| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 065370 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Littleton | 1500 W Mineral Ave<br>Littleton, CO 80120 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064<br><br>Based on observations, record review and interviews, the facility failed to honor resident choices for one (#201) of one resident out of 41 sample residents.<br><br>Specifically, the facility failed to ensure Resident #201's rehabilitation therapy was scheduled per her preference.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Resident Rights policy and procedure, revised on 9/10/24, was received from the nursing home administrator (NHA) on 11/11/24 at 10:54 a.m. It revealed in pertinent part At the time of admission and periodically throughout their stay, the facility will inform each resident, orally and in writing, of their rights. The resident has a right to dignified existence, self-determination, and communication with and access to persons and services [NAME] and outside the facility.<br><br>The resident has the right to reside and receive services in the facility with reasonable accommodations of resident preferences except when to do so would endanger the realty and safety of the resident or other residents.<br><br>The resident has a right to choose activities. Schedules (including sleeping and waking times), health care and providers of healthcare services consistent with his or her interests, assessments, plan of care.<br><br>The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>The resident has a right to organize and participate in resident groups in the facility.<br><br>II. Resident #201<br><br>A. Resident status<br><br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #201, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included fracture of the left femur (broken bone of the upper leg) and hypertension (high blood pressure).<br><br>The 11/4/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required maximum staff assistance with transfers and partial assistance from staff for toileting and dressing.<br><br>B. Resident interview<br><br>Resident #201 was interviewed on 11/5/24 at 9:55 a.m. She said she did not know what her schedule was for therapy. Resident #201 said therapy would just show up and take her to therapy. Resident #201 said she would like to know what time therapy was so she could participate in other activities in the facility.<br><br>Resident #201 said she was afraid to attend activities because she did not want to miss her therapy session, as this was a main reason she was in the facility.<br><br>Resident #201 said she would like to know when therapy was coming so she could ensure she took pain medication an hour prior to aid in pain control as her pain increases during therapy sessions.<br><br>Resident #201 was interviewed a second time on 11/7/24 at 9:05 a.m. She said she still did not know when therapy was coming for her. Resident #201 said she had already worked with therapy this morning and was thankful she had already asked the nurse for pain medication otherwise she may not have been able to do it when they came for her.<br><br>C. Observations<br><br>On 11/6/24 at 8:54 a.m. an unidentified therapy personnel was observed talking with an unidentified nurse that was assigned to Resident #201 about her pain medications. The unidentified nurse said the resident had received her pain medication approximately 15 minutes prior. The unidentified therapist said she was glad that Resident #201 had pain medication. The unidentified therapist said Resident #201 refused to do therapy without pain medications on board.<br><br>At 9:05 a.m. Resident #201 was walking with a walker and the same unidentified therapist down the hallway. The unidentified therapist asked Resident #201 what her pain level was while walking. Resident #201 said her pain was a 5 out of 10.<br><br>D. Record review<br><br>The admission/readmission collection tool used by the facility failed to show Resident #201 therapy preferences were assessed on admission.<br><br>The 10/31/2 comprehensive care plan failed to reveal Resident #201 preferences regarding therapy.<br><br>The November 2024 CPOs revealed the following orders for therapy services:<br><br>-Ordered on 10/31/24 physical therapy (PT) five times a week.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Ordered on 10/31/24 occupational therapy (OT) five times a week.<br><br>A review of Resident #201's electronic medical record (EMR) did not reveal documentation indicating the facility had assessed Resident #201's preferences.<br><br>A review of Resident #201's EMR did not indicate Resident #201 had a care conference since admission to determine the residents therapy preferences.<br><br>III. Staff interviews<br><br>The director of rehabilitation (DOR) was interviewed on 11/7/24 at 9:11 a.m. The DOR said she attended the resident's care conferences. She said at the care conferences she asked the residents their preferences, such as male or female providers and the time of day they preferred to have therapy. The DOR said she did not document the resident preferences anywhere in the EMR.<br><br>The DOR said she did not attend Resident #201's care conference. She said she usually sent another therapist in her place in the event she was unable to attend. The DOR said physical therapist (PT) #2 usually went in her place but she said PT #2 did not attend Resident #201's care conference.<br><br>The DOR said she had not checked with Resident #201 since her admission to see her preferences.<br><br>PT #2 was interviewed on 11/7/24 at 9:31 a.m. PT #2 said she scheduled the resident's therapy based on their personal needs, such as needing pain medications prior to therapy. PT #2 said she would check in with the nurse to assess who had received pain medication prior to working with them.<br><br>PT #2 said she would sometimes have residents who preferred to have therapy at a certain time and she would then set up a routine with them if the resident requested it.<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:38 p.m. The DON said the admission paperwork had questions for residents regarding their preferences. She said the case manager also went and spoke with residents on their preferences. The DON said during care conferences all departments meet with the resident to address questions or concerns including the therapy department. The DON said the therapy department should set up preferences with residents as far as times or type of care provider as needed. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163<br><br>Based on record review and staff interviews, the facility failed to incorporate the recommendations from the PASRR (preadmission screening and resident review) Level II determination and evaluation report into the assessment, care planning and transition of care for one (#39) of five residents reviewed for PASRR out of 41 sample residents.<br><br>Specifically, the facility failed to ensure Resident #39 was followed by a psychiatrist for medication management, per the resident's PASRR Level II recommendations.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Pre-Admission Screening and Resident Review (PASRR) policy and procedure, reviewed September 2024, was provided by the nursing home administrator (NHA) on 11/8/24 at 1:45 p.m. It revealed in pertinent part, Incorporate the recommendations from the PASRR Level II determination and the PASRR evaluation report into a resident's assessment, care planning, and transitions of care.<br><br>Recommendations from PASRR Level II determination and PASRR evaluation report are to be incorporated into the person-centered care plan as well as in transitions of care.<br><br>As part of the PASRR process, the facility is required to notify the appropriate state mental health authority or state intellectual disability authority when a resident with a mental disorder (MD) or intellectual disability (ID) has a significant change in their physical or mental condition. This will ensure that residents with a mental disorder or intellectual disability continue to receive the care and services they need in the most appropriate setting.<br><br>II. Resident #39<br><br>A. Resident status<br><br>Resident #39, age 81, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included schizoaffective disorder (mental health condition that occurs when a person has symptoms of both schizophrenia and a mood disorder at the same time), chronic kidney disease stage 3 and dementia with behavioral disturbance.<br><br>The 10/11/24 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 required minimal assistance with her activities of daily living (ADL).<br><br>The assessment indicated the resident had hallucinations and did not have any episodes of refusing care during the assessment period.<br><br>B. Record review<br><br>(continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The behavior care plan, revised 7/29/24, documented Resident #39 had episodes of paranoia, hallucinations and talked to people who were not there. The interventions included administering medications as ordered, providing a psychiatric consult as indicated and providing redirection and reassurance as needed.<br><br>The 5/14/21 PASRR Level two evaluation recommended Resident #39's medications and symptoms of psychosis should be monitored by a psychiatric medication prescriber.<br><br>-A review of the resident's electronic medical record (EMR) revealed the most recent psychiatric provider visit for Resident #39 was on 1/24/24.<br><br>-There was no documentation in Resident #39's EMR to indicate why the resident had not been seen by the psychiatric provider since 1/24/24.<br><br>C. Staff interviews<br><br>Certified nurse aide (CNA) #7 was interviewed on 11/7/24 at 11:30 a.m. CNA #7 said Resident #39 talked to herself often. He said he would check on her to ensure she was okay when she would have those episodes.<br><br>Licensed practical nurse (LPN) #7 was interviewed on 11/7/24 at 11:51 a.m. LPN #7 said Resident #39 had active delusions, heard voices and would talk to herself. She said when Resident #39 heard voices, she would ask the resident if the voices were getting worse or wanted to harm her.<br><br>The social services director (SSD) and the social services assistant (SSA) were interviewed together on 11/7/24 at 1:55 p.m. The SSD said Resident #39 had active delusions, often talked to herself and had a diagnosis of schizoaffective disorder.<br><br>The SSD said the facility had a psychiatric provider but that provider was not involved in the psychotropic medication management for residents. She said Resident #39 was not actively being followed by a psychiatric provider. She said she was not aware the resident's PASRR Level two recommended the resident was to be followed by a psychiatrist for medication management.<br><br>The SSA said Resident #39 was very calm and personable.<br><br>The NHA was interviewed on 11/7/24 at 4:39 p.m. The NHA said all PASRR Level II recommendations should be followed. She said Resident #39 had refused follow-up with psychiatric care. She said the refusal should be documented in the resident's medical record.<br><br>-However, Resident #39's EMR did not reveal any documentation that the resident had refused to be seen by a psychiatrist (see record review above).<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:21 p.m. The DON said PASSR Level II recommendations should be followed and implemented timely. She said if a resident refused psychiatric services, the refusal should be documented in the resident's medical record. |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163<br><br>Based on observations, record review and interviews the facility failed to ensure one (#66) of one resident with limited range of motion received the appropriate treatment and services out of 41 sample residents.<br><br>Specifically, the facility failed to ensure Resident #66's hand brace, used for his left hand contracture, was included in the restorative program to include how often and duration for donning (putting on) and doffing (taking off), had a physician's order in place and was included in the comprehensive care plan.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Restorative policy, revised 8/7/21, was provided by the nursing home administrator (NHA) on 11/8/24 at 1:45 p.m. It read in pertinent part, To promote the resident's optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring a resident's assessments and indicators. Nursing assistants must be trained in techniques that promote resident involvement in restorative activities.<br><br>Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities on activities of daily living do not diminish, this includes the facility ensuring that a resident is given the appropriate treatment and services to maintain or improve their ability to carry out activities of daily living.<br><br>A resident may be started on a restorative nursing program when he or she is admitted with restorative needs.<br><br>Restorative nursing functions can be within one of the following categories: range of motion (active and passive), splint or brace assistance, bed mobility, transfers, walking, dressing and or grooming, eating and or swallowing, amputation/prosthesis care, communication, toileting program, bladder retraining.<br><br>II. Resident #66<br><br>A. Resident status<br><br>Resident #66, age 72, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following nontraumatic intracerebral hemorrhage (brain bleed) affecting left non-dominant side, vascular dementia unspecified severity with agitation and a contracture of muscle to the left hand.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 9/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial to maximum assistance with mobility and transfers.<br><br>The MDS assessment documented Resident #66 was receiving restorative therapy for active range of motion and for splint or brace assistance.<br><br>B. Resident interview and observations<br><br>On 11/5/24 at 11:59 a.m. a navy blue hand brace was strapped to Resident #66's wheelchair, which was located in the hallway. Resident #66 was lying in bed.<br><br>Resident #66 was interviewed on 11/5/24 at 4:13 p.m. Resident #66 said he had a contracture to his left hand. He said he only wore the navy blue brace for only a few hours a day. He said he wore another small brace (palm guard) all of the time unless he was taking a shower. At this time he was wearing the palm guard which was smaller than the blue brace and wrapped around his palm. His left hand was in a fist position.<br><br>Resident #66 said the facility did not have a set time to put his other brace (navy blue) on his left hand. He said he never knew when it would be put on his hand.