| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065387 | A. Building<br>B. Wing | 07/16/2024 |

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| Forest Street Compassionate Care Center | 3345 Forest St<br>Denver, CO 80207 |

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| F 0575<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency.<br><br>50219<br><br>Based on observations and interviews, the facility failed to ensure residents received notices orally and in writing which included a written description of their legal rights.<br><br>Specifically, the facility failed to have the state contact information posted in a readable font size and placed in an area that had ease of access for the residents.<br><br>Findings include:<br><br>I. Resident council interview<br><br>Seven residents (#20, #18, #33, #34, #35, #41 and #31) who frequently attended the monthly resident council meetings and were identified as alert and oriented by facility and assessment were interviewed on 7/11/24 at 3:13 p.m. The residents said they did not know how to file a complaint with the State Agency.<br><br>II. Observations<br><br>-Observations on 7/15/24 at 8:47 a.m. and at 2:57 p.m. did not reveal the required postings throughout the facility.<br><br>III. Staff interviews<br><br>The social services director (SSD) and nursing home administrator (NHA) were interviewed together on 7/15/24 at 1:58 p.m. The SSD and NHA said they were unable to locate the contact information for the State Agency and nursing home advocacy groups anywhere in the facility.<br><br>The NHA said she was sure that the posting was hanging up earlier in the day, but could not locate it.<br><br>The SSD and the NHA were interviewed again on 7/15/24 at 2:04 p.m. The NHA and SSD said they had found a poster on the bulletin board in the common area that had only the information for the facility's corporate contact information.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0575<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | The NHA said she had found another required posting in the administration office that included the information for the State Agency and police department contact information on her bulletin board in her office.<br><br>-The State Agency posting was not accessible for the residents. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350<br><br>Based on interviews and record review, the facility failed to ensure that two (#155 and #25) of two residents reviewed for abuse out of 31 sample residents were kept free from physical abuse.<br><br>Resident #38 had a known history of physically aggressive behaviors towards others. Nursing progress notes documented the resident had a tendency to throw food, drinks, plates and cups in the dining room.<br><br>On 3/22/24, the facility initiated behavior monitoring of Resident #38's physically aggressive behavior, including biting and scratching, during activities of daily living (ADL) and refusal of care. However, staff did not consistently document the behavior monitoring. Additionally, the facility failed to identify specific person-centered interventions to address Resident #38's physically aggressive behaviors.<br><br>On 4/9/24, Resident #38 bit her roommate, Resident #155, on the finger after Resident #155 touched Resident #38's puzzle book. Resident #155 sustained a wound on her left finger which required wound care, a tetanus vaccination and antibiotics.<br><br>Following the 4/9/24 incident, the facility failed to identify and implement interventions to prevent Resident #38 from biting other residents.<br><br>Due to the facility's failure to implement person-centered interventions to prevent further episodes of biting, Resident #38 bit Resident #25 on 7/8/24.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Identifying Types of Abuse policy and procedure, last reviewed September 2022, was provided by the nursing home administrator (NHA) on 7/10/24 at 4:01 p.m. It revealed in pertinent part,<br><br>Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.<br><br>Abuse toward a resident can occur as resident to resident abuse, staff to resident abuse, or visitor to resident abuse.<br><br>Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking.<br><br>II. Facility investigation of abuse between Resident #38 and Resident #155 on 4/9/24<br><br>The 4/9/24 abuse investigation documented an unwitnessed resident to resident altercation between Resident #38 and Resident #155. It indicated that Resident #155 was in her room and started screaming that her roommate, Resident #38, had bitten her on the finger.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A certified nurse aide (CNA) entered the room and removed Resident #155 from the room and Resident #155 told her that Resident #38 had bitten her after she (Resident #155) had touched Resident #38's puzzle book.<br><br>The on duty nurse and the director of nursing (DON) were notified. A skin assessment was performed and a skin tear of 1 centimeter (cm) by 2.5 cm was observed. The provider was notified and orders for wound care, tetanus vaccination and antibiotics were received.