STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065327	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Juniper Village - the Spearly Center	2205 W 29th Ave Denver, CO 80211

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on interviews and record review, the facility failed to ensure one (#181) of three residents out of 56 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to provide a satisfactory resolution to Resident #181's grievance, which the resident representative had communicated to staff on multiple occasions, regarding the resident's missing glasses. Findings include: I. Facility policy and procedure The Grievance policy and procedure, undated, was provided by the nursing home administrator (NHA) on 3/14/24 at 1:35 p.m. It read in pertinent part, When a grievance exists, residents, family members, and/or resident advocates may submit the grievance to the administrator or designee. Within two business days after the submission of a grievance, a status report will be provided by the director of the department to who the grievance was directed, to the individual who filed the grievance. The resident or person acting on behalf of the resident will be informed of the findings of the investigation within seven working days of the filing date and have the right to obtain a written decision regarding the grievance. A copy of the initial grievance and the associative action will be filed in the social services office for no less than three years. II. Resident #181 A. Resident status Resident #181, age 78, was admitted on [DATE], readmitted [DATE] and discharged [DATE]. According to the November 2023 computerized physician orders (CPO), diagnoses included dementia, Parkinson's disease (brain disorder causing involuntary movements), sepsis (infection of the blood), post-traumatic stress disorder (PTSD) and depressive episodes. The 11/17/23 discharge minimum data set (MDS) assessment revealed the staff assessment for mental status was conducted and documented the resident had short-term memory problems and was moderately impaired for daily decision making. (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He was dependent on staff assistance with shower/bathing, upper body dressing, personal hygiene, putting on/taking off footwear, rolling left/right, transfering from sitting to lying, transfering from sitting to standing and transferring from bed to chair. The assessment documented the resident had no behavioral symptoms present and no rejection of care. B. Resident representative interview The resident representative was interviewed on 5/20/24 at 3:49 p.m. She said after the resident was discharged , the facility mailed Resident #181 plastic reader glasses which were not his. The resident's representative said she had already told the facility those glasses were not his. She said in the box that was shipped from the facility she had received items that went missing during Resident #181's stay at the facility. She said she continued to miss Resident #181's blue prescription glasses which the facility did not replace. She said she did not receive any other boxes from the facility. The resident representative said she filed a written grievance on 11/30/23 and received an email from the facility on 12/13/24 addressing the other missing items but not the blue prescription glasses. The resident representative said the glasses were listed on the intake inventory sheet on admissions. C. Record review The admissions inventory list dated 6/20/23 (date of admission 6/16/23) revealed the resident was admitted with glasses. -The inventory sheet did not document the color of the resident's glasses. The 11/30/23 grievance form, completed by the resident's representative, was provided by the NHA on 5/16/24 at 1:35 p.m. It revealed the following: The description of the grievance section documented the resident and his representative needed to be reimbursed for several items including blue prescription eyeglasses. Receipts and photos were included for replacement. The section for facility follow-up was not filled out. The section for the resolution of the grievance section was not filled out. There was additional information documented on the grievance form that indicated on 12/5/23 a few items were located and an email was attached to the form. The NHA signed the grievance form indicating it was resolved. -However, the form was not dated when the NHA approved the resolution . -The grievance form failed to address the resident's missing blue prescription glasses. Invoice documents for a vision and eye clinic were provided to the facility by the resident's representative upon filing the grievance. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The first document, dated 11/3/22, was for the purchase of a pair of blue eyeglasses (which the resident had upon admission to the facility on [DATE]). The invoice amount was $424.20. The second document, dated 11/27/23, was for the purchase of a pair of blue eyeglasses to replace the previous pair. The invoice amount was $424.20. The 12/13/23 email, sent at 11:00 a.m., from the facility to the resident's representative documented the facility recovered several of Resident #181's missing items, which included one cream colored slipper with fur, one medium gray zip-up jacket, one hearing aid with batteries and filters in a clear box, one bag of hearing aid cleaning tools, one gray zip-up case and one clear box. A picture of the box contents that was shipped to the resident's representative was attached to the grievance form. -However the email did not address the missing blue prescription glasses and was not in the picture of the box shipped by the facility. A review of the Resident #181's electronic medical record (EMR) revealed the following progress notes: The 10/6/2023 social services note documented at 10:45 a.m. documented a telephone call was made to the resident's representative to inform her that Resident #181 had his glasses. The 11/15 23 (late entry) physician progress note documented the