<br><br>On 11/6/24 at 11:26 a.m. restorative nurse aide (RNA) #1 entered Resident #66's room. RNA #1 asked Resident #66 if she could place the navy blue brace on his left hand. The brace was lying in Resident #66's wheelchair. RNA #1 wiped it down and applied it to Resident #66's left hand.<br><br>C. Record review<br><br>The activities of daily living (ADL) care plan, revised on 8/28/24, documented Resident #66 had left-sided weakness due to a stroke. It indicated the resident should use a palm guard<br><br>The functional goal care plan, revised on 4/30/24, documented Resident #66 had limited physical mobility due to neurological deficits and weakness. The interventions included active range of motion for both lower extremities and both upper extremities.<br><br>-A review of the comprehensive care plan did not indicate the use of the blue hand brace that was observed on the resident's arm.<br><br>The 10/30/24 restorative program evaluation documented the RNA and the director of restorative therapy discussed Resident #66's restorative plan of care. The recommendation was to continue passive range of motion to the resident's left hand and continue use of the palm guard.<br><br>-It did not address the use of the blue hand splint that was observed on the resident's left hand.<br><br>-The facility failed to ensure the hand brace used for Resident #66's left hand contracture was included in the restorative program and comprehensive care plan for Resident #66, to include how often and the duration the brace should be applied to Resident #66's left hand.<br><br>(continued on next page) |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Review of Resident #66's electronic medical record (EMR) did not reveal a physician's order indicating when Resident #66 was to wear the blue brace.<br><br>D. Staff interviews<br><br>Certified nurse aide (CNA) #7 was interviewed on 11/7/24 at 11:30 a.m. CNA #7 said Resident #66 had a contracture to the left hand. He said there was no documented schedule of when to don or doff the hand brace or for how long it should be placed on Resident #66's left hand. He said the RNA was responsible to place the brace onto the resident's left hand. CNA #7 said sometimes he would assist Resident #66 with donning the hand brace if he had not worn it yet that day. He said Resident #66 wore the palm protector all of the time.<br><br>RNA #1 and licensed practical nurse (LPN) #8 were interviewed together on 11/7/24 at 2:28 p.m. RNA #1 said Resident #66's restorative program only included passive range of motion to Resident #66's left hand. RNA #1 said Resident #66 also had a brace to the left hand, but the brace was not included in the resident's restorative program. RNA #1 said she did not know how often or for how long the hand brace should be applied to Resident #66's left hand. RNA #1 said she thought there was a verbal physician's order for the brace.<br><br>LPN #8 said she provided oversight for the restorative program. She said the palm guard was the only brace being tracked for Resident #66. She said there was not a physician's order for the hand brace, it was not part of the comprehensive plan of care, nor the restorative program for Resident #66.<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:21 p.m. The DON said the therapy department assisted in the development of the restorative program, but she was not sure who was responsible for the program.<br><br>The DON said Resident #66's use of the left hand brace should have been included in the restorative program. She said it should indicate how often the brace should be placed on the resident's hand and for how long. She said the left hand brace should be included in the comprehensive care plan and have a physician's order. |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160<br><br>Based on interviews and record review, the facility failed to ensure three (#89, #59 and #67) of three residents out of 41 sample residents received adequate supervision to prevent accidents.<br><br>Resident #89, who had a history of falls, was admitted to the facility on [DATE] after sustaining multiple pelvic fractures related to a fall sustained at home. The facility initiated a fall care plan on 11/15/23 which identified the resident was at risk for falls due to a gait imbalance (unsteady gait), poor cognition and a history of falls. The care plan documented generalized fall interventions which were not specific to the resident. The facility completed an initial fall risk assessment on 11/15/23 which was not consistent with the resident's care plan and inaccurately documented the resident had no history of falls, was independent and ambulated without problems using an assistive device.<br><br>On 11/16/23, one day after the resident's admission to the facility, nursing documentation identified Resident #89 had poor safety awareness and did not use her call light for assistance. However, the facility failed to implement further person-centered fall interventions for the resident.<br><br>Resident #89 sustained unwitnessed falls without injury on 12/16/23 and 2/4/24. The facility failed to implement new resident-specific fall interventions after either of the falls.<br><br>On 7/17/24, Resident #89 sustained a third fall that resulted in the resident sustaining a sternal contusion (bruising of the flat bone in the center of the chest) and three left-sided rib fractures which required hospitalization in the intensive care unit. The facility implemented a fall intervention for a call, don't fall sign to be hung in the resident's room. However, per documentation, the resident had already been identified to not use her call light to call for assistance and the facility did not identify further interventions.<br><br>On 8/5/24 Resident #89 sustained a fourth fall that resulted in a laceration to her forehead which required a transfer to the hospital for staples to the laceration. The hospital identified the resident had additionally sustained rib fractures to different ribs than her 7/17/24 rib fractures. An intervention for a checklist to anticipate the resident's needs was implemented.<br><br>Following the fall on 8/5/24, Resident #89 experienced a decline in condition, however, the facility did not implement further fall interventions. On 8/22/24, Resident #89 sustained a fifth fall which resulted in the resident being transferred to the hospital where the resident was diagnosed with a left femur (thigh bone) fracture. The resident returned to the facility on hospice services and passed away at the facility on 8/23/24.<br><br>Furthermore, Resident #59, who had a history of falls, sustained a fall on 1/27/24 without injury. The facility failed to identify new person-centered fall interventions for the resident. On 5/26/24 Resident #59 sustained a second fall which resulted in the resident being transferred to the hospital where she was diagnosed with a left pubic (lower pelvic bone) fracture. Despite the resident's fall with injury, the facility failed to implement additional fall interventions for the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Additionally, Resident #67, who was severely cognitively impaired, was admitted on [DATE]. The facility identified the resident as a fall risk and implemented generalized fall interventions which were not specific to the resident. On 10/12/24 Resident #67 sustained a fall which resulted in the resident being transferred to the hospital where she was diagnosed with a right wrist fracture.<br><br>Due to the facility's failures to to ensure fall risk assessments were completed accurately and timely and person-centered fall interventions were implemented, Resident #89, Resident #59 and Resident #67 sustained falls which resulted in major injuries.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Fall Management policy and procedure, dated 4/7/22, was provided by the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It read in pertinent part, The facility will assess the resident upon admission, readmission, quarterly, with change in condition, and with any fall event for any fall risks and will identify appropriate interventions to minimize the risk of injury related to falls. During the admission and readmission process, a care plan will be developed and initiated by the admitting nurse on any residents assessed to be at risk for falls.<br><br>The interdisciplinary team (IDT) will review any additional fall risk indicators and revise the resident's care plan as indicated. Accurate and thorough assessment of the patient is fundamental in determining indicators for potential falls.<br><br>II. Resident #89<br><br>A. Resident status<br><br>Resident #89, age greater than 65, was admitted on [DATE] and passed away at the facility on 8/23/24. According to the August 2024 computerized physician orders (CPO), diagnoses included generalized weakness, history of falling, difficulty in walking, localized edema, multiple fractures of the pelvis, multiple fractures of ribs (left side) and anemia.<br><br>The 8/9/24 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. It revealed the resident was independent for sit to stand and toilet transfers.<br><br>The MDS assessment indicated the resident had sustained two falls resulting in major injuries.<br><br>B. Record review<br><br>The 11/15/23 admission fall risk assessment documented a fall risk score of 16 for the resident. The assessment documented Resident #89 had no falls, was independent and ambulated without problem with an assistive device.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 was admitted with multiple pelvic fractures related to a fall sustained at home, had a history of repeated falls, was observed with an unsteady gait with the use of an assistive device and was prescribed a diuretic medication which had the potential to contribute to falls (see care plan below).<br><br>The fall care plan, initiated 11/15/23, documented Resident #89 was at risk for falls related to gait imbalance, poor cognition, and a history of falls with a goal that the resident would not sustain a serious injury requiring hospitalization related to falls. The interventions included assisting the resident with activities of daily living (ADL) as needed, placing the call light within the resident's reach, completing a fall risk assessment, and orienting Resident #89 to her room.<br><br>The 11/16/23 nurse progress note documented Resident #89 had required frequent monitoring related to poor safety awareness and not using her call light prior to ambulating. Resident #89 had an unsteady gait even with the use of her front wheeled walker. Resident #89 did not utilize call light for assistance.<br><br>-However, the facility failed to update the care plan and implement fall interventions after the above documented safety concerns.<br><br>The 11/21/23 physician's admission progress note documented Resident #89 had generalized weakness, chronic debility that required assistance with self-care, fall precautions and required prompt pericare.<br><br>The ADL care plan, initiated 11/29/23, documented Resident #89 had a self-care performance deficit related to generalized weakness. The interventions included encouraging the resident to participate in ADLs to the fullest extent possible, encouraging the resident to use the call light for assistance, praising all efforts at self-care and reporting any changes, potential for improvements, reasons for deficit, expected course or decline in function.<br><br>The urinary incontinence care plan, initiated 11/29/23, documented Resident #89 had urinary incontinence. The pertinent interventions included assisting Resident #89 with toileting as needed and performing pericare as needed.<br><br>1. Fall incident on 12/16/23<br><br>The 12/16/23 progress note documented Resident #89 sustained an unwitnessed fall. Resident #89 was found seated on the floor under a tray table with her back against the nightstand after the resident was heard calling out for help.<br><br>The 12/18/23 fall risk assessment completed after the fall documented a fall risk score of 18 for the resident. The assessment indicated Resident #89 was independent and continent of bowel and bladder, had one to two relevant health conditions or risk factors and had only been taking one to two medications that increased her fall risk.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 had been care planned as being incontinent and prescribed a diuretic medication, had more than three relevant conditions (anemia, heart failure, edema, pelvic fractures, hearing impairment and depression) that could contribute to falls and was taking three or more relevant medications which had the potential to contribute to falls.<br><br>-A review of Resident #89's fall care plan revealed the care plan was not updated with new person-centered fall interventions following the resident's fall on 12/16/23.<br><br>2. Fall incident on 2/4/24<br><br>The 2/4/24 nurse progress note documented Resident #89 was found on the bathroom floor after an unwitnessed fall. The resident reported hitting her head but denied losing consciousness. Resident #89 complained of left shoulder pain after the fall, which improved with the administration of acetaminophen (Tylenol).<br><br>The 2/5/24 x-ray result was negative for a fracture to the resident's left shoulder.<br><br>A review of the resident's electronic medical record (EMR) did not reveal a determination of the cause of the fall or a root cause analysis.<br><br>The 2/5/24 fall risk assessment completed after the fall documented a fall risk score of 13 for the resident. The assessment indicated Resident #89 was independent, continent of bowel and bladder, had one to two relevant health conditions or risk factors that could contribute to falls and was taking one to two medications that increased the resident's fall risk.<br><br>-However, the fall risk assessment was documented inaccurately and was not consistent with the resident's care plan. Resident #89 was incontinent, had more than three relevant conditions and medications that increased her fall risk and was taking three or more relevant medications which had the potential to contribute to falls.<br><br>Based on the inaccurate assessment, Resident #89's fall risk score decreased indicating she was less of a fall risk, however, since she had been admitted , she had sustained two falls.<br><br>A review of Resident #89's fall care plan revealed the care plan was not updated with new person-centered interventions following the resident's fall on 2/5/24.<br><br>3. Fall incident on 7/17/24<br><br>The 7/17/24 nurse progress note documented Resident #89 sustained an unwitnessed fall and reported hitting her head and back. Redness was noted to the left side of the scalp and the left lumbar area. Resident #89 was sent to the hospital for further studies.