<br><br>-However, the facility failed to substantiate or unsubstantiate the allegation of physical abuse in the conclusion of the internal investigation.<br><br>III. Resident #38<br><br>A. Resident status (assailant)<br><br>Resident #38, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician order (CPO), diagnosis included dementia with behavioral disturbance and cognitive communication deficit.<br><br>The 4/18/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of 12 out of 15. She required substantial/maximal assistance with bed mobility, transfers, dressing, toileting and personal hygiene.<br><br>The assessment indicated the resident exhibited physical behaviors towards others.<br><br>B. Record review<br><br>The behavioral care plan, initiated 2/21/24 and revised on 5/29/24, indicated Resident #38 exhibited physically aggressive behaviors towards staff and had a history of physical abuse by her husband. It indicated she did not like male caregivers. It indicated on 4/9/24 she bit a roommate's finger with injury and on 7/8/24 bit another resident's hand without injury. The interventions included two persons for all cares, analyzing times of day, places, circumstances, triggers and what deescalates behavior and documenting, assessing and anticipating the resident's needs and providing physical and verbal cues to alleviate anxiety.<br><br>-An intervention of attempting to position Resident #38 out of reach of other residents unless supervised, was added on 7/10/24 (following a second incident of biting another resident).<br><br>The cognition care plan, initiated 1/15/24, indicated Resident #38 was alert and only oriented to self and family consistently and chose when she wanted to speak to others. Interventions included staff meeting and anticipating the resident's needs.<br><br>The activities care plan, initiated 2/7/24 and revised 5/29/24, indicated Resident #38 was dependent on staff for meeting emotional, intellectual, physical and social needs related to cognitive deficits and behaviors. Interventions included staff to converse with the resident while providing care, encouraging family involvement, providing the resident with an activities calender and providing the resident with assistance to activity functions.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -A review of Resident #38's comprehensive care plan did not reveal effective personalized communication interventions when she was unable to communicate an unmet need. It did not reveal effective personalized behavioral interventions for identification or prevention of triggers for the resident's aggressive behaviors towards other residents.<br><br>-The comprehensive care plan did not reveal any additional interventions added until 7/10/24, after a second incident occurred of Resident #38 biting another resident.<br><br>The facility initiated daily behavior monitoring of resident's aggressive behaviors, including biting and scratching, during activities of daily living (ADL) and refusals of care on 3/22/24.<br><br>-However, a review of Resident #38's electronic medical record (EMR) did not reveal routine behavior monitoring towards other residents or documentation of frequent behavior monitoring after incidents of resident to resident aggressive behaviors.<br><br>A 3/11/24 nursing progress note documented Resident #38 threw her food, juice and water on the floor in her room when she was served her dinner.<br><br>-There were no interventions implemented to address the resident's behaviors (see care plan review above).<br><br>A 3/15/24 nursing progress note documented Resident #38 was throwing her cup and plates on the floor in the dining room and was taken back to her room to avoid hurting other residents or caregivers.<br><br>-There were no interventions implemented to address the resident's behaviors (see care plan review above).<br><br>A 4/9/24 nursing progress note documented Resident #38 had an altercation with Resident #155, her roommate, and bit her left index finger over word search books and personal space and inflicted a wound. Resident #38 was moved to another room.<br><br>-There were no interventions implemented to address the resident's behaviors (see care plan review above).<br><br>A 4/10/24 nursing progress note documented Resident #38 was being monitored related to an altercation with Resident #155 and was not cooperating with staff. Resident #38 was taken to the dining area and was not cooperative. She was then taken to her room and moved to her bed when she scratched a certified nurse aide (CNA).<br><br>A 7/8/24 nursing progress note documented Resident #38 was witnessed by a staff member biting another Resident #25 on the hand in the television room. Resident #25 was assessed, did not sustain an injury, did not have any pain and was unable to remember the incident.