resident had glasses and dentures. The 11/20/23 wellness progress note documented the nurse spoke with the resident's representative to get an update on Resident #181 and to ensure that the resident's representative was doing okay. The resident's representative stated Resident #181's glasses needed to be found. The writer's contact information was given to the resident's representative in case the resident's representative needed anything. -Resident #181 was discharged to the hospital on 11/17/23. The 11/23/23 progress note documented the resident's representative came to the facility to pick up some of Resident #181's belongings, which included his dentures, hearing aids and glasses that were found with the residents' possessions. Upon receiving the glasses in question, the resident's representative told the concierge that the glasses were not the resident's glasses and threw them at the concierge. The resident's representative then asked if she would be able to grab some clothes and other items to take to the resident in the hospital. The resident's representative took the residents' hearing aids, dentures, cowboy hat and a pack of gloves with her upon leaving the facility. The NHA provided an email communication between the facility and the resident's representative on 5/20/24 at 4:39 p.m. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's representative emailed the facility on 1/26/24 at 10:36 a.m. The email to the NHA read the resident's representative had not heard from the facility in regards to Resident #181's missing blue prescription glasses nor had she received reimbursement for their replacement. The resident's representative said she provided receipts and photos to the facility when the Veterans administration liaison met there with her about two months ago (November 2023). The resident's representative said she would like to resolve the issue. The facility responded to the resident's representative email on 1/26/24 at 11:54 a.m. The facility attached the personal belongings agreement signed by the resident's representative upon Resident #181's admission outlining the policy regarding lost, stolen, damaged items. The facility informed the representative they were not able to find the glasses on any of Resident #181's inventory sheets. As a result of the facility's investigation, the facility was not approved to refund the amount for the glasses. -However, the admissions inventory list dated 6/20/23 (date of admission 6/16/23) revealed the resident was admitted with glasses, but the color of the glasses was not specified on the inventory list. A review of Resident #181's electronic medical record (EMR) on 5/20/24 at 4:27 p.m. revealed the resident's glasses were an auxiliary device (supplementary). The profile picture in the resident's EMR revealed the resident was wearing glasses. III. Staff interview The NHA was interviewed on 5/20/24 at 3:07 p.m. The NHA said the facility attempted to return the glasses to the resident's representative but she threw the glasses at the concierge. The NHA said all of the other missing items were shipped to the family including the glasses. -However the plastic reading glasses were not the blue prescription glasses that the resident's representative was requesting. The NHA was interviewed again on 5/20/24 at 4:36 p.m. The NHA reviewed the written grievance. The NHA said she would look for evidence that the blue prescription glasses were sent to the resident. The NHA said the facility had mailed a second box to the resident however they did not take a picture of the second box sent to the resident. -The NHA did not provide evidence that the facility found, replaced or reimbursed the resident's representative for the missing blue prescription glasses. The social services director (SSD) was interviewed on 5/23/24 at 10:30 a.m. The SSD said that once a grievance was filed the turnaround time was about two days to proceed with a response/resolution. She said items listed on an inventory list that were not returned were reimbursed by the facility.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on record review and interviews, the facility failed to ensure four (#118, #32, #49 and #90) of four residents reviewed for abuse out of 56 sample residents were kept free from abuse. Specifically, the facility failed to: -Implement person-centered interventions to prevent a resident to resident altercation between Resident #118 and Resident #32; and, -Implement person-centered interventions to prevent a resident to resident altercation between Resident #90 and Resident #49. Findings include: I. Facility policy and procedure The Abuse Policy, undated, was provided by the nursing home administrator (NHA) on 5/13/24 at 2:22 p.m. It read in pertinent part: This policy is intended to provide guidance on investigating and reporting suspected resident rights violations and abuse, neglect, and misappropriation of resident property. To assist our community's associate members in recognizing abuse, the following definitions of abuse are provided. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. The facility staff and agency supplemental personnel will be trained regarding abuse prevention, reporting and investigation upon orientation and annually. Strategies for dealing with difficult and/or aggressive behavior. Prevention of abuse, neglect or misappropriation of property will be implemented through: ongoing associate, resident and family training monthly safety committee meetings ongoing rounds and quarterly staff meetings that focus on possible root causes. An immediate investigation will be conducted. Wellness Director or designee will complete the investigative form. The physician and Executive Director will review and sign the form. The resident will be provided with an interview to determine how and what situations provide comfort and a feeling of well-being. The Administrator will analyze all occurrences to determine if changes are needed to policies and procedures to prevent further occurrences. The Managing