STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065345	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suites at Someren Glen Care Center, The	5000 E Arapahoe Rd Centennial, CO 80122

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observation, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries for two (#1 and #27) of three residents out of 39 sample residents. Resident #27, who was known to be at risk for skin breakdown due to immobility, developed two stage 3 pressure injuries to his left and right ischium (lower part of the pelvic bone that helps absorb weight when sitting) on 4/17/24. Resident #27's care plan documented the resident was to be offered repositioning at night during care and encouraged to lie in bed after lunch. Additionally, the resident was always incontinent of urine and frequently incontinent of bowel. However, the care plan failed to include an intervention to encourage the resident to reposition while he was sitting in his recliner and offer toileting/incontinence care to the resident frequently. Continuous observations during the survey revealed Resident #27 was not offered frequent repositioning or toileting by the staff. Due to the facility's failures to provide Resident #27 with timely interventions, such as frequent repositioning and incontinent care, the resident developed two Stage 3 pressure injuries to his left and right ischium. Additionally, Resident #1, who was frequently incontinent of urine, always incontinent of bowel and at risk for developing pressure injuries due to a decrease in mobility, was identified by a nurse to have an open area to her coccyx on 4/1/24 during a routine skin assessment. However, there was no further documentation in the resident's electronic medical record (EMR) to indicate the wound care physician (WCP) was notified of the wound and no new physician's orders were obtained to treat the wound. On 4/14/24, Resident #1 it was identified by another nurse that she had pressure wounds on her coccyx and left buttock. A physician's order was obtained for wound treatment. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility failed to initiate a treatment to the unstageable pressure wounds to Resident #1's coccyx and left buttock for 13 days following the initial identification. Furthermore, Resident #1's care plan failed to include interventions for frequently repositioning the resident while she was in her recliner and providing frequent incontinent care. Continuous observations during the survey revealed Resident #1 was not offered frequent repositioning or toileting by the staff. Due to the facility's failures to provide Resident #1 with timely interventions, such as frequent repositioning and incontinent care, the resident developed unstageable pressure injuries to her coccyx and left buttock. Findings include: I. Professional reference The Pressure Ulcer and Other Wounds in the Post-Acute and Long-Term Care Settings (2018), retrieved on 4/29/24 from https://online.fliphtml5.com/zlds/jffd/#p=2, revealed in pertinent part Employ repositioning or offloading measures for wound prevention. According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA: 2019, retrieved on 4/29/24 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Injury Prevention and Management policy and procedure, dated November 2022, was received from the nursing home administrator (NHA) on 4/25/24 at 8:47 a.m. It revealed in pertinent part To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries. Preventative interventions can be, but not limited to, frequent position changing and support of pressure points, adequate hydration and nutrition, appropriate exercise and movement, frequent perineal care and application of barrier cream for incontinence, proper lifting technique, correct application of pressure relieving devices and frequent inspection and assessment of skin integrity. Compliance with interventions will be documented in the medical record. III. Resident #27 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #27, age greater than 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included heart failure, type II diabetes, chronic kidney disease and atrial fibrillation (abnormal heart function). The 3/21/24 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. He required extensive one to two person assistance with toileting, transfers and bed mobility. He required set up assistance with personal hygiene and eating. The assessment documented Resident #27 was at risk for developing pressure injuries but did not have a pressure injury. B. Observations On 4/22/24 at 12:35 p.m. Resident #27 was sitting in his recliner in his room. On 4/23/24, during a continuous observation beginning at 10:35 a.m. and ending at 2:04 p.m., Resident #27 was sitting in his recliner. At 12:22 p.m. Resident #27's lunch tray was delivered by CNA #1. Resident #27 remained sitting in his recliner for lunch. -CNA #1 failed to offer Resident #27 repositioning or toileting before lunch. At 2:04 p.m. Resident #27 was assisted by CNA #1 and licensed practical nurse (LPN) #1 to lay in bed. CNA #1 exited Resident #27 room with a trash bag containing Resident #27's brief. The brief was observed to be visibly wet as the inside of the trash bag was noted to be wet. -Resident #27 was not provided with toileting or repositioning in his recliner