. Changes in pain medications were made on 2/28/25 to add PRN medication (oxycodone), 3/3/25 to change the scheduled oxycodone from three times a day to four times a day, and 3/10/25 to add an order for an additional PRN dose of oxycodone.

Resident #201 was also on a muscle relaxant and PRN valium. This combination of medications required careful monitoring to avoid over medication of the resident (which this resident did not experience).

Resident #201 also had a note on his chart indicating cares in pairs indicating the facility's heightened awareness of communication with this particular resident. His BIMS was also 12 indicating possible mild cognitive issues further complicating pain management in this resident. There were no reports from therapy that his progress was limited by pain. Resident #201's blood pressures were reviewed and were well controlled throughout his stay, further supporting the patient was not in excessive pain.

In summary, this is almost a textbook perfect example of the careful and judicious use of narcotics in an elderly resident.

-However, according to review of the resident's March 2025 MAR, Resident #201's pain levels were above his stated acceptable pain level of 3 on 3/5/25, 3/6/25, 3/7/25, 3/8/25 and 3/10/25, despite the increase in the scheduled pain medication from three times to four times per day (see March 2025 MAR above).

-Additionally, review of Resident #201's electronic medical record (EMR) revealed the resident had not been seen by the MD during his stay in the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease on two of two units. Specifically, the facility failed to: -Ensure enhanced barrier precautions (EBP) were followed during wound care; -Ensure high touch surfaces in resident rooms were cleaned; and, -Ensure residents' personal hygiene items in shared bathrooms were labeled and stored in a sanitary manner. Findings include: I. EBP failures A. Professional reference According to the Centers for Disease Control and Prevention (CDC), Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDRO)'s, updated 4/2/24, retrieved on 3/13/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ target gown and glove use during high contact resident activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status and infection or colonization with an MDRO. Examples of high contact resident care activities requiring gown and glove use for EBP include: dressing, bathing/showering, transferring, providing hygiene, changing linens changing briefs or assisting with toileting, device care or use (central line urinary catheter, feeding tube, tracheostomy/ventilator), wound care (any skin opening requiring a dressing). B. Facility policy and procedure The IPCP Standard and Transmission-Based Precautions policy and procedure, reviewed April 2024, was provided by the nursing home administrator (NHA) on 3/10/25 at 6:18 p.m. It revealed in pertinent part, (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBP involves the use of gown and gloves during high contact resident care activities. Use of PPE is indicated for residents with wounds, including chronic wounds and pressure injuries. C. Observations During a continuous observation on 3/10/25, beginning at 10:27 a.m. and ending at 10:37 a.m., the following was observed: An EBP sign was on the outside of Resident #2's door and there was PPE hanging on the inside of the door. Registered nurse (RN) #1 entered Resident #2's room and with wound care supplies for Resident #2's. RN #1 washed her hands and put on gloves before beginning Resident #2's wound care. She provided wound care and dressing changes for Resident #2's two wounds. -However, RN #1 failed to don (put on) a gown prior to starting Resident #2's wound care. D. Facility education An infection prevention facility in-service record, dated 11/20/24, was provided by director of nursing (DON) #2 on 3/12/25 at 12:22 p.m. It revealed in pertinent part, EBP includes a gown and gloves and should be worn when there is direct contact with a resident. E. Staff interviews RN #1 was interviewed on 3/10/25 at 10:40 a.m. RN #1 said she thought Resident #2's roommate was on EBP because they used to have an intravenous catheter (IV). RN #1 said if a resident had a peripherally inserted central catheter (PICC) or a urinary catheter the resident would be on EBP. She said she did not think residents who had wounds required EBP. She said EBP should be used for any resident who had an opening into their body, so she should have put on a gown to do the wound care. DON #1, who was also the infection preventionist (IP), was interviewed on 3/11/25 at 1:34 p.m. DON #1 said EBP involved the use of gloves and gowns. He said EBP should be worn when performing dressing changes on resident wounds. II. Housekeeping failures A. Professional reference Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 3/21/25 from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltextIt read in pertinent part, High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease). Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stays, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment. B. Observations During a continuous observation on 3/11/25, beginning at 10:11 a.m. and ending at 10:55 a.m., the following was observed: The housekeeper (HK) sanitized her hands and donned gloves. She took a cloth from the sanitizer bucket and entered room [ROOM NUMBER], which was a double-occupancy room. She cleaned the surfaces of bedroom furniture on both sides of the room, sanitizing her hands and changing gloves before each new cloth was used. She then swept the floors on both sides of the room and mopped the floors. At 10:25 a.m. the HK exited room [ROOM NUMBER]. -The HK failed to clean and sanitize the high touch areas in room [ROOM NUMBER] including door knobs, light switches and the call lights. At 10:26 a.m., the HK entered room [ROOM NUMBER]. The HK washed her hands with soap and water. She donned gloves and sprayed the bathroom surfaces. While the bathroom surfaces were soaking, she cleaned the surfaces of bedroom furniture on both sides of the room, sanitizing her hands and changing gloves before each new cloth was used. She swept the floors in the bedroom and then sanitized her hands and changed gloves. She then returned to the bathroom and emptied the garbage. After sanitizing and changing her gloves again, she scrubbed the sink and toilet. She mopped the bathroom. At 10:55 a.m., she finished and exited the room. -The HK failed to clean high touch areas in room [ROOM NUMBER], including door knobs, light switches, call lights and the call light rope in the bathroom shared with room [ROOM NUMBER]. C. Staff interviews DON #1 was interviewed on 3/11/25 at 1:34 p.m. DON #1 said that high touch areas in resident rooms should be cleaned every 24 hours. He said it made sense for high touch areas to be cleaned every time a resident's room was cleaned. The maintenance director (MTD) was interviewed on 3/11/25 at 4:00 p.m. The MTD said high touch areas in resident rooms, such as bedside tables, grab bars, door knobs, light switches, call lights and toilet handles should be cleaned every day. He said there was a binder of cleaning checklists, but he did not think it mentioned high touch areas as a separate task. He said there had been meetings to reinforce the cleaning of surfaces. He said in this case, he would needed to do some re-training of the housekeeping staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Failure to store personal items in a sanitary manner A. Facility policy and procedure The Resident Rights policy and procedure, undated, was provided by DON #1 on 3/11/25 at 12:39 p.m. It revealed in pertinent part, Residents in shared rooms will have their personal hygiene items labeled. B. Observations On 3/11/25 at 11:43 a.m., there was a plastic bag containing a bed pan hanging next to the sink in the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. -The bag/bed pan were not labeled with the resident's name. At 11:44 a.m. there was an emesis basin on the sink in the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. The emesis basin contained a toothbrush and toothpaste. There was a plastic cup on the sink that contained another toothbrush and toothpaste. -None of the items in the bathroom were labeled with resident names. At 11:47 a.m. a labeled, plastic urine collection cylinder was sitting on top of the toilet in the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. -The urine collection container was not stored in a bag. At 11:49 a.m. a toothbrush and tube of toothpaste were laying on the sink in the shared bathroom between room [ROOM NUMBER] and room [ROOM NUMBER]. -Neither item was labeled with the resident's name. C. Staff interviews DON #1 was interviewed on 3/11/25 at 1:34 p.m. DON #1 said that resident's toiletry items were typically labeled by certified nurses aides (CNA) or the admissions staff. He said toothbrushes were usually kept at the resident's bedside because the sinks were too small and there was not enough room for personal hygiene items in the shared bathrooms. He said many residents were alert and oriented so they would not necessarily label their personal hygiene items. He said the residents may have brought their personal hygiene items into the bathroom themselves. He said other items, such as bed pans may be labeled, depending on which resident was using it. He said if only one of the residents using the shared bathroom used a bedpan, it might not be labeled because the resident and CNA knew whose it was.