Challenging Behaviors policy and procedure, undated, was provided by the NHA on 5/13/24 at 2:22 p.m. It read in pertinent part: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy: Staff employee therapeutic approach with residents that will minimize the occurrence of challenging behaviors and maximize successful management of such behaviors should they occur. Purpose: To foster the creation of a harmonious community and to minimize behavioral distress for each resident. Procedure: Staff may assist in preventing challenging behaviors by knowing and appreciating the background, values, preferences and abilities of the resident and engaging the resident in activities based on needs. II. Resident to resident physical abuse between Resident #118 and Resident #32 on 5/8/24. The abuse investigation, dated 5/8/24, revealed Resident #118 entered the room of Resident #32 and laid in her bed. Resident #32 asked Resident #118 to leave her room. Resident #118 allegedly responded by pushing Resident #32 and Resident #32 responded by pushing Resident #118 back. Staff responded and assisted Resident #118 to leave the room. The abuse investigation indicated Resident #32 was interviewed and said Resident #118 was in her bed and she wanted him out of her room. Resident #118 was non interviewable due to his cognitive status. The abuse investigation indicated both residents were placed on 15 minute checks, the police were notified, along with the family/guardian and the physician. The abuse investigation indicated neither Resident #32 or Resident #118 had injuries. The abuse investigation revealed Resident #118's and Resident #32's care plans were updated regarding the incident. Resident #32 was seen by an existing community mental health provider and Resident #118 was referred to a community mental health provider. The abuse investigation indicated other staff and residents were interviewed and expressed no concern. -A request for the other staff and resident interviews was made on 5/13/24, however the facility did not provide them by the survey exit on 5/23/24. -A review of Resident #118's and Resident #32's comprehensive care plans did not reveal updated person-centered interventions to prevent future resident to resident altercations following the incident on 5/8/24. III. Resident #118 A. Resident status Resident #118, age 73, was admitted on [DATE]. According to the May 2024 computerized physicians orders (CPO), diagnoses included Alzheimer's disease, bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration) and post traumatic stress disorder (PTSD). According to the 3/24/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He was independent with eating, toileting, bed mobility and transferring. He did not use any mobility devices. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The maladaptive behavior care plan, initiated on 12/1/23, indicated Resident #118 had maladaptive behaviors secondary to his dementia and occasionally became verbally aggressive and swatted at caregivers during care. The pertinent interventions included administering medications and monitoring for side effects, anticipating and meeting Resident #118's needs, providing an opportunity for positive interactions and attention and stopping to talk with the resident while passing by. -A review of the resident's comprehensive care plan revealed the facility did not implement an intervention after Resident #118 was involved in a resident to resident altercation. A review of Resident #118's electronic medical record (EMR) revealed the resident had a history of behaviors directed towards staff and residents. The 5/9/24 progress note indicated Resident #118 wandered into the room of Resident #32's room and laid in her bed. When Resident #32 asked Resident #118 to get out of her bed, Resident #118 pushed Resident #32 in the stomach which resulted in the two residents engaging in a physical altercation that staff had to break up. (see resident to resident physical abuse above). IV. Resident #32 A. Resident status Resident #32, age less than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included schizoaffective disorder (mental health condition characterized by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), personality disorder, anxiety and insomnia. According to the 4/29/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with all activities of daily living (ADL). B. Record review The behavior care plan, initiated on 11/15/13 and revised on 11/2/22, revealed Resident #32 had a history of hitting a staff member at a previous facility, experienced auditory and visual hallucinations and had a history of yelling and crying. It indicated Resident #32 would have a reduction and stabilization of behaviors and symptoms that necessitated facility placement and maintain psychiatric stabilization. The pertinent interventions included Resident #32 being supported by her community mental health case manager. -A review of the resident's comprehensive care plan revealed the facility did not implement an intervention after Resident #32 was involved in a resident to resident altercation. V. Incident of resident to resident altercation between Resident #49 and Resident #90 on 12/30/23 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility reported event, dated 12/30/23, revealed Resident #49 was walking through the communal dining area and was gesturing to Resident #90 with his middle finger. Resident #90 responded by slapping resident Resident #49 on the left cheek. The facility responded by separating the two residents from each other and both were assessed for injuries. The facility report noted Resident #49 had a reddened area on the left cheek. The report indicated both residents were put on 15 minute checks and the police were notified. The facility report indicated Resident #90 was unable to participate in an interview related to cognition and Resident #49 stated, I'm just mad when interviewed. The facility report indicated other staff and residents were interviewed and there were no other