for three hours and 30 minutes. On 4/24/24 at 1:04 p.m. the regional nurse consultant (RNC) assessed the edge of the cushion Resident #27 was sitting on in his recliner and said it was a gel type cushion. The RNC assessed Resident #27's air mattress and said it was a mattress that could alternate pressure. On 4/24/24 at 2:00 p.m. Resident #27's wound care was observed with the wound care physician (WCP). The old dressings were removed from the resident's wounds and the wound beds were pink with no signs of infection. The wounds were cleaned with normal saline, skin prep applied to the peri wounds, honey gel applied to the wound beds and covered with border dressings. -On 4/24/24 at 2:30 p.m. the gel cushion in Resident #27's recliner did not have cushion cover on it and the resident was sitting directly on the plastic surface of the gel cushion. C. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #27's comprehensive care plan, dated 3/27/24, revealed Resident #27 had a potential for impairment to skin related to decreased mobility. The interventions included a pressure reducing cushion to chair and mattress (initiated 8/3/22), offering to reposition Resident #27 at night during care and encouraging the resident to lie on his bed after lunch (initiated on 1/20/23). -The care plan only addressed repositioning the resident during night care and not throughout the day. The 4/17/24 skin and wound evaluation form identified two new stage three pressure injuries to the left and right ischium. The wound appeared pink and moist with no signs of infection. The wound area was cleansed with Dakin's, honey gel was applied to the wound bed, skin prep the peri wound and covered with border gauze. Resident #27's 4/19/24 Braden scale (a tool used to determine the risk of pressure injury development) revealed Resident #27 was at risk of developing a pressure ulcer. It revealed his skin was occasionally moist requiring an extra linen change daily. Resident #27 was chair fast, his ability to walk was severely limited and he was unable to bear weight and required assistance into a chair or wheelchair. Resident #27 had very limited mobility, was able to make occasional slight changes in body position but was unable to make frequent or significant changes independently. Resident #27's April 2024 CPO revealed the following physician's order: Cleanse the left and right ischium with Dakin's (specialized wound cleaner), apply honey gel (used to remove dead tissue)to the wound bed, skin prep the peri wound (area around the opening) and cover with border gauze dressing once daily, ordered on 4/18/24. Resident #27's initial wound physician visit on 4/17/24 revealed stage three pressure injuries to both the right and left ischium. The left ischium wound measured 3.4 centimeters (cm) by 2 cm by 0.2 cm with 100% granulation (new connective tissue) tissue and minimal drainage. The right ischium measured 1 cm by 2.5 cm by 0.2 cm with 100 % granulation tissue and no drainage. Orders were given to cleanse the wounds with Dakin's, apply skin prep to peri wounds, apply honey gel to wound beds and cover with bordered gauze dressings daily and as needed. -Review of Resident #27's care plan, progress notes and MDS assessment did not reveal any documentation which indicated the resident frequently refused care or repositioning (see interviews below). D. Staff interviews CNA #1 was interviewed on 4/23/24 at 4:10 p.m. CNA #1 said Resident #27 was changed this morning (4/23/24) when he got up and then when he was laid in bed around 2:00 p.m. CNA #1 said Resident #27 did not always tell staff when he needed to be changed so staff should be checking in with him every couple of hours. CNA #1 was aware Resident #27 had a wound on his bottom and should be offered repositioning. CNA #1 said Resident #27 often refused to be repositioned when asked, however, she said the resident had not refused care that day (4/23/24). CNA #1 did not know where to document any refusal of care for repositioning. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Despite CNA #1's interview indicating Resident #27 frequently refused repositioning, the resident's EMR did not reveal documentation that the resident refused care or repositioning (see record review above). -Despite CNA #1's interview indicating Resident #27 should be offered repositioning and staff should check on him every couple of hours, the resident was not offered repositioning during continuous observations for three and half hours (see observations above). LPN #1 was interviewed on 4/23/24 at 4:21 p.m. LPN #1 said she was unaware Resident #27 had not been offered repositioning in at least three and a half hours. LPN #1 said Resident #27 would benefit from repositioning due to the pressure injuries on his bottom. The WCP was interviewed on 4/24/24 at 2:29 p.m. The WCP said he was unable to determine if Resident #27's pressure injuries were avoidable or unavoidable as he was still speaking with facility staff to determine possible causes of the wounds. The WCP said facility staff told him Resident #27 refused to change positions and preferred to sit in his recliner during the day. -However, there was no evidence of documented refusals of care (see record review above). IV. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the April 2024 CPOs, diagnoses included diabetes mellitus (abnormal blood glucose), dementia (memory impairment) and chronic kidney disease (abnormal kidney function). The 4/9/24 MDS assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. She required substantial assistance for transfers, toileting, dressing and supervision for eating. The assessment documented the resident was at risk of developing a pressure injury but did not have a pressure injury. B. Observations On 4/22/24 at 10:30 a.m. Resident #1 was sitting in her recliner leaning to her left side. On 4/22/24 at 1:35 p.m. Resident #1 was sitting in her recliner and continued to lean to her left. On 4/23/24, during a continuous observation beginning at 10:35 a.m. and ending at 2:51 p.m., Resident #1 was sitting in her recliner, leaning to her left side. At 12:22 p.m. Resident #1's lunch tray was delivered while the resident was asleep and remained sitting in the recliner. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	At 12:34 p.m. LPN #1 entered Resident #1's room, woke the resident up and offered her assistance with eating. Resident #1 said she was not having a good day because her bottom hurt. LPN #1 told Resident #1 that she got a new dressing on her bottom and the wound physician would be in the next day. -LPN did not offer repositioning to the resident. At 2:26 p.m. LPN #1 entered Resident #1's room and told the resident as soon as the CNA returned from lunch, she would assist the CNA to lay the resident in bed. Resident #1 remained sitting in the recliner leaning to her left side. -At 2:51 p.m. LPN #1 and CNA #1 entered Resident #1's room with the sit to stand mechanical lift. Resident #1 was assisted with the use of the sit to stand lift to the bathroom. Resident #1's brief was removed and was observed to have been soiled with bowel and urine. -Resident #1 was not provided with toileting or repositioning in her recliner for four hours and 15 minutes. LPN #1 collected items to complete the resident's dressing change due to the dressing being soiled. CNA #1 used the sit to stand lift to take Resident #1 out of the bathroom. The old dressing was removed and noted to be soiled with feces on the edges of the dressing. The wound bed to the coccyx was pink and moist and the area around the wound was nonblanchable (discoloration of skin that does not turn white when pressed) when the nurse pressed the surrounding tissue with her finger. The left buttock wound had eschar (dead tissue) around the upper edge of the wound and yellow tissue (slough) throughout. The surrounding tissue of the wound was nonblanchable. LPN #1 cleaned the wounds with Dakins, dried the wounds with gauze, applied skin prep to the peri wounds, added honey gel to the wound beds, and covered the wounds with a border dressing. Resident #1 told LPN #1 it hurt when the nurse was cleaning the wounds. On 4/24/24 at 1:01 p.m. Resident #1 was observed to be seated on a cushion in her recliner. The RNC touched the chair cushion without moving Resident #1 from her seated position in the recliner and identified the cushion as a standard foam cushion. The RNC identified the resident's pressure relieving mattress as an air mattress that could alternate pressure. On 4/24/24 at 2:10 p.m. Resident #1's wound dressing changes were observed with the WCP. The coccyx wound had a pink wound bed. The wound area was cleansed with Dakin's, dried with gauze, skin prep was applied to the periwound, honey gel was applied to the wound bed and the area was covered with border gauze. The left buttock wound was observed to have yellow colored tissue in the center and the upper corner of the wound was observed to have eschar (dead tissue). The wound area was cleaned with Dakin's, dried with gauze, skin prep was applied to the peri wound, honey gel was applied to the wound bed and the area was covered with border gauze. C. Record Review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #1's comprehensive care plan, dated 3/29/24, revealed potential impairment to skin related to decreased mobility with interventions of pressure reducing cushion while up in chair, pressure reducing mattress and follow facility protocol for treatment of injury, initiated 12/13/22. Apply nutrishield cream to coccyx every shift and at each incontinence episode initiated on 5/24/23 -There was no intervention for repositioning or frequent incontinent care documented on Resident #1's care plan Resident #1's 1/7/24 Braden scale assessment revealed Resident #1 was at moderate risk for developing pressure injuries. It revealed Resident #1's skin was very moist requiring extra linen changes, the resident was chair fast (requiring assistance to a chair or wheelchair) and had very limited mobility (unable to make frequent or significant changes independently). Resident #1's weekly skin assessment dated [DATE] revealed the resident had an open area starting on her coccyx but did not document a stage of the wound or measurements. It revealed Resident #1 was more comfortable lying on her sides than lying flat because lying flat caused her extreme pain. -The assessment did not document Resident #1 frequently refused repositioning (see interviews below). -There was no progress note indicating whether or not the WCP was notified of the wound and no new physician orders were added for treatment of the wound. Resident #1's weekly skin assessment dated [DATE] revealed a pressure injury to the resident's coccyx but had no measurements or narrative notes. -There was no progress note indicating whether or not the WCP was notified of the wound and no new physician orders were added for treatment of the wound. A progress note dated 4/14/24 revealed CNAs were changing Resident #1 and an open area to the resident's coccyx measuring 2 cm by 2.2 cm was found. The area was cleaned and a dry dressing was applied. Resident #1 also had a shearing area to the left buttock measuring 3 cm by 2.2 cm, the area was cleansed with normal saline and nutrashield cream was applied. The nurse notified the unit manager to speak with Resident #1's representative about getting a new cushion for her wheelchair. -The wounds were initially identified by a nurse on 4/1/24, however, there was no further documentation of the wounds or treatment orders obtained until 4/14/24. -There was no documentation to indicate whether a new cushion was provided to Resident #1. Resident #1's April 2024 CPO documented the following physician's orders: Pressure relief mattress: check inflation and settings every shift, ordered on 2/2/24. Apply nutrishield cream to coccyx every shift and with every incontinence episode, ordered on 5/23/23. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound care order for coccyx: Clean open areas to coccyx with normal saline and apply dry dressing once daily, ordered on 4/14/23. -The order did not specify a treatment for the left buttock wound. -The order was not put into place until 13 days after the initial identification of the open area to Resident #1's coccyx. Wound care order for coccyx and left buttock, cleanse with Dakin's, apply honey gel to wound bed, skin prep the periwound and cover with border gauze once daily, ordered on 4/18/24. The WCPs initial encounter with Residents #1's wounds for the coccyx and left buttock on 4/17/24 revealed the coccyx and left buttocks were unstageable pressure injuries. The coccyx wound measured 1.1 (cm) by 1 cm by 0.1 cm and the left buttock wound measured 0.9 cm by 1.3 cm by 0.1. -Review of Resident #1's care plan, progress notes and MDS assessment did not reveal any documentation which indicated the resident frequently refused care or repositioning (see interviews below). D. Staff interviews CNA #1 was interviewed on 4/23/24 at 4:10 p.m. CNA #1 said residents should be offered toileting or repositioning every two hours to ensure they were not soiled and to off load pressure areas. CNA #1 said Resident #1 would not call if she was soiled so staff needed to offer toileting and check her for incontinence episodes. CNA #1 said Resident #1 was changed around 9:00 a.m. and then at around 3:00 p.m. (on 4/23/24). CNA #1 did not have a response as to why Resident #1 was not offered repositioning or toileting in almost six hours. CNA #1 said Resident #1 had wounds on her buttocks. -Despite CNA #1's interview indicating Resident #1 should be offered repositioning and staff should check on her every couple of hours, the resident was not offered repositioning during continuous observations for four hours and 15 minutes (see observations above). LPN #1 was interviewed on 4/23/24 at 4:21 p.m. LPN #1 said residents should be offered repositioning every two hours especially if they had pressure injuries or were at risk of developing pressure injuries. LPN #1 said repositioning would be beneficial to residents with pressure injuries to promote healing. LPN #1 was unaware if Resident #1 was not offered repositioning or toileting between 10:35 a.m. and 2:51 p.m. LPN #1 said Resident #1 had not had the pressure injuries long but would refuse staff when she was asked to reposition. LPN #1 said she had not documented any Resident #1 refusal of repositioning. -Despite LPN #1's interview indicating Resident #1 frequently refused repositioning, the resident's EMR did not reveal documentation that the resident refused care or repositioning (see record review above). The WCP was interviewed on 4/24/24 at 2:10 p.m. The WCP said he felt Resident #1's pressure injuries were avoidable but when he talked with the facility staff he was told Resident #1 refused to change positions. -However, there was no documented refusal of care (see record review above). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	V. Additional interviews The WCP was interviewed again on 4/24/24 at 2:48 p.m. The WCP said Resident #1's and #27's wounds would benefit from frequent positioning changes despite them both sitting on cushions when up in their recliners. The WCP said a pressure injury could develop within two hours and incontinence increased the risk of a wound developing or worsening. The WCP said wound textbooks recommended a resident in bed be repositioned every two to three hours and, when in a chair, they should be repositioned every two hours to offload pressure. The director of nursing (DON) was interviewed on 4/25/24 at 10:10 a.m. The DON said Resident #1 started having skin issues on 4/1/24, however, she said the floor nurse did not relay this information to the unit manager. The DON said Resident #1's skin issue was brought up again on 4/14/24 by another nurse. She said the facility started to review what could have caused the wounds and found the weekly skin documentation dated 4/1/24. The DON said the facility immediately started