<br><br>-A review of Resident #38's EMR did not reveal documentation of an interdisciplinary team (IDT) note with a root cause analysis or further interventions identified to prevent behaviors immediately after the 4/9/24 or the 7/8/24 incidents.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -An intervention of attempting to position Resident #38 out of reach of other residents, unless supervised, was added following the 7/8/24 incident, however, the intervention was not added until two days after the incident.<br><br>IV. Resident #155 (victim)<br><br>A. Resident status<br><br>Resident #155, age 85, was admitted on [DATE] and discharged to the hospital on 4/16/24. According to the April 2024 CPO, diagnoses included end stage renal disease (ESRD) and hypertension.<br><br>The 3/29/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 12 out of 15. She was dependent with transfers, required substantial/maximal assistance with personal hygiene and required partial/moderate assistance with toileting and bed mobility.<br><br>B. Record review<br><br>The abuse care plan, initiated 4/12/24, indicated Resident #155 was at risk for being abused related to a dementia diagnosis. Interventions included administering medications, analyzing circumstances and triggers and what deescalated behavior, providing physical and verbal cues to alleviate anxiety, giving the resident choices about care and activities, monitoring any signs of resident posing danger to self and others, removing the resident from harm's way providing a safe environment and intervening when the resident was agitated before escalation and guiding away from sources of distress.<br><br>The skin impairment care plan, initiated 1/10/24 and revised 4/12/24, indicated Resident #155 had skin integrity impairment related to a bite received from another resident. Interventions included avoiding scratching and keeping hands and body parts from excessive moisture, keeping fingernails short, encouraging nutrition and hydration, following up with facility protocols for treatment of injury, monitoring for side effects of antibiotics, monitoring treatment and documenting location of injury, obtaining blood work of any open wounds as ordered by physician.<br><br>-A review of Resident #155's comprehensive care plan did not reveal personalized interventions to prevent further abuse from aggression by other residents.<br><br>The 4/9/24 nursing progress notes documented Resident #155 hollered for help and the CNA alerted the nurse about Resident #155's left index finger which had a skin tear with some blood. The resident was grimacing in pain.<br><br>The assessment documented the resident had a skin tear of 1 centimeter (cm) by 2.5 cm. An order was received for wound care and to administer tetanus vaccine and Augmentin (an antibiotic). It documented Resident #155 was bitten by her roomate after an altercation over word search books and personal space.<br><br>The 4/10/24 nursing progress note documented an order for an x-ray to the left index finger and the x-ray result was negative for fracture or dislocation.<br><br>V. Resident #25 (victim)<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | A. Resident status<br><br>Resident #25, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included anxiety and encephalopathy.<br><br>The 5/28/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of two out of 15. She was dependent with personal hygiene, transfers, required substantial/maximal assistance with toileting, bed mobility and required supervision with eating.<br><br>B. Record review<br><br>The skin integrity care plan, initiated 11/10/22 and revised 6/10/24, indicated Resident #25 was bitten on the right hand by another resident on 7/8/24. Interventions included observing the resident's right hand for bruising for 72 hours.<br><br>-A review of Resident #25's comprehensive care plan did not reveal an abuse care plan or personalized interventions to prevent abuse by other residents after Resident #38 bit Resident #25 on 7/8/24.<br><br>The 7/8/24 nursing progress note documented Resident #25 was in the television room when a CNA observed Resident #38 biting Resident #25. Resident #25 denied pain or discomfort. Resident #25's right posterior hand was assessed and the skin was observed intact without redness<br><br>VI. Staff interviews<br><br>CNA #1 was interviewed on 7/15/24 at 10:25 a.m. CNA #1 said Resident #38 had a history of fighting and biting staff and other residents. She said she observed the 7/8/24 interaction of Resident #38 biting Resident #25's hand. She said Resident #38 reached out for Resident #25's arm and bit her. She said she reported it to the on duty nurse and obtained vital signs on the victim. She said the victim was assessed, had no injury and did not recall the incident. She said a report was filled out and submitted to the DON. She said staff separated the two residents. She said after the incident occurred, staff monitored Resident #38 but she said staff were not given a set frequency of how often to check on the resident. She said staff did not fill out a frequent 15 minute check form for the resident. She said the interventions staff would try with Resident #38 were redirection, separating her from other residents and giving her plenty of personal space. She said staff would also try other activities such as coloring books. She said interventions and special requirements for residents were communicated in the change of shift report. She said she was not sure where to get further pertinent information regarding interventions for residents and would get further guidance.