concerns expressed. Resident #49 would be referred to a community mental health provider. The abuse investigation indicated other staff and residents were interviewed and expressed no concern. -However, none of the interviews were provided during the survey -Resident #90's care plan was not updated after he was involved in a resident to resident altercation on 12/30/23. -Resident #49 was not referred for community mental health services. On 5/15/24 the NHA provided the following facility investigation for another resident to resident altercation between Resident #90 and Resident #49 on 4/10/24: On 4/10/24 Resident #90 was being aggressive towards Resident #49 in the dining room of their shared unit. Resident #49 attempted to physically hit Resident #90 in the face without success. The investigation revealed the facility had reviewed surveillance video and witnessed Resident #49 did not physically hit Resident #90 as staff were able to successfully prevent a resident to resident altercation. It indicated Resident #49 would be referred to a community mental health agency and Resident #90 would be seen by an existing mental health provider. -A review of Resident #49's EMR during the survey revealed he still had not been referred to receive services from a community mental health agency even though it had been recommended following the resident to resident altercations on 12/30/23 and again on 4/10/24 VI. Resident #49 A. Resident status Resident #49, age less than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included anoxic brain damage (brain damage due to lack of oxygen), dementia, mood disorder (mental illnesses that cause a person's emotional state to be persistently disturbed) and major depressive disorder. According to the 4/5/24 MDS assessment, the resident had severe cognitive impairment with a BIMS score of nine out of 15. He required set-up assistant for eating, toileting and personal hygiene. He was independent with mobility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment revealed Resident #49 displayed verbal behavioral symptoms directed at others, such as, threatening, screaming or cursing at others. The resident displayed other behavioral symptoms, such as, hitting or scratching self, pacing, rummaging, public sexual acts and disrobing in public. B. Record review The mood and behavior care plan, initiated on 5/21/14 and revised 12/14/16 revealed Resident #49 had a history of gesturing to others with his middle finger and was cognitively unaware he was doing so related to his diagnosis of an anoxic brain injury. He frequently used profanity and offensive language and had a history of provoking peers due to this behavior in which it had caused his peers to become verbally/physically aggressive with him. The pertinent interventions included encouraging Resident #49 to make a peace sign when gesturing with his middle finger. -A review of the comprehensive care plan did not reveal the care plan had been updated after Resident #49 was involved in a resident to resident altercation on 12/30/23 or 4/10/24. VII. Resident #90 A. Resident status Resident #90, age less than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included major depressive disorder, anxiety and a traumatic brain injury (TBI). According to the 4/22/24 MDS assessment, the resident was cognitively intact with a BIMS of 13 out of 15. He required supervision with all ADLs and was independent with mobility. The assessment revealed Resident #90 had displayed verbal behavioral symptoms directed towards others to include threatening, screaming or cursing at others. B. Record review A review Resident #90's electronic medical record (EMR) revealed the resident had a history of behaviors directed towards staff and residents. VIII. Staff interviews On 5/13/24 at 2:22 p.m. the NHA said the facility entered facility reportable events directly into the state agency portal. The NHA said the facility was not using a separate investigation form for information gathering by the facility. The NHA said resident to resident altercations were discussed daily in morning meetings and interventions to avoid continued altercations were decided as an interdisciplinary team (IDT). The director of nursing (DON) was interviewed on 5/21/24 at 11:30 a.m. The DON said behaviors were documented in the EMR or the 24-hour report binder. The DON said any of the IDT members could put in an order for a mental health referral if it was warranted. The DON said Resident #118 was not seen by a community mental health provider sooner because of scheduling constraints with the mental health provider. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #3 was interviewed on 5/21/24 at 4:40 p.m. RN #3 said staff had to get to know the residents to work with resident behaviors and anticipate needs. RN #3 said she did not work with Residents #118, #32, #49 and #90 on a regular basis. RN #3 said every resident on the second floor had behaviors. RN #3 said the staff used verbal redirection if an altercation occurred. CNA #4 was interviewed on 5/21/24 at 4:40 p.m. CNA #4 said she did not know where to locate resident centered behaviors or interventions. CNA #4 said she used verbal redirection of asking or telling a resident to stop doing something that had the potential to cause an altercation. CNA #4 said the facility trained direct care staff on crisis prevention intervention one time annually. CNA #4 said she started as an employee after an annual training but knew of crisis prevention interventions from a different community she had worked at. The social services director (SSD) and the social services assistance (SSA) were interviewed together on 5/21/24 at 5:30 p.m. The SSD said resident to resident incidents were discussed during the daily interdisciplinary (IDT) meeting. The SSD said resident to resident altercations and resident's displaying behaviors were considered an occurrence that were discussed. The SSD said behaviors and interventions were not necessarily care planned and were mainly communicated verbally from staff to staff. The SSD said she did not know if this was an effective method for tracking resident specific behaviors and interventions. The SSD said Resident #49 was not a good candidate for community mental health because of his brain injury and the SSD did not know why this was being recommended as an intervention.