wound care treatment for Resident #1's wounds on 4/14/24 and had the WCP see the resident on his next wound round visit, which was 4/17/24. The DON said Resident #1 did not like to be repositioned and liked to sit in her recliner. The DON said Resident #27 did not like to be moved from his recliner but should still be offered position changes every two hours. -Despite the DON's interview indicating Resident #1 and Resident #27 frequently refused repositioning, the residents' EMRs did not reveal documentation that the residents refused care or repositioning (see record review above). -The DON did not provide any documentation for refusal of care for Resident #1 or Resident #27. The DON said residents should be repositioned every two hours to help prevent pressure injuries and promote wound healing if they had a pressure injury. The DON said if a resident refused to be repositioned it should be documented in the nurses progress notes. The DON said residents should be offered toileting upon rising, before and after meals and as needed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 40960 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of those reviews for five of five certified nurse aides. Specifically, the facility had not completed annual performance reviews for certified nurse aide (CNA) #4, CNA #5, CNA #6, CNA #7 and CNA #8, in order to determine potential training needs. Findings include: I. Facility policy and procedure -The facility did not have a performance evaluation policy per the nursing home administrator (NHA). II. Record review On 4/23/24 at 3:00 p.m. annual performance reviews were requested for CNA #4 (hired 12/10/2020), CNA #5 (hired 6/2/22), CNA #6 (hired 3/31/2008), CNA #7 (hired 8/3/2020) and CNA #8 (hired 8/3/2020). On 4/25/24 at 9:14 a.m. the NHA said CNA #4, CNA #5, CNA #6, CNA #7, CNA #8 did not have an annual performance review and had not completed annual inservice education based on the outcome of their reviews on 4/25/24 at 9:14 a.m (see interview below). Cross-reference F947 failure to ensure CNAs received adequate training as required. III. Staff interviews The NHA was interviewed on 4/25/24 at 9:14 a.m. The NHA said annual performance evaluations had not been completed and should have been completed annually. The NHA said going forward the facility would reinitiate a process to ensure all performance evaluations were completed timely, as well as inservice education based on the outcomes. The director of nursing (DON) was interviewed on 4/25/24 at 11:13 a.m. The DON said performance evaluations should be conducted annually. The DON said the facility scheduled a performance evaluation fair, however the facility was coming out of an illness outbreak and it was not well attended by staff. The DON said the facility would schedule a performance evaluation fair in the near future to complete the evaluations per the regulation.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 40960 Based on observations, record review and staff interviews, the facility failed to ensure staffing information was posted in a prominent place, readily accessible to residents and visitors. Specifically, the facility failed to post the total number of actual hours worked by the licensed and unlicensed staff directly responsible for resident care per shift. Findings include: I. Failure to have staffing posted Observations in the facility on 4/22/24 at 9:00 a.m. revealed that, on the first floor, staffing was posted and dated 4/22/24. -However, it did not include the actual working hours for the licensed and unlicensed staff. Observations in the facility on 4/23/24 at 11:15 a.m. revealed that, on the first floor, staffing was posted and dated for the previous day 4/22/24. -It did not include the actual working hours for the licensed and unlicensed staff and was not for the current day. Observations in the facility on 4/24/24 at 10:05 a.m. revealed that, on the first floor, staffing was posted and dated 4/24/24. -However, it did not include the actual working hours for the licensed and unlicensed staff. Observations in the facility on 4/25/24 at 10:15 a.m. revealed that, on the first floor, staffing was posted and dated for the previous day 4/24/24. -It did not include the actual working hours for the licensed and unlicensed staff. II. Staff interviews The director of nursing (DON) was interviewed on 4/25/24 at 11:13 a.m. The DON said on 4/23/24 a receptionist who only worked when the facility needed her to fill in was working and did not post a current staffing schedule. The DON said she was not sure why the actual working hours were not in place on the daily postings. The nursing home administrator (NHA) was interviewed on 4/25/24 at 11:15 a.m. The NHA said he was aware that the regulation required the actual working hours to be included on the daily staffing post and was not sure why it was not included. The NHA said he would immediately correct the posting.