<br><br>-The progress note did not contain any further information regarding the fall including location and cause of the fall.<br><br>The 7/17/24 computed tomography (CT) scan results from the hospital documented the resident sustained posterior left-sided fractures to ribs #4, #7 and #11.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The resident's fall care plan was updated on 7/18/24 and identified Resident #89 sustained a fall with major injury. The updated intervention included placing a call don't fall sign in the resident's room.<br><br>-However, per documentation, the resident had already been identified to not use her call light to call for assistance and the facility did not identify further fall interventions.<br><br>The ADL care plan was revised on 7/18/24 and identified Resident #89 had sustained a recent fall with multiple rib fractures which caused a decrease in mobility.<br><br>-There were no new interventions added to the care plan following the resident's fall on 7/17/24.<br><br>The 7/19/24 fall risk assessment completed after the fall documented a fall risk score of 20 for the resident.<br><br>The 7/20/24 nurse progress note documented Resident #89 had been non-compliant with safety throughout the night. Resident #89 had repeatedly walked to the bathroom without calling for help. Resident #89 had been educated by staff to call for assistance and had been apologetic, yet still continued to not call for assistance. Resident #89 required the floor to be decluttered multiple times by the nursing staff, however, Resident #89 had been observed frequently stepping on or over her oxygen tubing.<br><br>-However, the facility failed to update the care plan and implement additional fall interventions after the above documented safety concerns.<br><br>4. Fall incident on 8/5/24<br><br>A review of the resident's EMR revealed documentation that Resident #89 sustained a fall and was transferred to the emergency department and returned on 8/6/24 with a laceration to the right forehead, which required staples and newly identified rib fractures.<br><br>The resident's fall care plan was revised on 8/5/24 to include a new fall intervention of a checklist to anticipate the resident's needs.<br><br>The 8/16/24 nursing progress note documented Resident #89 had a significant decline, which included confusion, lethargy and poor appetite.<br><br>-However, the facility failed to update the care plan and implement additional fall interventions after Resident #89's significant decline was identified.<br><br>5. Fall incident on 8/22/24<br><br>The 8/22/24 nursing progress note documented the physician was notified of the x-ray result which indicated a left femur fracture.<br><br>-The progress note did not indicate the resident had sustained a fall or the reason the x-ray was ordered in the first place.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The fall care plan was updated on 8/23/24 (the day after the x-ray was obtained) and identified Resident #89 sustained a left femur fracture related to a fall. New fall interventions included anticipating and meeting the resident's needs, bed in lowest position at all times and educating resident/family/caregivers about safety reminders and what to do if a fall occurred.<br><br>The 8/23/24 nurse progress note documented Resident #89 was assessed at 5:40 p.m. with an absence of breathing. Chest auscultation (listening with a stethoscope) revealed the absence of heart sounds and breathing which was confirmed with a second nurse at 5:45 p.m.<br><br>C. Staff interviews<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:24 p.m. The DON said a fall risk assessment should be completed during the admission process along with a fall care plan listing the interventions related to the fall risk assessment. The DON said after a resident sustained a fall, the nurse should assess the resident for injury and neurological status and notify the physician, the family and the DON.<br><br>The DON said the fall risk assessment, care plan, and documented interventions should be updated after a sustained fall. The DON said a root cause analysis should be completed the following day with the IDT. The DON said there should be a weekly reassessment to ensure that the updated fall interventions were effective.<br><br>The DON said Resident #89 had sustained multiple falls throughout her time at the facility and she had three falls with confirmed major injuries. She said she was not the DON at the time the resident was in the facility, but based on a review of the resident's EMR, the facility did not implement person-centered interventions following each fall, nor did the facility identify the root cause of the falls. The DON said the root cause analyses that were completed for only three of Resident #89's falls repeated the circumstances of the fall but did not identify the cause.<br><br>The DON said each fall risk assessment should be completed accurately with a comprehensive look at the resident to ensure the accurate fall risks were identified. She said Resident #89's fall risk score should not have decreased after she had sustained a fall with a major injury.<br><br>The DON said fall prevention had been an area of improvement that the facility had identified during the survey process, after fall investigations had been requested. She said she had begun to implement care plan updates for residents throughout the facility.<br><br>50219<br><br>III. Resident #59<br><br>A. Resident status<br><br>Resident #59, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia, osteoporosis, glaucoma and history of falling.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The 10/29/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of nine out of 15. The resident required partial to moderate assistance with most activities of daily living (ADL). The resident was independent for transfers. The resident was frequently incontinent of both bowel and bladder.<br><br>The MDS assessment indicated the resident had not sustained any recent falls.<br><br>B. Record review<br><br>The fall care plan, initiated on 3/16/22, revealed Resident #59 was at risk for falls due to weakness, difficulty with gait, history of falls and poor safety awareness. Pertinent interventions included anticipating and meeting the resident's needs (initiated on 8/29/23), assisting with ADLs as needed (initiated on 3/16/22), having the call light within reach (initiated on 3/16/22), orienting the resident to her room (initiated on 3/16/22) and keeping items of personal importance within reach (initiated on 3/16/22).<br><br>-The care plan did not reveal any new interventions added after Resident #59's falls on 1/27/24 or 5/26/24 (see risk management reports below).<br><br>A risk management report, dated 1/27/24 at 3:05 p.m., revealed Resident #59 had an unwitnessed fall while trying to transfer herself to a chair. The report revealed Resident #59 did not have any apparent injuries and did not complain of any pain. Resident #59 said she was trying to get to her chair and slipped. Resident #59 was assessed by a member of the nursing staff, did not have any apparent injuries and her vitals and neurological assessments were both at baseline following the fall.<br><br>-The report did not reveal any root cause analysis to identify the reason for the resident's fall.<br><br>The report did not identify any new interventions added to prevent further falls for Resident #59.<br><br>A risk management report, dated 5/26/24 at 1:50 a.m., revealed Resident #59 had an unwitnessed fall while trying to ambulate to the bathroom. The report revealed Resident #59 was heard crying for help by the nursing staff and found against the wall on her side. Resident #59 was trying to go to the bathroom and urinated on the floor which caused her to slip and fall. Resident #59 reported to the nursing staff that she had hit the back of her head on the wall and reported having pain in her left hip. Resident #59 was assessed and assisted onto her feet where it was noted she was unable to bear weight on her left leg. The nurse practitioner was contacted and Resident #59 was transported to the emergency department.<br><br>-The report did not reveal any new interventions added to prevent further falls for Resident #59.<br><br>A progress note dated 6/1/24 revealed Resident #59 had a left pubic (lower pelvic bone) fracture and was receiving physical therapy for strengthening and conditioning.<br><br>C. Staff interviews<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | CNA #6 was interviewed on 11/6/24 at 3:04 p.m. CNA #6 said Resident #59's last fall was a few months prior. CNA #6 said to prevent falls for Resident #59, she encouraged her to use her call light. CNA #6 said Resident #59 was very good about using her call light to ask for assistance after the fall when she sustained the fracture, however, she said as the resident had healed she had gotten more independent. CNA #6 said she tried to catch Resident #59 before she tried to get up on her own and made sure her room was cleared of any trip hazards.<br><br>LPN #4 was interviewed on 11/7/24 at 10:42 a.m. LPN #4 said Resident #59's fall interventions included keeping her call light within reach, assisting with ADLs as needed, educating the resident and her family with safety reminders and notifying Resident #59's doctor if she had any signs of confusion.<br><br>D. Additional information<br><br>A fall performance improvement plan (PIP), initiated 5/15/24, was received from the NHA on 11/11/24 at 2:46 p.m. The PIP revealed a fall review was conducted by the facility administration team and system process gaps were noted. Pertinent interventions for this PIP included discussing recent falls and interventions in grand rounds and fall huddles were to be conducted after each fall with the facility administrators, direct care staff and the resident.<br><br>The PIP revealed the facility would monitor for systemic changes by completing weekly risk management meetings to review current falls, unit managers would complete weekly fall audits and the DON would track and trend falls and review weekly audits.<br><br>-However, Resident #59 sustained a fall with major injury on 5/26/24, after the PIP was put in place and no new fall interventions were implemented for the resident on the care plan.<br><br>47064<br><br>IV. Resident #67<br><br>A. Resident status<br><br>Resident #67, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included, fracture of the right radius (broken bone in the lower arm), pulmonary embolism (blood clot in the lungs), respiratory failure with hypoxia (decreased ability to exchange oxygen), congestive heart failure (inability of the heart to push blood throughout the body) and chronic kidney disease ( decrease kidney function).<br><br>The 10/9/24 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of three out of 15. The resident required maximum staff assistance with toileting and transfers and moderate assistance for dressing, personal hygiene and eating. She used a walker and a wheelchair for mobility and was frequently incontinent of bowel and bladder but was not on a toileting program.<br><br>The MDS assessment indicated the resident had a fall within the last month.<br><br>B. Resident/family interview<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #67 was interviewed with a family member present on 11/5/24 at 2:59 p.m. Resident #67 said she fell and hurt her hand and results from the x-ray done in the hospital revealed a broken bone in her arm. She said she got up in the middle of the night to use the bathroom and fell in the bathroom. She said her walker had sat against the wall of her room since the fall, even though her fracture had healed. Resident #67 said the staff would not let her use her walker after the fall.<br><br>Resident #67's family member said she was told Resident #67 had gotten up early in the morning and fell in the hallway. The family member said since the fall, the facility only wanted her to use the wheelchair to get around even though she had been able to use the walker when she was admitted to the facility.<br><br>C. Record review<br><br>The 10/3/24 fall risk assessment, completed upon the resident's admission to the facility revealed Resident #67 was at risk for falls and had a history of falls within the 90 days prior to her admission. The assessment documented the resident required staff assistance for toileting and mobility but did not follow directions.<br><br>The comprehensive care plan, initiated 10/4/24, identified Resident #67 was at risk for falls with a goal that the resident would not sustain a serious injury requiring hospitalization through the review date. Interventions included assisting the resident with activities of daily lying (ADL) as needed, keeping the call light within reach, completing fall risk assessments and orienting the resident to her room.<br><br>-The care plan did not reveal any new fall interventions added after Resident #67's fall on 10/12/24 (see fall documentation below).<br><br>A facility event progress note on 10/12/24 at 12:58 a.m. revealed the certified nurse aide (CNA) informed the nurse that Resident #67 was sitting on the floor in the bathroom with her back up against the wall. Resident #67 reported she went to the bathroom and accidentally fell on to the floor. Resident #67 reported pain to her right hand. The resident was educated on the use of her call light and verbalized understanding and her ability to use the call light. The note documented the resident was sent to the emergency department, per facility protocol, because she was on an anticoagulant (blood thinning medication) at the time of her fall.<br><br>Hospital documentation for Resident #67, from 10/12/24 to 10/14/24, revealed the resident sustained a complex distal radial metaphyseal fracture (fracture of the wrist area) as seen in x-ray imaging. Resident #67 was placed into a splint and instructed to follow up with an orthopedic specialist in one week.<br><br>A facility physician's note on 10/14/24 at 7:57 p.m. revealed Resident #67 was sent out to the hospital after a fall in the bathroom with pain to her right wrist. The note documented the hospital findings of a complex distal radial metaphyseal fracture and application of a splint. The note indicated orthopedic follow up would be arranged.<br><br>The facility provided the incident report for Resident #67's 10/12/24 unwitnessed fall on 11/6/24 at 3:18 p.m. The documentation revealed the resident had no injuries at the time of fall on 10/12/24.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -However, Resident #67's hospital records indicated the resident sustained a radial fracture and the facility's nurse progress note dated 10/12/24 indicated the resident complained of pain in her right hand (see record review above).