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on record review, observations, and interviews, the facility failed to ensure that six (#118, #126, #121, #115, #72 and #20) of nine residents out of 56 sample residents were free from involuntary seclusion and were receiving the least restrictive approach for their needs. Specifically, the facility failed to ensure Residents #118, #126, #121, #115, #72 and #20, who resided on the secure locked unit, had the required documentation to justify such restrictions. Findings include: I. Resident #118 A. Resident status Resident #118, age 73, was admitted on [DATE]. According to the May 2024 computerized physicians orders (CPO), diagnoses included post traumatic stress disorder (PTSD), Alzheimer's disease and bipolar disorder. According to the 3/24/24 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He was independent with eating, toileting, bed mobility and transferring. He did not use any mobility devices. The assessment indicated Resident #118 had not exhibited wandering behavior. B. Record review A review of Resident #118's electronic medical record (EMR) failed to reveal a pre-admission evaluation for secure unit placement, a physician's order for secure unit placement, a care plan for secure unit placement or any ongoing evaluations for secure unit placement. C. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 5/21/24 at 4:40 p.m. CNA #4 said Resident #118 mainly stayed in his room and did not wander. CNA #4 said Resident #118 was able to walk on his own but not more than 10 to 15 steps without getting tired and needing to sit down. 47960 II. Resident #126 A. Resident status Resident #126, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included bipolar disorder, dementia, post-traumatic stress disorder (PTSD) and anxiety disorder. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/5/24 MDS assessment revealed the resident had a moderate cognitive impairment with a BIMS score of nine out of 15. He required supervision and assistance with activities of daily living (ADLs). B. Record review -A review of Resident #126's May 2024 CPO did not reveal a physician's order for secure unit placement. -A review of Resident #126's elopement risk evaluation revealed it was initiated on 4/1/24 but was not complete at the time of the survey and did not contain a score. -A review of Resident #126's comprehensive care plan, initiated 4/3/24, revealed there was not a care plan focus related to Resident #126's secure unit placement to include person-centered individualized interventions, personalized triggers, or personalized signs and symptoms. -The semi-secure neighborhood placement evaluation for Resident #126 did not specify why the resident needed placement in a secure unit. The evaluation documented Resident #126 benefited from the structure of the semi secure unit and had a guardian for major decisions. The evaluation was signed by the nursing home administrator (NHA), a social worker, the assistant director of nursing (ADON), the director of nursing (DON) and the legally responsible party. The referral for secured unit placement from the Veterans Administration (VA) documented the residents' need for secure unit placement or a wander guard system. -However, the facility did not perform its own admission assessment or a 30-day post-admission assessment with input from an individual with mental health or social work training who was not a staff member. III. Resident #121 A. Resident status Resident #121, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included secondary malignant neoplasm of unspecified kidney and renal pelvis (kidney cancer), type II diabetes mellitus, hypertension (high blood pressure), and atrial flutter (abnormal heart beat). -There were not any mental health or dementia diagnoses identified. The 4/5/24 MDS assessment revealed the resident had a mild cognitive impairment with a BIMS score of 12 out of 15. He was independent in mobility with the use of a cane. He did not have any behaviors or refusal of care. B. Record Review -A review of Resident #121's May 2024 CPO did not reveal a physician's order for secure unit placement. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #121's elopement risk evaluation was completed on 2/2/24 and it documented a low risk of wandering with a score of two. -A review of Resident #121's comprehensive care plan, revised on 2/13/24, revealed there was not a care plan focus related to Resident #121's secure unit placement to include person-centered individualized interventions, personalized triggers, or personalized signs and symptoms. -The semi-secure neighborhood placement evaluation for Resident #121 did not specify why the resident needed placement in a secure unit. The evaluation documented Resident #121 benefited from the secure unit due to dementia and had a guardian for major decisions. The evaluation was signed by the NHA, a social worker, a member of the nursing department, DON and verbal consent from the legally responsible party. -However, the facility did not perform its own admission assessment or a 30-day post-admission assessment with input from an individual with mental health or social work training who was not a staff member. -The referral from a hospice service provider and family did not document a need for secure unit placement. -The semi secure unit placement evaluation included in Resident #121's pre admission packet was not completed. C. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 5/20/24 at 2:05 p.m. LPN #4 said it was his first day working at the facility. He could not locate any information in Resident #121's EMR that justified the need for secured unit placement for Resident #121. LPN #4 said there should be orders in the CPO for secured unit placement based on his experience at other nursing facilities. Registered nurse (RN) #3 was interviewed on 5/20/24 at 3:48 p.m. RN #3 said Resident #121 was placed in the secured unit due to his behaviors, however she could not locate any documented information in the resident's EMR. She said sometimes family members were involved in the decision to place a resident on the secured unit. RN #3 said the facility did not have wander guards and the secure unit was the least restrictive alternative available at the facility. RN #3 said the social workers and the DON were responsible for ensuring the secure unit placement was in the care plans for each resident placed there. RN #3 said diagnoses alone did not justify placement on the secure unit, but in the case of Resident #121 no one ever knew when he was going to blow up and have behavioral issues. IV. Resident #115 A. Resident status (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #115, under the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included Wernicke's encephalopathy (an acute neurological condition characterized by a clinical triad of ophthalmoparesis with nystagmus, ataxia, and confusion), type one diabetes mellitus, anxiety disorder and alcohol dependence with alcohol-induced persisting dementia. The 4/22/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was independent with all ADLs. She did not have any behaviors or refusals of care. B. Resident interview Resident #115 was interviewed on 5/16/24 at 9:48 a.m. The resident resided on the second floor and said she did not want to live at the facility and she felt trapped. She said she could not leave the second floor without an escort and did not know why. C. Record Review -A review of Resident #115's May 2024 CPO did not reveal a physician's order for secure unit placement. A review of Resident #115's elopement risk evaluation was completed on 10/25/23 and documented a high risk of wandering with a score of 13. -A review of Resident #115's comprehensive care plan, revised on 4/23/24, revealed there was not a care plan focus related to Resident #115's secure unit placement to include person-centered individualized interventions, personalized triggers, or personalized signs and symptoms. -The semi-secure neighborhood placement evaluation for Resident #115 did not specify why the resident needed placement in a secure unit. The evaluation documented Resident #115 benefited from the structure of the secure unit due and the guardian supports placement on the semi secure unit. The evaluation was signed by the NHA, a social worker, the DON and verbal consent from the legally responsible party. -However, the facility did not perform its own admission assessment or a 30-day post-admission assessment with input from an individual with mental health or social work training who was not a staff member. V. Resident #72 A. Resident status Resident #72, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 CPO, diagnoses included Ahlzeimers disease with early onset, unspecified dementia, generalized anxiety disorder and a cognitive communication deficit. The 3/15/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of zero out of 15. She did not have any behaviors or refusal of care. She required setup or clean up assistance with ADLs and partial to moderate assistance with toileting hygiene. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record Review -The semi-secure neighborhood placement evaluation for Resident #72 did not specify why the resident needed placement in a secure unit. The evaluation documented Resident #72 benefited from the structure of the secure unit due and the proxy gave verbal consent for semi secure unit placement. The evaluation was signed by the NHA, a social worker , an ADON and the DON. -However, the facility did not perform its own admission assessment or a 30-day post-admission assessment with input from an individual with mental health or social work training who was not a staff member. VI. Resident #20 A. Resident status Resident #20, under the age of 65, was readmitted on [DATE]. According to the May 2024 CPO, diagnoses included unspecified intracranial injury, mood disorder with depressive features, brief psychotic disorder, and unspecified psychosis not due to a substance or known physiological condition. The 4/16/24 MDS assessment revealed the resident was cognitively impaired with a BIMS score of zero out of 15. He had experienced hallucinations and delusions but did not refuse care. He required supervision and assistance with ADLs and was dependent on staff for bathing. B. Record Review -A review of Resident #20's May 2024 CPO did not reveal a physician's order for secure unit placement. A review of Resident #20's elopement risk evaluation was completed on 4/15/24 and it documented a high risk of wandering with a score of 11. -The semi-secure neighborhood placement evaluation for Resident #20 did not specify why the resident needed placement in a secure unit. The evaluation documented Resident #20 benefited from the structure of the secure unit and the guardian agreed to placement on the semi secure unit. The evaluation was signed by the NHA, a social worker , a nursing department representative, the DON and verbal consent from the legally responsible party. -However, the facility did not perform its own admission assessment or a 30-day post-admission assessment with input from an individual with mental health or social work training who was not a staff member. VII. Staff interviews (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social services director (SSD) was interviewed on 5/16/24 at 2:00 p.m. The SSD said the second floor was considered semi secured so it was not really a secure unit. The SSD said the unit had egress doors that would open when pushed on for more than 15 seconds. The SSD said residents were re-evaluated for a move from the semi secured unit to the non secured third floor on an ongoing basis and it depended