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47064 Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly in one of three medication carts and one of two medication storage rooms. Specifically the facility failed to: -Ensure expired medications were not stored with current medications in the medication carts; -Ensure insulin pens (medication used for glucose control) were labeled with resident names and open dates; and, -Ensure medications were not stored in a dormitory style refrigerator/freezer combination. Findings include: I. Professional reference According to the Vaccine Storage and Temperature Monitoring Equipment (January 2023), retrieved on 4/25/24 from https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, Do not store any vaccines in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units have a single exterior door and an evaporator plate/cooling coil, usually located in the freezer compartment. These units pose a significant risk of freezing vaccines, even when used for temporary storage. According to the Lantus glargine insulin package insert, retrieved on 4/29/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/021081s076lbl.pdf, When not in use store in refrigerated temperatures of 36 to 46 degrees. When in use can be kept at room temperature for up to 28 days. According to the Trulicity package insert, retrieved on 5/1/24 from https://uspl.lilly.com/trulicity/trulicity.html#mg, Store Trulicity in the refrigerator, do not freeze Trulicity. Do not use Trulicity if it has been frozen. II. Facility policy and procedure The Medication Storage policy, dated January 2023, was received from the nursing home administrator (NHA) on 4/25/24 at 8:47 a.m. It read in pertinent part, Medications and biologicals were stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe and effective drug administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note the date on the label for insulin vials and pens when first used. The refrigerator should be kept clean and frost free. To protect refrigerated medications from freezing. Outdated, contaminated, discontinued, or deteriorated medications and those in containers that were cracked, soiled or without secure closure were immediately removed from stock. III. Observations and staff interviews On 4/24/24 at 9:53 a.m. the Juniper medication cart was observed with licensed practical nurse (LPN) #3. The following items were found: -An open bottle of one milligram (mg) of Melatonin (sleep aid medication) that expired in January 2024. One Lantus insulin pen had no resident name or open date on the pen. LPN #3 said the Melatonin should have been removed from the medication cart when it expired in January. LPN #3 said the Lantus insulin pen should have had a resident's name on it to ensure it was used for only one resident and an open date to ensure the medication was used before the use by date of 28 or 30 days from first use. LPN #3 said if insulin was used past the open date it was not as effective for treating high blood glucose levels for the resident. -However, according to the medication package insert, Lantus insulin should be discarded after 28 days (see professional reference above). The Juniper medication room was observed on 4/24/24 at 10:00 a.m. with LPN #3. The medication refrigerator was dormitory style. The freezer compartment had ice build up around it and the freezer lid was unable to open due to the amount of ice build up. -The ice build up was touching a box of Trulicity (injectable medication for treatment of high blood glucose) that was on the top shelf of the refrigerator. LPN #3 was interviewed on 4/24/24 at 10:04 a.m. LPN #3 said she did not feel the medications in the refrigerator were compromised due to the ice build up from the freezer. LPN #3 said she did not know medications and injectables were not to be stored in a dormitory style refrigerator. The director of nursing (DON) was interviewed on 4/25/24 at 10:10 a.m. The DON said it was the responsibility of the nurses to ensure medication carts were kept free of expired medications. The DON said the night shift staff had a schedule to indicate when to clean the medication carts and check the carts for expired medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said open dates on medications, such as insulin, were important to ensure the medication was not used past the recommended use date and that insulins were good for 28 days. The DON said medications should have residents' names on them to identify who they belonged to and multiple dose medications needed to be resident specific. The DON said the medication refrigerators were monitored daily for temperatures to ensure medications were stored appropriately. The DON said she did not know medications should not be stored in a dormitory style refrigerator. The DON said she was not concerned that any of the medications in the refrigerator were compromised as the temperature logs did not document any temperatures out of range.