<br><br>D. Staff interview<br><br>The DON was interviewed on 11/7/24 at 5:42 p.m. The DON said there were no new fall interventions added to Resident #67's care plan after her fall on 10/12/24. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064<br><br>Based on record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#205) of one resident reviewed for catheters of 41 sample residents.<br><br>Specifically, the facility failed to obtain physician's orders and documentation for catheter care and maintenance for Resident #205.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Indwelling Urinary Catheter (Foley) Management policy and procedure, revised on 9/10/24, was received from the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It revealed in pertinent part, The facility will ensure that residents admitted with a urinary catheter, or determined to need a urinary catheter for medical indication will have the following areas addressed.<br><br>Timely and appropriate assessment related to the indication for use of indwelling catheter.<br><br>Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures.<br><br>II. Resident # 205<br><br>A. Resident status<br><br>Resident #201, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO) diagnoses included, fournier gangrene (tissue infection), colostomy (opening in abdominal wall for stool), cellulitis of abdominal wall (infection of tissue), pressure ulcer(skin/tissue damage) of right buttock, hypertension (high blood pressure) and dysphagia (difficulty swallowing).<br><br>The 11/1/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff for toileting, dressing and transfers. She required set up assistance for eating.<br><br>The MDS assessment indicated she had an indwelling catheter and a colostomy.<br><br>B. Observations and resident interview<br><br>Resident #205 was interviewed on 11/5/24 at 9:17 a.m. She said her urinary catheter leaked sometimes. Resident #205 said she had concerns because she wanted to make sure her wounds did not become infected from urine leaking. Resident #205 said she admitted to the facility with the catheter. Resident #205 was lying in bed with a catheter bag hanging on her bed.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | C. Record review<br><br>A review of the November 2024 CPO did not reveal a physician's order for routine catheter care, maintenance or monitoring of the resident's catheter.<br><br>The 10/29/24 baseline care plan did not document the resident had a urinary catheter.<br><br>The 10/29/24 comprehensive care plan revealed the resident had an indwelling catheter to allow surgical wounds to perineum to heal without contamination. Interventions included providing catheter care every shift and educating the resident/family regarding indwelling catheter care.<br><br>A nursing progress note on 11/3/24 at 2:00 p.m. revealed the resident had a foley catheter and it was leaking and the nurse flushed the foley catheter. After flushing the catheter was no longer leaking.<br><br>-Review of the November 2024 CPO did not reveal a physician's order to flush the catheter (see record review above).<br><br>-Review of the resident's electronic medical record (EMR) did not reveal the physician was notified the catheter was leaking.<br><br>The Kardex (staff directive tool) reveled Resident #205 required catheter care every shift<br><br>III. Staff interviews<br><br>Certified nurse aide (CNA) #4 was interviewed on 11/6/24 at 2:03 p.m. CNA #4 said he provided catheter care to all residents who had a catheter every shift to prevent infection. CNA #4 said he knew who needed catheter care based on the electronic charting system.<br><br>Registered nurse (RN) #2 was interviewed on 11/6/24 at 2:09 p.m. SRN #2 said a resident with a catheter required a physician's orders for care and maintenance.<br><br>RN #2 said Resident #205 had a leaking catheter recently that required it to be flushed. RN #2 was not sure if a physician's order was needed to flush a catheter.<br><br>LPN #1 was interviewed on 11/6/24 at 2:13 p.m. LPN #1 said residents who had a catheter required a physician's order for care and maintenance. LPN #1 said flushing a catheter required a physician's order because the physician may want it flushed with a certain solution. He said flushing a catheter involved putting something into the body which had the potential for infection if not done correctly.<br><br>LPN #1 said nurses were not to perform catheter care or flushing without a physician order.<br><br>LPN #1 said he was unable to find any physician's orders for Resident #205's catheter. LPN #1 said there should be physician's orders for Resident #205's catheter and catheter maintenance.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #3, who was also the unit manager, was interviewed on 11/6/24 at 2:21 p.m. LPN #3 said every resident who had a catheter should have a physician's order in place to ensure staff were following orders for care.<br><br>LPN #3 said the facility should know about all devices a resident had in order to properly provide care for them.<br><br>LPN #3 said a physician's order was needed to flush a catheter. She said a catheter should not be flushed without a physician's order. The UM said the physician should be aware of issues with residents and make the decision on how to care for the issue so nurses can carry out the care.<br><br>LPN #3 said she reviewed the November 2024 and October 2024 CPO and was unable to locate any orders for the urinary catheter or catheter care for Resident #205.<br><br>LPN #3 said she was not sure how catheter care was indicated on the Kardex for the CNAs to complete, when there were no physician's orders for the catheter.<br><br>LPN #3 said he would complete an assessment of Resident #205's catheter to determine the type and size of the catheter. He said he would call the physician to get care orders for the catheter.<br><br>The director of nursing (DON) was interviewed on 11/6/24 at 2:35 p.m. The DON said if a resident was admitted with a catheter it was the responsibility of the admitting nurse to ensure physician's orders for the catheter and catheter care were obtained from the physician. The DON said the physician's order needed to include the type of catheter, the size, catheter care every shift, placing bag below level of the bladder, changing bag as ordered and for the catheter to be checked daily and as needed. The DON said a physician's order was needed to flush a catheter.<br><br>The DON said physician's orders were important so staff knew how the physician wanted care to be delivered. The DON said catheters can lead to infection and monitoring them was important to prevent or treat infection if it occurs. The DON said she was not sure how the orders were missed on admission.<br><br>The DON said the facility would initiate a performance improvement plan moving forward. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160<br><br>Based on observations, record review, and interviews the facility failed to ensure residents with percutaneous endoscopic gastrostomy (PEG) tubes received treatment and services to prevent complications for one (#21) of one resident reviewed for enteral feeding management (the delivery of nutrients through a PEG tube directly into the stomach, also called tube feeding)<br><br>out of 41 sample residents.<br><br>Specifically, the facility failed to:<br><br>-Ensure Resident #21 received his tube feeding as ordered by the physician; and,<br><br>-Label Resident #21's tube feeding containers with the residents' names, room number, date, start time, formula type, feeding rate and nurse initials.<br><br>Findings include:<br><br>I. Professional reference<br><br>Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022) Basic Nursing, Thinking, Doing and Caring, (Third edition), pages 2270-2277. Retrieved on 11/19/247/24/25. It read in pertinent part, Prior to administration, check the prescription for type of feeding, rate of infusion, and frequency of feeding. Label the container with the patient's name, room number, date, start time, formula type, feeding rate, and nurse initials.<br><br>II. Facility policy and procedure<br><br>The Enteral Nutrition Therapy policy and procedure, dated 9/10/24, was received by the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. via email post survey. The policy read in pertinent part, The facility will provide continuous enteral nutrition therapy in accordance with physician orders and professional standards of practice.<br><br>III. Resident #21<br><br>A. Resident status<br><br>Resident #21, age less than 65, was admitted on [DATE]. According to the November 2024 computerized physicians order (CPO), diagnoses included dysphagia (difficulty swallowing), protein calorie malnutrition, abnormal weight loss, iron deficiency, vitamin D deficiency, gastroesophageal reflux disease (GERD) (stomach contents leak back up into esophagus and cause irritation) and quadraplegia (paralysis in all four extremities).<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 8/27/24 minimum data set (MDS) assessment revealed the resident was alert and non-verbal. The resident had been able to answer yes/no questions with minor hand movement or blinking. The resident was dependent on two staff members for all activities of daily living (ADL).<br><br>The assessment revealed the resident had a feeding tube.<br><br>B. Observations<br><br>On 11/4/24 at 10:37 a.m. Resident #21 was laying in bed. The tube feed pump at his bedside was disconnected and off.<br><br>-However, the Resident #21 should have been receiving enteral feeding until 11:00 a.m. (see physician's order below).<br><br>On 11/5/24 at 8:40 a.m. Resident #21 was laying in bed. The tube feed pump at his bedside was administering an unlabeled tube feeding formula at 62 milliliter (ml) per hour. The automatic water flush was programmed at 75 ml every three hours.<br><br>-However, the current physician's order was for automatic water flush 100 ml every three hours.<br><br>-The tube feeding bag and water flush bag were both unlabeled.<br><br>C. Record review<br><br>According to the November 2024 CPO Resident #21 had the following physician's orders related to nutrition:<br><br>-Enteral feed one time a daily Jevity 1.5 at 62 ml per hour for 18 hours (on at 5:00 p.m. and off at 11:00 a.m.) for a total of 1116 ml. Programmed automatic water flush at 75 ml every three hours, ordered on 2/16/24 and discontinued on 11/1/24.<br><br>-Enteral feed one time daily Jevity 1.5 at 62 ml per hour for 18 hours (on at 5:00 p.m. and off at 11:00 a.m.) for a total of 1116 ml. Programmed automatic water flush 100 ml every three hours, ordered on 11/1/24 at 5:00 p.m.<br><br>The nutritional care plan, dated 5/21/19, revealed the resident was at a nutritional risk related to dysphagia, traumatic brain injury, and history of aspiration requiring enteral feeding to meet all nutritional needs. The invention of administering tube feed as ordered was initiated on 10/28/20, and the administering water flushes as ordered intervention was initiated on 2/3/20.<br><br>IV. Staff interviews<br><br>Registered nurse (RN) #1 was interviewed on 11/5/24 at 8:53 a.m. registered nurse (RN) #1 was interviewed. RN #1 said that day shift nursing staff started the tube feed for Resident #21 per the physician's order at 5:00 p.m. each day. RN #1 said it should be administered per the order until 11:00 a.m. the next morning.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RN #1 said the tube feed bag should be labeled with the date, time of administration, resident name, and the nurse initials. RN #1 said it was important to label the bag to prevent medication errors. RN #1 said that a labeled bag would ensure the correct tube feed formula, the correct rate, and correct calorie intake for the resident. RN #1 said that all tubing supplies for the feeding tube should be changed every 24 hours to prevent bacterial growth and potential infection. RN #1 said Resident #21's tube feeding bag that the bag had been labeled, but the label must have fallen off.<br><br>RN #1 was interviewed on 11/6/24 at 4:08 p.m. RN #1 was interviewed. RN #1 said that the ordered water flush rate was important because Resident #21 had NPO (nothing by mouth) status. RN #1 said that ordered water flushes were the only source of hydration that Resident #21 received.<br><br>RN #1 said that the tube feed formula rate and water flush rate were calculated by the registered dietitian (RD). RN #1 said that the rates were calculated by the RD based on a resident's labs, medical diagnosis, and a residents tolerance to varied rate levels.<br><br>RN #1 said that if a resident did not receive the correct amount of water they could experience dehydration, low urine output, altered labs, decreased kidney function that could lead to harm. RN #1 said that too much waterflush could cause a resident to become fluid overloaded, alter their labs and electrolytes, cause gastrointestinal upset, emesis, and edema which could cause harm. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219<br><br>Based on observations, record review and interviews, the facility failed to use a person-centered approach when determining the use of a grab bar/bed rail for one (#59) of one resident reviewed for grab bars/bed rails out of 41 sample residents.<br><br>Specifically, for Resident #59, the facility failed to:<br><br>-Assess the resident for risk of entrapment prior to installing a grab bar/bed rail;<br><br>-Obtain consent, which included the risks versus benefits of grab bars/bed rails, from the resident and/or the resident's representative prior to grab bar/bed rail installation;<br><br>-Identify alternatives to using grab bars/bed rails; and,<br><br>-Conduct routine assessments and maintenance of the resident's grab bar/bed rail to evaluate the continued safety and/or the continued need for the grab bar/bed rail.<br><br>Findings include:<br><br>I. Professional reference<br><br>The U.S. Food and Drug Administration (FDA) Recommendations for Health Care Providers Using Adult Portable Bed Rails (2/27/23) was retrieved on 11/13/24 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails. It read in pertinent part,<br><br>Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. Follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed frame and bed rails used. Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards.<br><br>II. Facility policy and procedure<br><br>The Bed Rails policy and procedure, revised 12/30/22, was provided by the nursing home administrator (NHA) on 11/11/24 at 10:43 a.m. It revealed in pertinent part, If a bed or side rail is used, the facility must ensure correct installation, use and maintenance of bed rails.<br><br>Residents will be assessed upon admission, readmission, or upon initiation utilizing the Evaluation for Use of Bed Rails Assessment.