on the residents' ability and motivation to leave the facility and input from the interdisciplinary team, the physician, family or guardian. The SSD said there was not an official assessment that occurred for evaluation. ADON #2 was interviewed on 5/20/24 at 3:51 p.m. ADON #2 said when a resident was admitted to the secure unit she went through the resident's record to ensure there was justification for placement. She said the assessment was done prior to admission. ADON #2 said the team assessed each resident after admission for appropriateness of the secure unit placement. She said every resident on the secure unit had a physician's order for placement which would be located in the CPO and it would be identified in the residents' care plans. The DON was interviewed on 5/20/24 at 3:56 p.m. The DON said a resident qualified for secure unit placement if there was an elopement risk or if the resident had behavior risks that compromised safety to themselves or others. He said resident placement on the secure unit was discussed in care conferences on a quarterly basis. The DON said social services was responsible for ensuring the care plan reflected the secure unit placement. He said if a resident or guardian requested a resident to move off of the unit, the team would reassess, but if things were going well they would just keep the resident on the secured unit. The NHA was interviewed on 5/20/24 at 4:03 p.m. The NHA said a resident qualified for secure unit placement if there was a safety concern to the resident themself or others, if it was deemed by court order or if the resident or family/guardian preferred secure unit placement. She said the residents on the secured unit were reassessed every six months by staff and the initial assessment was in the residents' EMRs.She said all recurrent assessments were a hard copy and kept by the SSD. The NHA said it was the responsibility of social services and anyone in the nursing department to ensure an order was in the EMR for secure unit placement. She said if a resident showed evidence of exit seeking they were placed on the secured unit. The NHA said the facility did not have a wander guard system. The medical director (MD) was interviewed on 5/21/24 at 1:04 p.m. The MD said he always recommended to the staff that they include the need for secure placement in the care plan and notes. He said the primary care provider needed to complete paperwork to attest that each resident had failed in less restrictive environments and the attending physician would sign that document. The MD said the second floor was considered a secure unit because everyone had to have a key fob to access or leave the floor.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on record review and interviews, the facility failed to thoroughly investigate an allegation of neglect involving one (#8) of two residents reviewed for neglect out of 56 sample residents. Specifically, the facility failed to conduct a thorough investigation to determine the cause of reddened skin and blisters found on Resident #8's left and right thigh. Findings include: I. Facility policy The Abuse and Neglect policy, undated, was provided by the nursing home administrator (NHA) on 5/13/24 at 2:17 p.m. It documented in pertinent part, This policy is intended to provide guidance on investigating and reporting suspected resident rights violations and abuse, neglect, and misappropriation of resident property. This policy will be accomplished through the following: a. Pre-Screening of all facility associates and agency supplemental personnel. b. Training and documentation of training for all associates and agency supplemental personnel through orientation and on-going sessions. c. Prevention through training of all residents d. Identification of suspected cases of abuse e. Investigation of all incidents and allegations by qualified and trained individuals f. Protection of residents during investigations. g. Reporting of abuse as required by law/regulations. To assist our community's associate members in recognizing abuse, the following definitions of abuse are provided. a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish. b. Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An immediate investigation will be conducted. a. Wellness Director or designee will complete the investigative form. The physician and Executive Director will review and sign the form. b. The following action will be taken regarding the employee involved. 1. The associate will be suspended without pay pending a full investigation 2. The associate will have thirty days to request a hearing to present evidence, either in person, in writing, or through witness to refute the allegation. 3. The associate may have an attorney present at the hearing. 4. In the event, it is determined that the associate did not neglect, abuse, and/or misappropriate resident property, they will be reinstated and paid for all days lost from work. c. A final report will be submitted to the Administrator within five working days of occurrence. II. Resident #8 A. Resident status Resident #8, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2024 computerized physicians orders (CPO), diagnoses included personality disorder, paraplegia, systemic sclerosis, type 2 diabetes mellitus and anxiety disorder. The 4/24/24 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 had no behaviors and did not reject care. The resident was dependent on staff for toileting, dressing, personal hygiene and bathing. B. Resident interview Resident #8 was interviewed on 5/15/24 at 2:15 p.m. Resident #8 said she was recently readmitted to the facility in the late afternoon on 12/27/23. She said she was given a shower in the morning on 12/28/23 and when she went to bed that night staff found red skin and blisters on both of her thighs. Resident #8 said she requested to go to the hospital again for treatment but the staff refused to call an ambulance so she called 911 from her personal cell phone. She said she did not have much feeling in