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47064 Based on observations and interviews, 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 and infection. Specifically the facility failed to: -Ensure a foley catheter was stored in a sanitary manner; and, -Ensure mechanical lifts were cleaned between residents. Findings include: I. Foley catheter A. Facility policy and procedure The Foley Catheter policy and procedure, dated November 2022, was received from the nursing home administrator (NHA) on 4/25/24 at 8:47 a.m. It read in pertinent part Foley catheters are to be placed in a dignity bag to provide privacy for the resident. B. Observations and resident interview On 4/22/24 at 12:46 p.m. Resident #69' s foley catheter collection bag was on the floor next to the resident who was lying in bed. On 4/22/24 at 2:26 p.m. Resident #69' s foley catheter bag was on the floor as the resident was sitting up in bed. On 4/24/24 at 9:25 a.m. Resident #69 was sitting up at the bedside eating breakfast and the foley catheter bag was laying on the floor. Resident #69 said his catheter bag was always on the floor unless he was in his wheelchair. On 4/24/24 at 9:32 a.m. registered nurse (RN) #1 said Resident #69' s foley catheter bag was on the floor. C. Staff interviews RN #1 was interviewed on 4/24/24 at 9:29 a.m. RN #1 said catheter bags should not be stored on the floor as it could lead to the resident getting a urinary tract infection. RN #1 said the foley catheter bag should be stored in a dignity bag or placed into a basin on the floor to provide a barrier from the floor. She said the catheter bag could also be hung above the ground using a hook. The director of nursing (DON) was interviewed on 4/25/24 at 10:10 a.m. The DON said foley catheter bags should not be on the floor as the floor was dirty and it could lead to infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Multiple use durable medical equipment A. Professional reference According to The Centers for Disease Control and Prevention (CDC) Disinfection and Sterilization, retrieved on 4/29/24 from https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html#anchor_1555613917. It read in pertinent part, Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis such as after use on each patient. B. Observation On 4/23/24 at 3:28 p.m. certified nurse aide (CNA) #1 was transferring Resident #1 from the recliner to the bathroom with the use of the sit to stand mechanical lift. After transferring Resident #1 from the bathroom to the recliner, CNA #1 proceeded to use the sit to stand lift to transfer Resident #1' s roommate from bed to the bathroom. -CNA #1 did not disinfect the sit to stand mechanical lift between residents. CNA #1 did not disinfect the sit to stand lift after it was in the bathroom and she left it in the resident' s room. C. Staff interview CNA #1 was interviewed on 4/23/24 at 4:10 p.m. CNA #1 said it was the responsibility of the night shift CNAs to clean the sit to stand mechanical lift. Licensed practical nurse (LPN) #1 was interviewed on 4/23/24 at 4:21 p.m.LPN #1 said the mechanical lifts should be cleaned between each resident with the purple top sanitization wipes or sprayed with Oxivir disinfectant. LPN #1 was unsure where the CNAs kept the sanitization wipes with the purple lid to clean the mechanical lifts between uses but she had some locked in her medication cart. The DON was interviewed on 4/25/24 at 4:10 p.m. The DON said the sit to stand mechanical lift should be cleaned between residents with the sanitization wipes with the purple lid to disinfect them. The DON said the flushing mechanism of the toilet could splatter droplets from the toilet onto the sit to stand lift, therefore it should be cleaned after taking a resident to the restroom to prevent the spread of bacteria.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40960 Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received the required 12 hours of annual in-service training for continued competence. Specifically, the facility failed to ensure one CNA (#9) of five CNAs received 12 hours of annual training. Findings include: I. Facility policy and procedure The Team Member Orientation and Training Program policy, revised July 2018, was provided by the nursing home administrator (NHA) on 4/25/24 at 4:33 p.m. It read in pertinent part, The Community recognizes the need to present comprehensive orientation and training programs designed to prepare associates to successfully perform their role. Successful orientation and training programs play a critical role in determining the effectiveness of the community in realizing its values, goals, and strategies. All team members are expected to participate in training programs that facilitate acquisition of specific skills and knowledge. These programs teach associates how to perform particular activities or a specific job, become proficient in a skill, or learn about policies, procedures, regulations and requirements. The Community strives to conduct a regular training needs analysis to determine appropriate training topics. Some issues examined in this needs analysis include community vision and goals, successful onboarding, and legal and regulatory compliance. The Executive Director or designee is responsible for developing, implementing and evaluating the orientation and training program. II. Training review A review of CNA #9' s training was reviewed on 4/24/24 at 1:15 p.m. It revealed CNA #9 had only completed . 75 hours of the required 12 hour continued education units (CEU). III. Staff interviews The director of nursing (DON) was interviewed on 4/25/24 at 11:13 a.m. The DON said all CNAs should have completed 12 hours of CEU annually. The DON said CNA #9 had been written up for not completing his 12 hours of CEU. The NHA was interviewed on 4/25/24 at 12:01 p.m. The NHA said the facility just hired a new staff development coordinator who would be responsible for tracking and ensuring the CNAs were completing their required training. The NHA said CNA #9 was a good CNA and he was not sure why he had not completed most of his annual training.