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | If a bed rail will be utilized, the risks and benefits of bed rail usage will be reviewed with the resident and/or resident representative and consent will be obtained prior to installation of the bed rails or as soon as practically possible.<br><br>The facility will document alternatives to the use of a bed rail and how these alternatives did not meet the resident's assessed needs prior to the utilization of a bed rail.<br><br>A person-centered care plan will be developed within 48 hours of admissions to address the bed rail, if indicated.<br><br>The interdisciplinary team (IDT) will review and revise the care plan, if indicated, upon completion of each comprehensive, significant change and quarterly MDS assessment for the need to continue the use of bed rails.<br><br>III. Resident #59<br><br>A. Resident status<br><br>Resident #59, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included dementia, osteoporosis, glaucoma and history of falling.<br><br>The 10/29/24 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. The resident required partial to moderate assistance with most activities of daily living (ADL). The resident was independent for transfers. The resident was frequently incontinent of both bowel and bladder.<br><br>-The MDS assessment documented Resident #59 did not use grab bars/bed rails.<br><br>B. Resident interview and observations<br><br>On 11/4/24 at 10:55 a.m. Resident #59 was in bed. A grab bar/bed rail was attached to the bed frame. Resident #59 said the grab bar/bed rail was used to help her get up and she found it very handy. Resident #59 said she was not sure if the facility staff checked her grab bar/bed rail to see if it was secure. Resident #59 said if the staff did check the grab bar/bed rail, it was when she was asleep, as she had not seen them do so.<br><br>On 11/5/24 at 3:18 p.m. the grab bar/bed rail was observed again. There was a gap approximately three inches wide between the mattress and the grab bar/bed rail.<br><br>C. Record review<br><br>-Review of Resident #59's comprehensive care plan, initiated 3/16/22, revealed Resident #59 revealed there was no care plan focus for the resident's grab bar/bed rail<br><br>Grab bar/bed rail assessments were completed for Resident #59 on 3/15/22, 4/20/24 and 5/29/24.<br><br>-Each assessment documented Resident #59 was not using a grab bar/bed rail.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -A comprehensive review of the resident's electronic medical record (EMR) failed to reveal documentation to indicate the facility attempted to find alternatives to bed rails for Resident #59, assessed Resident #59 for entrapment risks prior to installing the grab bar/bed rail, reviewed the risk versus the benefits of using a grab bar/bed rail with the resident or the resident's representative prior to use or obtained informed consent for the installation and use of grab bar/bed rail prior to use.<br><br>-There was no documentation in Resident #59's EMR to indicate the facility was conducting ongoing assessments and maintenance of the resident's grab bar/bed rail to ensure the continued safety and/or need of the grab bar/bed rail.<br><br>D. Staff interviews<br><br>Certified nurse aide (CNA) #6 was interviewed on 11/6/24 at 3:04 p.m. CNA #6 said the grab bar/bed rail on Resident #59's bed was to help her get to a standing position or to transfer to her wheelchair. CNA #6 said the maintenance staff had put the grab bar/bed rail on the resident's bed and she believed the maintenance staff checked it CNA #6 said the grab bar/bed rail was very securely placed.<br><br>Licensed practical nurse (LPN) #4 was interviewed on 11/7/24 at 10:42 a.m. LPN #4 said the therapy team were the ones that installed the grab bar/bed rail. LPN #4 said the grab bar/bed rail helped Resident #59 with turning and repositioning. LPN #4 said he did not see anything about the grab bar/bed rail in Resident #59's care plan so he would call and alert the MDS team about that.<br><br>Physical therapist (PT) #1 was interviewed on 11/7/24 at 12:00 p.m. PT #1 said Resident #59 was on the physical therapy caseload from 5/30/24 to 6/24/24. PT #1 said the therapy team worked with Resident #59 on transfers, bed mobility and gait. PT #1 said the facility needed documentation to install a grab bar/bed rail, as it was not something that could just be put on a bed randomly for any resident. PT #1 said grab bars/bed rails were to be assessed by the therapy team, approved by the director of nursing (DON), then placed on the resident's bed by the maintenance staff.<br><br>PT #1 said she did not see any documentation about a grab bar/bed rail for Resident #59 and the only equipment she had documented was a front wheel walker. PT #1 said residents were assessed prior to receiving grab bars/bed rails as there were risks involving getting caught in the grab bar/bed rail (entrapment), and the therapy team needed to make sure the resident was aware of those risks. PT #1 said once the grab bar/bed rail was installed, the maintenance staff checked on the equipment to ensure it was secured.<br><br>The NHA was interviewed on 11/7/24 at 12:36 p.m. The NHA said she had called the representatives for Resident #59 (during the survey) and found out the representative had installed the grab bar/bed rail. The NHA said the representative was furious that it was being taken off Resident #59's bed.<br><br>The DON was interviewed on 11/7/24 at 5:23 p.m. The DON said the facility had a stringent policy on any grab bars/bed rails and residents had to be evaluated by therapy prior to initiating grab bars/bed rail. The DON said residents needed to be assessed by therapy before receiving grab bars/bed rails as it could be a hazard for falls, broken extremities and choking, as there was quite a gap between the bed and the grab bar/bed rail. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163<br><br>Based on record review and interviews, the facility failed to ensure two (#66 and #56) of five out of 41 sample residents were as free from unnecessary medications as possible.<br><br>Specifically, the facility failed to:<br><br>-Ensure consent was obtained for Risperdal (antipsychotic medication) prior to administering the medication to Resident #66;<br><br>-Ensure behavior tracking was in place for Resident #66's use of Risperdal; and,<br><br>-Monitor Resident #56 for antipsychotic medication side effects.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Psychotropic Medication policy and procedure, revised October 2022, was provided by the nursing home administrator (NHA) on 11/8/24 at 1:45 p.m. It read in pertinent part, Psychotropic medication is prescribed for a diagnosed condition and not being used for<br><br>convenience or discipline.<br><br>The facility should not use psychotropic medications to address behaviors without first<br><br>determining if there is a medical, physical, functional, psychological, social or environmental<br><br>cause of the resident's behaviors.<br><br>All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for efficacy, risks, benefits, and harm or adverse consequences.<br><br>Antipsychotic medications used to treat Behavioral or Psychological Symptoms of Dementia (BPSD) must be clinically indicated, be supported by an adequate rationale for use, and may not be used for a behavior with an unidentified cause. Antipsychotics used to treat BPSD must receive gradual dose reduction and behavioral interventions, unless contraindicated. Gradual dose reduction is used in an effort to discontinue antipsychotics.<br><br>Where Physician/Prescriber orders a psychotropic medication for a resident, Facility should ensure that Physician/Prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary.<br><br>(continued on next page) |

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| | 065370 | A. Building<br>B. Wing | 11/07/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Life Care Center of Littleton | 1500 W Mineral Ave<br>Littleton, CO 80120 |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Facility staff should monitor the resident's behavior pursuant to Facility policy using a behavioral monitoring chart or behavioral assessment record for residents receiving psychotropic medication for organic mental syndrome with agitated or psychotic behavior(s). Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions.<br><br>II. Resident #66<br><br>A. Resident status<br><br>Resident #66, age 72, was admitted on [DATE] and readmitted on [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following nontraumatic intracerebral hemorrhage (brain bleed) affecting left non-dominant side and vascular dementia with agitation.<br><br>The 9/26/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required substantial to maximum assistance with mobility and transfers.<br><br>The MDS assessment indicated the resident had episodes of delusions.<br><br>B. Record review<br><br>The antipsychotic medication care plan, initiated on 8/10/24, documented the resident used an antipsychotic medication due to the potential for injury to self or others. The pertinent interventions included administering medications as ordered by the physician; educating the resident and family about the risks, benefits and side effects of Risperdal; observing and reporting any adverse reactions of the antipsychotic medications and observing and documenting for occurrence of target behavioral symptoms such as violence, aggression toward staff and others.<br><br>The November 2024 CPO documented Resident #66 was prescribed Risperdal tablet 0.25 milligrams (mg)), give one tablet one time per day, ordered on 7/6/24.<br><br>The consent for psychotropic medication documented the consent for the use of Risperdal was obtained verbally by Resident #66's spouse on 10/4/24, three months after Resident #66 had been prescribed and administered the medication.<br><br>The behavior tracking record documented Resident #66's behavior was being monitored for physical aggression, which started on 7/6/24. The behavior tracking was documented from 7/6/24 until 8/23/24 when the resident was sent to the hospital.<br><br>Upon his return, on 8/27/24, the facility failed to ensure behavior tracking for the use of Risperdal was reinstated.<br><br>C. Staff interviews<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Certified nurse aide (CNA) #7 was interviewed on 11/7/24 at 11:30 a.m. CNA #7 said Resident #66 could become verbally aggressive, usually when he talked about the prior facility where he resided. CNA #7 said Resident #66 had never been physically aggressive.<br><br>CNA #7 said behavior monitoring was documented in the point of care (POC) system every day. He said the behavior tracking was put into place on 11/7/24, during the survey process. He said he was unable to find any documentation for Resident #66's behaviors prior to 11/7/24.<br><br>Licensed practical nurse (LPN) #6 was interviewed on 11/7/24 at 11:45 a.m. LPN #6 said Resident #66 had a history of being verbally inappropriate with females and at times becoming verbally aggressive, but had never been physically aggressive.<br><br>LPN #6 said psychotropic medication consents were overseen by the medical doctor. He said he was not aware who was responsible to ensure consents were signed prior to administration of the medication.<br><br>LPN #6 was interviewed again on 11/7/24 at 12:00 p.m. He said social services was responsible for obtaining consent for all psychotropic medications.<br><br>LPN #7 was interviewed on 11/7/24 at 1:40 p.m. LPN #7 said when a CNA entered a behavior into the POC system, it would trigger the nurse to write a behavioral progress note. She said that was how the nurses documented any behaviors exhibited by a resident.<br><br>The social services director (SSD) and the social services assistant (SSA) were interviewed together on 11/7/24 at 1:55 p.m. The SSD said Resident #66 had a history of aggression and sexual inappropriateness with female staff members. She said social services was responsible for setting up behavior monitoring in the POC system for targeted behaviors related to the use of a psychotropic medication. She said she had not realized the facility had not been documenting behavior tracking for Resident #66's use of Risperdal.<br><br>The SSD said the nurse was responsible for explaining the risks and benefits of psychotropic medications to the resident and/or family member. She said social services was responsible to speak with the resident and family after the conversation with the nurse to obtain a written consent. She said she was aware that medications were being administered prior to consent being obtained.<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:21 p.m. The DON said behavior tracking for a psychotropic medication was completed in POC and in the medication administration record (MAR). She said Resident #66's behavior tracking was discontinued when he went to the hospital and was not restarted when he returned to the facility.<br><br>The DON said consents for psychotropic medications should be obtained prior to the administration of the medication. She said the provider or the nurse should obtain consent when the medication was ordered.<br><br>50219<br><br>III. Resident #56<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A. Resident status<br><br>Resident #56, age 84, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the November 2024 CPO, diagnoses included dementia with psychotic disturbance.<br><br>The 10/23/24 MDS assessment revealed the resident had short-term and long-term memory deficits, was severely cognitively impaired for daily decisions and had disorganized thinking per staff interview. The resident required touching to moderate assistance for most activities of daily living.<br><br>The assessment revealed the resident was taking antipsychotic and antianxiety medications.<br><br>B. Record review<br><br>The antipsychotic medication care plan, dated 5/29/24, revealed Resident #56 received an antipsychotic medication due to his dementia with behaviors. Pertinent interventions included administering the antipsychotic medication as ordered and observing for side effects and effectiveness each shift. The care plan indicated side effects listed included unsteady gait, frequent falls, refusal to eat, fatigue, and insomnia.<br><br>The August 2024 CPO revealed the following physician's orders related to psychotropic medications:<br><br>Risperdal 2 mg tablet, give one tablet by mouth one time a day for dementia with behaviors, ordered on 5/16/24 and discontinued on 8/7/24; and,<br><br>Antipsychotic medication side effects, monitor every shift and document if side effects are present and write a progress note, ordered on 6/12/24 and discontinued on 8/9/24.<br><br>-However, when the Risperdal 0.5 mg tablet was ordered on 8/21/24, the facility failed to restart side effect monitoring.