her legs so she did not know the water in the shower was too hot for her fragile skin. C. Record review (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 12/27/23 at 5:08 p.m. documented Resident #8 returned from the hospital at 4:15 p.m. accompanied by paramedics. It documented the resident was stable and cooperative and there were no new skin issues. A skin integrity evaluation dated 12/27/23 at 4:38 p.m. revealed an existing wound on the residents right buttock and left knee that was improved. There were not any other wounds or skin integrity issues documented. A nursing note dated 12/28/23 at 10:59 p.m. revealed that certified nurse aides (CNA) had provided care to the resident at 8:30 p.m. and discovered blisters between the resident's inner right and left thigh. It documented that the skin was open and not intact with the left wound measuring 15 centimeters (cm) long and 13 cm wide and the right wound measuring 6.5 cm long and 4 cm wide. The note documented the supervisor was informed and instructed the nurse to clean the wounds and apply abdominal pads. The note revealed the resident informed the nurse she wanted to go to the hospital. The note also documented that the resident called emergency medical services (EMS) from her cell phone without informing staff and was picked up by EMS at 11:06 p.m. An injury/incident report was dated 12/28/24 at 8:40 p.m. and was completed by assistant director of nursing (ADON) #2. The report documented the resident had blisters on her left and right inner thighs, the resident was alert and oriented to person, place, time and situation and there were no witnesses found. The discharge summary, dated 12/29/23 from a local hospital, documented the resident had 4% total body surface area (TBSA) partial thickness burns (second degree burns) sustained when she was in the shower at the resident's facility on 12/28/23. She was transferred to a burn center for autografting (skin transfer from one part of the body to another) of the burns. A nursing note dated 1/15/24 at 5:34 p.m. documented the resident returned to the facility from the hospital. It revealed the resident had discoloration to both of her thighs due to healing partial thickness second degree burns with autograft. D. Failure to investigate the 2nd degree burns The facility failed to complete a thorough investigation as to how the resident had sustained 2nd degree burns to both of her left and right thigh. The facility failed to interview the CNA who performed the shower on 12/28/23, failed to show that water temperatures in the the showers were monitored on a regular basis and failed to ensure other residents and staff were interviewed in regards to the water temperatures in the shower and the burns to Resident #8's thighs. -The facility investigation was requested. However, the DON said they had only done a soft investigation of the allegation (see interviews below). The DON provided a document he referred to as his soft investigation. It read in pertinent part, Soft file Resident #8 investigation -CNA reported to nurse blisters on legs on 12/28/23 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident sent out to hospital 12/28/23 -Wound nurse notified to have wound doctor assess on next rounds 12/29/23 -Documentation from hospital identified the source of blisters as minor burns. -On 12/29/23 notified adult protective services (APS) was involved and investigating source of burns -Facility asked to temperature check water in Spruce Spa on 12/29/23 -Shared it was 100 degrees consistent with two previous readings in December -Suspicion of self-inflicted origin related to previous periods when wound was improving and developed infection with no changes in wound care. -Facility notified guardian we would not take her back due to open APS case. -Resident stated at hospital to police department it was not intentional and did not want to hold individual at fault. -Guardians and APS determined facility is the best place for Resident #8. -Resident #8 returned on 1/15/24. An email dated 1/4/24 at 9:23 a.m., from the social worker at the burn center, documented the guardians for Resident #8 were trying to brainstorm what could have caused the burns to the resident's thighs. It revealed the guardians had several theories but did not specify any interviews conducted or witness statements. -The facility did not investigate further by interviewing Resident #8 once she returned to the facility. D. Interviews CNA #9 was interviewed on 5/15/24 at 3:40 p.m . CNA #9 said she had worked at the facility for three months and had showered residents. She said she checked the temperature with her hand and then asked the residents if the water felt okay. She said she did not use a thermometer to check the temperature of the water and thought she had learned the technique of checking the temperature with her hand before applying it to a resident in CNA school. CNA #9 said if a resident had delicate skin, she would check with the nurse before showering the resident. The DON was interviewed on 5/20/24 at 9:25 a.m. The DON said he did an internal soft investigation and had notes on what he discovered regarding Resident #8's wounds. He said the facility did not have a formal form that was used for investigations. The DON said he thought APS took over the investigation so he did not continue investigating further and just let it go. He said the water in the shower was temperature checked and it was fine. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The environmental service director (ESD) was interviewed on 5/20/24 at 3:39 p.m. The ESD said he checked the water temperature in the facility showers weekly and expected the temperature to read a minimum of 100 degrees fahrenheit. He said he was aware of an incident where a resident reported being burned in the shower but he was not sure what the facility had done when the resident reported that or if it had been determined to be true. The ESD said,to his knowledge, no residents had ever gotten burned in the facility showers.