<br><br>The November 2024 CPO revealed the following physician's orders related to psychotropic medications:<br><br>Risperdal 0.5 mg tablet, give one tablet by mouth at bedtime for dementia with psychotic disturbance, ordered on 8/21/24.<br><br>-A review of the November 2024 CPO did not reveal a physician's order to monitor Resident #56 for side effects or adverse reactions to the antipsychotic medication.<br><br>Review of the August 2024 (8/21/24 to 8/31/24) MAR revealed the resident received the Risperdal 0.5 mg tablet once a day as ordered from 8/21/24 through 8/31/24.<br><br>-Review of Resident #56's electronic medical record (EMR) did not reveal the resident was monitored for side effects of the antipsychotic medication on 8/24/24, 8/25/24, 8/26/24, 8/27/24, 8/29/24, 8/30/24 and 8/31/24.<br><br>Review of the September 2024 (9/1/24 to 9/30/24) MAR revealed the resident received the Risperdal 0.5 mg tablet once a day as ordered.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Review of Resident #56's EMR did not reveal the resident was monitored for side effects of the antipsychotic medication from 9/1/24 to 9/9/24 and 9/11/24 to 9/30/24.<br><br>Review of the October 2024 (10/1/24 to 10/31/24) MAR revealed the resident received the Risperdal 0.5 mg tablet once a day as ordered.<br><br>-Review of Resident #56's EMR did not reveal the resident was monitored for side effects of the antipsychotic medication from 10/1/24 to 10/31/24.<br><br>Review of the November 2024 (11/1/24 to 11/7/24) MAR revealed the resident received the Risperdal 0.5 mg tablet once a day as ordered.<br><br>-Review of Resident #56's EMR did not reveal the resident was monitored for side effects of the antipsychotic medication from 11/1/24 to 11/7/24.<br><br>A progress note, dated 8/21/24, revealed the interdisciplinary team met to review Resident #56's behaviors.<br><br>A progress note, dated 8/22/24 at 10:07 p.m., revealed Resident #56 was not given his dose of Risperdal due to side effect concerns and that the primary care provider would be notified.<br><br>A progress note, dated 8/23/24, revealed Resident #56 continued to be fatigued and the primary care provider was notified so the resident could be assessed. The note documented the fatigue could be due to restarting Risperdal, and that Resident #56's appetite was poor that day.<br><br>A progress note, dated 8/28/24 at 12:27 p.m., revealed Resident #56 had been weaker and more quiet during transfers and repositioning.<br><br>A progress note, dated 8/28/24 at 5:57 p.m,. revealed Resident #56 continued to have periods of lethargy, decreased appetite and energy. Resident #56 needed to be fed lunch and dinner.<br><br>A progress note, dated 9/10/24, revealed Resident #56 had been calm during that shift and had not had any yelling or behavioral concerns. Resident #56 had not had any adverse reactions from Risperdal nor the Ativan that was recently started.<br><br>C. Staff interviews<br><br>CNA #6 was interviewed on 11/7/24 at 10:31 a.m. CNA #6 said she knew Resident #56 used to be on a medication for his anxiety. CNA #6 said Resident #56 was previously acting out and having behaviors over the summer prior. CNA #6 said she did not monitor Resident #56 for specific symptoms but let the nurse know if she noticed any change in condition for the resident.<br><br>LPN #4 was interviewed on 11/7/24 at 10:42 a.m. LPN #4 said Resident #56 was on 0.5 mg Risperdal at night and had previously had fluctuations with his medications. LPN #4 said Resident #56 was a little sleepy for the first week he was on the Risperdal but it had worked well for him since then. LPN #4 said residents were monitored for medication side effects and it was recorded in the MAR each shift.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN #4 was interviewed a second time on 11/7/24 at 2:21 p.m. LPN #4 said the side effect monitoring for medications was done by nurses. LPN #4 said residents were monitored to see if they were having any adverse effects related to antipsychotic, antianxiety, or antidepressant medications. LPN #4 said he could not find any antipsychotic monitoring in the MAR for Resident #56 and was not sure why it was not in his MAR.<br><br>The DON was interviewed on 11/7/24 at 5:23 p.m. The DON said side effects for antipsychotic medications should be monitored each shift and marked in the MAR. The DON said residents were monitored because some psychiatric medications could have major adverse effects. The DON said she had not been made aware of Resident #56 having any side effects from his medications. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160<br><br>Based on observations and interviews, the facility failed to ensure that all drugs and biologicals were properly stored and labeled according to professional standards of practice in two of six medication carts.<br><br>Specifically, the facility failed to:<br><br>-Label medications to facilitate safe medication administration; and,<br><br>-Ensure medications were labeled and dated appropriately.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Storage and Expiration Dating of Medications, Biologicals policy and procedure, dated 8/7/23, was provided by the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It read in pertinent part, Once any medication package is opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. If a multi-dose medication has been opened the medication should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date. The facility should ensure that the medications for each resident are stored in the containers in which they were originally received.<br><br>II. Observations and interviews<br><br>During a continuous observation on 11/5/24, beginning at 3:30 p.m. and ending at 4:33 p.m. the following was observed:<br><br>At 3:34 p.m. LPN #1 was preparing medications for Resident #42. LPN #1 dispensed torsemide (diuretic medication) 10 milligrams (mg) into a medication cup. He then put magnesium oxide 400 mg into a separate medication cup.LPN #1 said he was unable to find a pill splitter in the medication cabinet and he needed to split the Magnesium Oxide in half.<br><br>At 3:35 p.m. LPN #1 locked the medication cup that contained the torsemide in the medication cart and walked away with the medication cup that contained the magnesium to find a pill splitter.<br><br>At 3:36 p.m. LPN #1 was unable to find a pill splitter in the medication room, LPN #1 returned to the medication cart and locked the medication cup that contained the magnesium oxide.<br><br>At 3:45 p.m. LPN #1 returned to the medication cart with a pill splitter. After splitting the magnesium tablet in half LPN #1 was unable to find a bottle of pill buster (a chemical that breaks down and deactivates medications) in the medication cart.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | At 3:46 p.m. LPN #1 locked the dispensed medications in the cart and walked away to dispose of the pill fragment in another medication cart.<br><br>At 3:48 p.m. LPN #1 returned to the cart and retrieved the dispensed medications. LPN #1 entered Resident #42's room and found Resident #42 using the bathroom.<br><br>At 3:50 p.m. the dispensed medications were placed back into the medication cart by LPN #1.<br><br>At 4:21 p.m. LPN #1 dispensed two tablets of senna 8.6 mg into the medication cup containing the split magnesium tablet and locked it back in the medication cart. LPN #1 said he planned to administer all the medications later when insulin was due closer to dinner.<br><br>-LPN #1 did not label the medication cup that contained the magnesium oxide table and senna or the medication cup that contained the torsemide with the contents or the residents name.<br><br>On 11/6/24 at 3:56 p.m. the east cart #1 was observed in the presence of LPN #5. The following item was found:<br><br>-Spiriva HandiHaler 18 microgram (mcg) was stored in a drawer without resident labeling information, or packaging containing resident information, or dose information. The inhaler had a 110 written on it in black marker.<br><br>-The inhaler was not labeled with a resident's name.<br><br>III. Staff interviews<br><br>LPN #5 was interviewed on 11/6/24 at 4:00 p.m. LPN #5 said the inhaler in question needed to be used first, then they would open the next inhaler that was still in the original packaging. LPN #5 said the resident may have brought the inhaler from home and that it may not have been delivered by the facility pharmacy. LPN #5 said the inhaler was labeled with 110 was for the resident in room [ROOM NUMBER] and there was only one resident that resided in that room currently.<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:24 p.m. The DON said all medications should be labeled with resident name, dose, route, date dispensed, number in package, pharmacy information, prescription number, in original packaging. The DON said the facility had double occupancy rooms.<br><br>IV. Facility follow up<br><br>On 11/11/24 at 3:26 p.m. (after the survey) the DON submitted an email with attached statement signed by LPN #1. LPN #1 signed a statement that he had labeled the medication cups with the resident name and placed a second medication cup over it prior to locking it in the cabinet.<br><br>-However observations revealed the cups were not labeled with identifiers or contents, and a third medication was dispensed into one of the cups without immediate intention to administer.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/11/24 at 3:26 p.m. the DON submitted an email which read in pertinent part, Please take into consideration that this patient is in a private room and inhaler was in a labeled box with open date and room number placed on inhaler.<br><br>-However, the inhaler was not stored in an opened box with resident and prescription information. It was out of all packaging and stored next to an unopened inhaler box. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219<br><br>Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen and three of three nourishment rooms.<br><br>Specifically, the facility failed to:<br><br>-Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross contamination in the main kitchen; and,<br><br>-Ensure safe and appropriate storage of food items in the nourishment room refrigerators.<br><br>Findings include:<br><br>I. Failed to ensure ready-to-eat foods were handled in a sanitary manner<br><br>A. Professional reference<br><br>The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment.<br><br>If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.<br><br>B. Facility policy and procedure<br><br>The Safe Food Handling policy and procedure, revised [DATE], was received from the nursing home administrator (NHA) on [DATE] at 10:13 a.m. It revealed in pertinent part, Associates shall wash their hands in accordance with the Hand Hygiene Policy and current Food Code Guidelines before handling or consuming food including working with clean equipment and utensils, and after handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, and before donning gloves to initiate a task that involves working with food.<br><br>C. Observations<br><br>During a continuous observation of the lunch meal service on [DATE], beginning at 10:43 a.m. and ending at 12:05 p.m. the following was observed:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | At 10:43 a.m. cook (CK) #1 was preparing sandwiches. CK #1 was wearing a single glove and used this gloved hand to handle mayonnaise packets, serving utensils, and a piece of paper. With the same gloved hand, CK #1 handled a hamburger bun to set it on a plate.<br><br>Using her same gloved hand, CK #1 took a marker out of her pocket and wrote on a piece of paper. With the same gloved hand, CK #1 handled bread to prepare peanut butter and jelly sandwiches before picking up the sandwiches and putting them onto plates. With the same gloved hand, CK #1 grabbed several pieces of bread out of a plastic bag and set them on the food preparation area. CK #1 used her gloved hand to adjust the plate warmer, then returned to assembling sandwiches. CK #1 used her gloved hand to stabilize the sandwiches while cutting them in half.<br><br>Using her same gloved hand, CK #1 took a marker out of her pocket and wrote on a piece of paper. With the same gloved hand, CK #1 grabbed several more pieces of bread out of a plastic bag and set them on the food preparation area. With the same gloved hand, CK #1 grabbed a slice of ham out of the cold storage, placed the ham onto the bread. CK #1 then used her gloved hand to grab a piece of lettuce and set it on the slice of ham. CK #1 then used the same gloved hand to break apart pieces of bacon and put them on a sandwich. CK #1 then used her ungloved hand to stabilize a sandwich as she transferred it to a plate.<br><br>At 11:34 a.m. CK #1 used her knuckle from her ungloved hand to push a dinner roll back on a plate to make room for another food item on the plate.<br><br>At 11:49 a.m. CK #1 used a pair of tongs to pick up a piece of cheese to set onto a cheeseburger. CK #1 then used these tongs to move a meal ticket aside. CK #1 used the same set of tongs to move a hamburger bun and toppings to a different plate.<br><br>D. Staff interview<br><br>The regional dietary consultant (RDC) was interviewed on [DATE] at 9:45 a.m. The RDC said she had noticed a few issues with CK #1 during the meal service observation and had a team huddle and training after the meal service.<br><br>The RDC was interviewed a second time on [DATE] at 1:23 p.m. The RCD said the dietary staff should wash their hands before using gloves or tongs to handle ready-to-eat foods. The RDC said gloves should only be used for a single task before being changed. The RDC said bare hands should not be used to handle foods.<br><br>II. Failed to store food items correctly in the refrigerators<br><br>A. Professional reference<br><br>The Colorado Retail Food Establishment Regulations, ([DATE]), were retrieved on [DATE] from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees celsius (41 degrees fahrenheit (F)) or less for a maximum of seven days. The day of preparation shall be counted as day one.<br><br>(continued on next page) |

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| | 065370 | A. Building<br>B. Wing | 11/07/2024 |

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| Life Care Center of Littleton | 1500 W Mineral Ave<br>Littleton, CO 80120 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.<br><br>B. Facility policy and procedure<br><br>The Safe Food Handling policy and procedure, revised [DATE], was received from the NHA on [DATE] at 10:13 a.m. It revealed in pertinent part, This facility must store, prepare, distribute and serve food in accordance with professional standards for food<br><br>service safety.<br><br>Snacks and other food items sent from the food service department will be handled safely in<br><br>regard to temperature, labeling and storage.<br><br>C. Observations<br><br>On [DATE] at 9:33 a.m. two cartons of vanilla yogurt with an expiration date of [DATE] were observed in refrigerator on the 200 hall.<br><br>At 9:39 a.m. the following was observed in the hallway refrigerator on the 400 hall:<br><br>-A nutritional shake carton, with an expiration date of [DATE]; and,<br><br>-Two yogurt cartons, with an expiration date of [DATE].<br><br>At 9:48 a.m. the following was observed in the refrigerator on the 100 hall:<br><br>-Approximately 10 cartons of milk, with an expiration date of [DATE];<br><br>-A bottle of heavy whipping cream, with an expiration date of [DATE];<br><br>-A three-pack individual services of rice pudding, with an expiration date of [DATE];<br><br>-Two yogurt containers, with an expiration date of [DATE]; and,<br><br>-Three yogurt containers, with expiration date of [DATE].<br><br>On [DATE] at 1:23 p.m. a nutritional shake carton with an expiration date of [DATE] was observed in the refrigerator on the 400 hallway.<br><br>D. Staff interviews<br><br>The dietary manager (DM) and the RDC were interviewed together on [DATE] at 1:23 p.m. The DM said the nourishment refrigerators on each hallway were checked twice daily, during which the dietary staff would go through and throw away expired items. The RDC and the DM said they had each looked through the nourishment refrigerators several times during the survey process and thrown items away each time. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>50219<br><br>Based on observations, record review and interviews, the facility failed to implement their policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption on two of three units.<br><br>Specifically the facility failed to ensure safe and appropriate storage of food items in Resident #51 and Resident #42's personal refrigerators.<br><br>A. Professional reference<br><br>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 11/13/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises or discarded<br><br>The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety.<br><br>B. Facility policy and procedure<br><br>The Resident Refrigerators policy and procedure, dated 8/22/23, was provided by the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It revealed in pertinent part, A temperature monitoring log will be maintained, and a designated staff member will document refrigerator temperatures on a daily basis.<br><br>Facility staff will check individual food items for expiration dates and discard outdated food<br><br>promptly from the residents' personal refrigerator.<br><br>Food will be labeled and dated to monitor for food safety. All food items should be consumed or discarded after three days. Food items in unmarked or unlabeled containers should be labeled with contents, and the date the food item was stored.<br><br>If the designated staff member is not permitted to perform weekly checks on the refrigerator, the resident or the resident's responsible party will be notified that they are responsible for the immediate removal of the personal refrigerator.<br><br>B. Observations and record review<br><br>1. Resident #51<br><br>On 11/4/24 at 10:13 a.m. the following items were found in Resident #51's refrigerator:<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Four yogurt containers, with an expiration date of 11/2/24;<br><br>-Three yogurt containers, with an expiration date of 10/15/24;<br><br>-Two yogurt containers, with an expiration date of 8/13/24;<br><br>-One sandwich that was unlabeled and undated;<br><br>-One cup of orange juice that was uncovered, undated, and unlabeled; and,<br><br>-One milk carton with, with an expiration date of 10/15/24.<br><br>The paper on the side of Resident #51's refrigerator was labeled October 2024 with columns for refrigerator and freezer temperatures. The temperatures for 10/1/24 through 10/27/24 were recorded. The temperatures for 10/28/24 through 10/31/24 had not been recorded. There was no log for November 2024 indicating the temperatures for 11/1/24 through 11/4/24 had been taken.<br><br>On 11/6/24 at 9:28 a.m. the November 2024 temperature log document on the side of Resident #51's refrigerator had temperatures recorded for 11/1/24 through 11/3/24. There were no temperatures recorded for 11/4/24 to 11/6/24.<br><br>At 9:40 a.m. the following items were found in Resident #51's refrigerator:<br><br>-The same four yogurt containers, with an expiration date of 11/2/24;<br><br>-The same three yogurt containers, with an expiration date of 10/15/24;<br><br>-The same two yogurt containers, with an expiration date of 8/13/24;<br><br>-The same sandwich that was unlabeled and undated;<br><br>-The same cup of orange juice that was uncovered, undated, and unlabeled; and,<br><br>-The same milk carton with, with an expiration date of 10/15/24.<br><br>The paper on the side of Resident #51's refrigerator was labeled October 2024 with columns for refrigerator and freezer temperatures. The temperatures for 10/1/24 through 10/27/24 were recorded. No further temperatures from 10/28/24 through 11/6/24 were recorded.<br><br>On 11/7/24 at 10:03 a.m. there was no temperature log observed for Resident #51's refrigerator for November 2024.<br><br>2. Resident #42<br><br>At 3:58 p.m. the November 2024 temperature log document on the side of Resident #42's refrigerator had one temperature recorded for 11/1/24. Temperatures for 11/2/24 through 11/6/24 had not been recorded.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | C. Staff interview<br><br>Dietary aide (DA) #1 and the dietary manager (DM) were interviewed together on 11/7/24 at 1:20 p.m. DA #1 said she tried to check the resident's refrigerators every other day. DA #1 said the residents sometimes refused to let her check their refrigerators so she would leave their rooms.<br><br>The DM said the facility had been having issues with the DAs not being able to assess the resident refrigerators as the residents had been refusing to let the DAs assess them. The DM said she had previously needed the administrators in the facility to talk to the residents in order to let the DAs check their refrigerators.<br><br>The DM and the regional dietary consultant (RDC) were interviewed together on 11/7/24 at 1:23 p.m. The RDC said the facility wanted the residents to care for their own refrigerators and that the residents did not like the facility staff going through their personal refrigerators. The RDC said the facility staff needed to help the residents with this task but they still did not allow them to help. The RDC said the facility's personal refrigerator policy did not assign a specific dietary aide to be designated to check the resident refrigerators.<br><br>The DM said the resident refrigerators should be checked daily.<br><br>The DM was interviewed again on 11/7/24 at 1:53 p.m. The DM said she had talked to the DA that took the temperatures of the personal refrigerators and the DA said the temperature log for Resident #52's refrigerator was on the refrigerator the day prior. The DM said they kept the temperature log documents on the refrigerators as they served as a reminder for the DAs to fill them out. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163<br><br>Based on record review and interviews, the facility failed to meet all the requirements for the provision of hospice care for one (#38) of one resident reviewed for hospice services out of 41 sample residents.<br><br>Specifically, the facility failed to ensure hospice notes were readily accessible and the comprehensive care plan was developed with a delineation of care responsibilities established between the facility and hospice for Resident #38.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Hospice policy and procedure, reviewed November 2023, was provided by the nursing home administrator (NHA) on 11/8/24 at 1:45 p.m. It read in pertinent part The facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the long term care (LTC) facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>The facility must designate a member of the interdisciplinary team (IDT) to ensure hospice representatives are oriented to the facility and that the resident receives quality care in collaboration with the facility staff and the hospice staff. The designated IDT member facilitates communication between the facility and hospice and includes the resident's representative in decision-making.<br><br>II. Resident #38<br><br>A. Resident status<br><br>Resident #38, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included myelodysplastic syndrome (a group of cancers that affect the bone marrow and blood), type 2 diabetes and chronic respiratory failure with hypoxia (low levels of oxygen in the blood).<br><br>The 10/1/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He was dependent on staff for all activities of daily living (ADL).<br><br>The assessment indicated the resident was receiving hospice care services.<br><br>B. Record review<br><br>The November 2024 CPO documented Resident #38 was admitted to hospice care services on 3/30/24.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the comprehensive care plan, reviewed on 9/25/24, revealed Resident #38 was receiving hospice care services, however it failed to include interventions and a delineation of services between the facility and hospice services.<br><br>-A review of Resident #38's electronic medical record (EMR) revealed the most recent hospice notes available for review were from 8/18/24 to 9/29/24.<br><br>C. Staff interviews<br><br>Certified nurse aide (CNA) #7 was interviewed on 11/7/24 at 11:30 a.m. CNA #7 said Resident #38 received hospice care services a couple of times per week. He said the hospice team had posted a schedule on the resident's dresser that indicated when they were coming to the facility. He said he did not have access to review hospice notes, but he said the hospice CNA would verbally inform him that Resident #38 had been given a bath or shower.<br><br>Licensed practical nurse (LPN) #6 was interviewed on 11/7/24 at 11:45 a.m. LPN #6 said he communicated with the hospice team by calling them on the phone. He said the hospice registered nurse (RN) would verbally communicate any changes to Resident #38's plan of care.<br><br>LPN #6 said a hospice binder was kept at the nurses station with all pertinent hospice information for each resident who was receiving hospice services.<br><br>-However, observations of the hospice binder, conducted with LPN #6 during the interview, revealed documentation in the binder for Resident #38 only included three hospice services notes from April 2024, a CNA visit and bed bath, a September 2024 visit note from the Chaplain and an October 2024 visit from a CNA and a bed bath.<br><br>LPN #6 said the hospice binder information for Resident #38 did not have up-to-date hospice services notes or plan of care. He said he was unaware who was responsible to ensure the hospice notes were readily accessible. He said social services was responsible for initiating the comprehensive care plan.<br><br>The director of medical records (DMR) was interviewed on 11/7/24 at 1:06 p.m. The DMR said medical records coordinated with social services and the hospice providers to obtain up-to-date hospice notes and the plan of care. She said, ideally, the previous seven days of hospice notes should be in the EMR of every resident who received hospice services. She said she had difficulty receiving the notes from the hospice providers timely to ensure they were easily accessible for the floor staff, even after she would send the hospice team multiple emails.<br><br>The social services director (SSD) and the social services assistant (SSA) were interviewed together on 11/7/24 at 1:55 p.m. The SSD said the hospice providers would email her progress notes and the hospice care plan. She said she thought she was sent the notes once per week.<br><br>(continued on next page) |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The SSD said the most recent email she had received from the Resident #38's hospice team was sent on 10/31/24 and it contained the notes from 9/30/24 to 10/6/24 for the resident. However, she said those hospice notes had not been uploaded into the residents EMR yet, therefore, she said they were not accessible to the nursing staff. She said the hospice binder at the nurses station was no longer being used because the facility had recently transitioned to a fully electronic medical record system a month prior.<br><br>The SSD said the hospice providers created the plan of care and then she was responsible for incorporating the hospice care plan into the resident's facility comprehensive care plan. She said she was unsure if there were any requirements for hospice care planning.<br><br>The NHA was interviewed on 11/7/24 at 4:39 p.m. The NHA said the facility tried to use one hospice services company to make everything more streamlined. She said the hospice nurse should be able to upload their notes and place them into the hospice binder at the nurses station. She said the DMR was responsible for scanning the hospice notes into the EMR timely.<br><br>The NHA said the DMR and social services should receive the hospice notes weekly via email from the hospice provider. She said she was not aware the process was ineffective and the hospice notes were not being sent to the DMR timely. She said she was unaware the facility was no longer using the hospice binder located at the nurses station.<br><br>The NHA said the hospice provider, in collaboration with social services, was responsible for developing the hospice plan of care. She said social services was responsible for ensuring the comprehensive care plan reflected the delineation of services between the facility and the hospice provider. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064<br><br>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 diseases and infection on one of three units.<br><br>Specifically, the facility failed to:<br><br>-Ensure housekeeping staff disinfected high-touch areas (call lights, door handles and handrails) when cleaning residents' rooms; and,<br><br>-Ensure staff followed appropriate infection control practices when providing catheter care.<br><br>Findings include:<br><br>I. Failure to disinfect high-touch areas when cleaning residents' rooms<br><br>A. Professional reference<br><br>Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 11/12/24 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part,<br><br>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.<br><br>The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 11/12/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part,<br><br>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs.<br><br>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.<br><br>B. Facility policy and procedure<br><br>The Housekeeping Service policy and procedure, revised 6/4/2024, was received from the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It revealed in pertinent part, the facility will provide a safe, clean, comfortable and homelike environment.<br><br>Clean and disinfect all high touch surfaces at least once daily. Examples of high touch surfaces include: bed rails, intravenous (IV) poles, sink handles, bedside tables, wheel chair handles, call bells, door knobs, and light switches.<br><br>C. Observations<br><br>On 11/6/24 at 9:35 a.m. housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER].<br><br>-HSKP #1 failed to disinfect the door handles, call light, television remotes, light switches and bed control remotes.<br><br>On 11/6/24 at 9:54 a.m. HSKP #1 was observed cleaning room [ROOM NUMBER], a double occupancy room.<br><br>-HSKP #1 failed to disinfect call lights, television remotes, light switches, bed control remote and door handles.<br><br>D. Staff interviews<br><br>HSKP #1 was interviewed on 11/6/24 at 10:16 a.m. HSKP #1 said high-touch areas in a residents' room that needed to be cleaned daily were phones, call lights, tables and door knobs. HSKP #1 said anything that was touched daily by either a resident or staff was considered high-touch and it was important to clean those areas to prevent the spread of infection.<br><br>HSKP #1 said she completed training as needed when policies were changed/updated.<br><br>HSKP #1 said she had disinfected all high-touch areas in room [ROOM NUMBER] and room [ROOM NUMBER].<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -However the door handles, television remotes, light switches, bed control remotes in both residents' rooms were not disinfected during observations (see observations above).<br><br>The housekeeping supervisor (HSKS) was interviewed on 11/7/24 at 2:05 p.m. The HSKS said she trained her housekeepers on the cleaning process, dwell times of chemicals used, how many rags and mops should be used per room on hire and as needed for changes in policy/procedures.<br><br>The HSKS said high-touch areas in residents' rooms were anything the resident or staff touched daily, such as bedside tables, door handles, toilet flushing handles, television remotes, call lights, light switches and bed control remotes. The HSKS said high-touch areas in residents' rooms should be disinfected daily to help prevent the spread of infection.<br><br>The HSKS said she conducted random audits of her staff's cleaning processes and would re-educate staff as needed.<br><br>-The HSKS was unable to provide documentation of the housekeeping staff audits or who and what areas she had to re-educate staff on.<br><br>The HSKS said she would re-educate HSKP #1 on disinfecting high-touch areas<br><br>The infection preventionist (IP) was interviewed on 11/7/24 at 3:08 p.m. The IP said high-touch areas to be cleaned daily by housekeeping staff were door knobs, light switches, television remotes, bedside tables, call lights and bed control remotes.<br><br>The IP said it was important to disinfect high-touch areas to help prevent the spread of infection.<br><br>50219<br><br>II. Failure to ensure staff followed appropriate infection control practices when providing catheter care<br><br>A. Facility policy and procedure<br><br>The Indwelling Urinary Catheter Management policy and procedure, revised 6/27/23, was provided by the NHA on 11/11/24 at 10:43 a.m. It revealed in pertinent part, Following aseptic insertion of the urinary catheter, maintain a closed drainage system. If breaks in aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment.<br><br>B. Observation<br><br>On 11/7/24 at 1:27 p.m. certified nurse aide (CNA) #5 was performing Foley catheter care for Resident #23. CNA #5 performed hand hygiene and donned (put on) a pair of gloves. CNA #5 brought two basins of warm water to the bedside table. CNA #5 said she mixed body soap into one basin of water for cleaning. CNA #5 changed gloves. CNA #5 folded a washcloth into quarters then proceeded to use a corner of the washcloth and soapy, warm water to clean the resident's groin area.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Using a different section of the same washcloth, CNA #5 proceeded to clean the Foley catheter tubing, beginning from the resident's meatus (opening in the resident's penis leading to the interior of the body) and down the rest of the tubing.<br><br>With the same pair of gloves, CNA #5 folded a second washcloth into quarters. Using the second wash cloth, CNA #5 placed the cloth into the warm water without soap and wiped Resident #23's groin area to remove the soap. CNA #5 then used a different section of the second washcloth and wiped the Foley catheter tubing, beginning from the resident's meatus and down the rest of the tubing.<br><br>With the same pair of gloves, CNA #5 folded a third washcloth into quarters and dried the resident's groin area. Using a different section of the third washcloth, CNA #5 wiped the Foley catheter tubing, beginning from the resident's meatus and down the rest of the tubing.<br><br>With the same pair of gloves, CNA #5 secured the tubing back into the stat-lock (a device that holds and stabilizes the Foley catheter to reduce the risk of accidental removal or pulling) on his left leg.<br><br>-CNA #5 failed to lift Resident #23's testicles and clean underneath them.<br><br>-CNA #5 failed to change gloves and perform hand hygiene after cleaning a dirtier area before cleaning a cleaner area in order to prevent contamination of the sterile catheter system.<br><br>C. Staff interviews<br><br>CNA #6 was interviewed on 11/6/24 at 3:04 p.m. CNA #6 said when she performed residents' catheter care she used wipes to clean around the area of the catheter along with saline and gauze. CNA #6 said she cleaned the catheter tubing itself and the groin area.<br><br>CNA #5 was interviewed on 11/7/24 at 1:34 p.m. CNA #5 said she was not as familiar with male catheter care. CNA #5 said catheter care was provided every day or every other day or if the catheter became soiled. CNA #5 said providing catheter care was important to prevent yeast and to prevent germs from getting into the bladder.<br><br>Licensed practical nurse (LPN) #4 was interviewed on 11/7/24 at 1:40 p.m. LPN #4 said catheter care should be performed once every shift or as needed. LPN #4 said providing catheter care was important to prevent infection.<br><br>The director of nursing (DON) was interviewed on 11/7/24 at 5:23 p.m. The DON said gloves should be changed during catheter care and hand hygiene should be performed after cleaning a dirtier area before cleaning a cleaner area in order to prevent contamination of the sterile catheter system. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064<br><br>Based on record review and interviews, the facility failed to implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for one (#69) of one resident reviewed for antibiotic use out of 41 sample residents.<br><br>Specifically, the facility failed to effectively track and monitor the use of long-term antibiotics for Resident #69.<br><br>Findings include:<br><br>I. Professional reference<br><br>The Centers for Disease Control and Prevention (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 11/14/24 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. It read in pertinent part,<br><br>Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections.<br><br>II. Facility policy and procedure<br><br>The Antibiotic Stewardship policy and procedure, revised on 5/16/24, was received from the nursing home administrator (NHA) on 11/11/24 at 10:13 a.m. It revealed in pertinent part,<br><br>The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic-resistant organisms and/or other adverse events. The program will be managed and overseen by the infection preventionist.<br><br>Leadership commitment and accountability: The infection preventionist (IP), the director of nursing (DON), the pharmacy consultant and the medical director are the facility leads responsible for promoting and overseeing antibiotic stewardship activities. The above members of the antibiotic stewardship team (AST) will demonstrate support and commitment to safe and appropriate antibiotic use.<br><br>Prescription record keeping: Dose, duration, and indication of each antibiotic prescription will be documented in the medical record for each resident.<br><br>Assessment of residents suspected of having an infection: The facility will utilize the McGeer's Criteria when considering initiation of antibiotics.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provider communication: It is encouraged that the standardized general SBAR (situation, background, assessment, and recommendation) form be used for all changes in condition communication.<br><br>Antibiotic time out at 72 hours after antibiotic initiated or first dose in the facility: Each resident should be reassessed for consideration of antibiotic needs. At that time laboratory testing results, response to therapy and resident condition will be considered.<br><br>Interventions for syndrome-specific antibiotic use and prophylaxis: The AST will identify actions to directly impact inappropriate antibiotic use for specific syndromes and for prophylactic indications.<br><br>The facility should provide feedback (verbal or written note in the record) to prescribing practitioners regarding antibiotic resistance data, their antibiotic use and their compliance with the facility antibiotic use protocols to improve prescribing practices and resident outcomes.<br><br>III. Resident #69<br><br>A. Resident status<br><br>Resident #69, age greater than 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included benign prostatic hyperplasia without lower urinary tract symptoms (enlarged prostate), hydronephrosis with renal and ureteral calculus obstruction (swelling of kidney related to kidney stones), tracheostomy status (surgical opening through the neck to aid with breathing), chronic obstructive pulmonary disease (COPD) (damage to lung tissue that makes breathing difficult), acute and chronic respiratory failure.<br><br>The 8/15/24 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. The MDS assessment revealed he required minimal assistance with ambulation.<br><br>B. Resident interview<br><br>On 11/4/24 at 11:20 a.m. Resident # 69 was interviewed. Resident #69 said he had been in the facility for a year and a half, and had received excellent care. Resident #69 said he could not recall all of his medications and was not sure if he was taking an antibiotic.<br><br>C. Record Review<br><br>The history and physical note, dated 4/21/23, documented Resident #69 had a urinary catheter placed on 2/23/23 for urinary retention and it was able to be removed after two weeks with no further urinary retention issues. Resident #69 had completed the intravenous (IV) antibiotic therapy ordered by infectious disease during hospital stay on 4/13/23.<br><br>A comprehensive review of Resident #69's electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE] with a physician's order for Macrobid (antibiotic) 100 milligrams (mg), give one capsule once daily for UTI (urinary tract infection) prevention.<br><br>-The physician's order did not have a stop date for the antibiotic.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The urinary incontinence care plan, initiated 5/2/23, documented Resident #69 had urinary incontinence. The goal was to prevent any skin breakdown related to urinary incontinence. Interventions included assisting the resident with toileting as needed and providing pericare as needed.<br><br>-The care plan did not indicate the resident had frequent UTIs or that the resident was receiving a long-term prophylactic antibiotic for UTI prevention.<br><br>A 2/26/24 critical care hospital physician's progress note documented Resident #69 was admitted to the hospital for pneumonia. The progress note documented the hospital changed Resident #69's Macrobid to to Keflex (antibiotic) prophylactically because the physician was concerned that long-term Macrobid use caused interstitial lung disease (ILD - inflammation and scarring in the lungs).<br><br>The November 2024 CPO revealed that Resident #69 had a physician's order for Keflex 500 mg by mouth one time daily for prophylaxis history of UTI. No stop date as this is prophylaxis, ordered 3/29/24.<br><br>-Review of Resident #69's EMR revealed there was no documentation from a urologist to justify the use of the resident's long-term antibiotic.<br><br>IV. Staff interviews<br><br>The IP was interviewed on 11/7/24 at 3:08 p.m. The IP said the facility followed McGeer's Criteria as part of their antibiotic stewardship program and all physicians were aware of the facility's use of McGeer's Criteria. The IP said the system the facility used for antibiotic tracking would prompt staff to ensure criteria were met for the use of an antibiotic. The IP said she would talk with the physician if an antibiotic did not meet McGeer's criteria.<br><br>The IP said she tracked all antibiotic use on paper and the facility had a tracking system they used.<br><br>The IP said antibiotic use was also discussed monthly at the quality assurance and performance improvement (QAPI) meetings and the medical director would talk with providers if they noted an issue with any antibiotics.<br><br>The DON was interviewed on 11/7/24 at 4:00 p.m. The DON said Resident #67 was on an oral antibiotic prophylactically and she was not aware of a stop date for the antibiotic. The DON said Resident #67 had a urologist and the urologist wanted the resident to continue the use of the antibiotic prophylactically.<br><br>-However, there was no documentation in Resident #67's electronic medical record (EMR) to indicate the urologist had provided justification for the long-term use of the resident's antibiotic and the facility was unable to provide documentation of the urologist's recommendations (see record review above).<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The regional nurse consultant (RNC) was interviewed on 11/7/24 at 4:32 p.m. The RNC said the urologist placed Resident #69 on antibiotics for UTI. The RNC said Resident #69 was still on antibiotics because he had a lithotripsy (shock waves used to break kidney stones) with stent placement (small tube allowing kidney stones fragments to leave the body) in August 2023. The RNC said a critical care doctor during a hospital admission switched Resident #69 from Macrobid to Keflex.<br><br>-However, there was no justification from a urologist in Resident #69's EMR for the use of the long-term antibiotic (see record review above).<br><br>51160 |