<br><br>Licensed practical nurse (LPN) #2 was interviewed on 7/15/24 at 10:30 a.m. LPN #2 said Resident #38 was known to refuse medications and care. She said she knew Resident #38 had a history of behaviors which included fighting and biting. She said she had not personally seen those behaviors. She said she knew in the past Resident #38 had to have a sitter but she did not have one anymore. She said if Resident #38 exhibited behaviors towards other residents, staff would separate the residents, redirect, diffuse the situation and provide distractions.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | LPN #2 said staff would report instances of abuse to the DON, obtain vital signs and assess the victim. She said staff would monitor both the assailant and the victim. She said staff would check on the residents involved in the abuse incident every five minutes but this was not documented. She said staff had a frequent 15-minute check sheet where they could document frequent monitoring but she did not know if this was part of the residents' permanent record. She said any pertinent information regarding behaviors would be documented on the care plan.<br><br>CNA #1 was interviewed again on 7/15/24 at 11:00 a.m. CNA #1 said pertinent information regarding resident behaviors and safety interventions was found on the Kardex (a tool utilized to provide consistent care to residents),which was populated from the care plan.<br><br>The DON and the NHA were interviewed together on 7/15/24 at 12:15 p.m. The NHA said she was the abuse coordinator.<br><br>The DON said when an incident of alleged physical abuse occurred, to ensure safety, the residents were removed from the situation. She said the nurse on duty would notify the DON and NHA and notify the physician and family or legal decision maker. The DON said the root cause analysis and interventions that were put into place depended on the outcome of the investigation, after staff and resident witness interviews were conducted. She said instances of alleged abuse were discussed in the morning meetings, which included the DON, the NHA and the social services director (SSD). She said these meetings were not documented in the medical record, she said all risk management documentation was included in the incident report.<br><br>The DON said new interventions that were identified were documented in the alert nurse charting and updated in the care plan. The DON said she was not at the facility at the time of the 4/9/24 incident and could not speak to what was done after that incident. She said however, she was at the facility for the 7/8/24 incident and frequent monitoring was not conducted due to the victim did not have an injury and did not recall the incident. She said the new intervention identified after the 7/8/24 incident was to keep Resident #38 out of arm's reach of other residents unless supervised. She said frequent monitoring sheets were part of the residents' permanent medical record. The DON said she was not aware if Resident #38 had one on one caregivers in the past, but a family member was with her every day. She said she was aware Resident #38 liked puzzles in her room but did not think she was open to doing any other activities. She said there were currently ongoing conversations and education with facility staff about personalizing interventions in care plans. She said since there was a history of behaviors there needed to be a care conference set up with Resident 38's family and her care plan needed to be updated with personalized behavior interventions. |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950<br><br>Based on record review and interviews, the facility failed to ensure an appropriate facility-initiated discharge procedure was followed for one (#105) of two residents reviewed for discharge out of 31 sample residents.<br><br>Resident #105, who had a diagnosis of rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder and chronic pain, was admitted to the facility on [DATE] and involuntarily discharged to a homeless shelter on 2/20/24. The facility failed to provide preparations for a safe and orderly facility-initiated discharge or provide a reason for the discharge.<br><br>Resident #105 began discharge planning with the facility on 1/11/24 during a care conference where his stated goal was to discharge to an assisted living facility (ALF). The last discharge plan discussion occurred on 2/16/24 when the facility offered to discharge the resident to homeless shelters and he declined this option. On 2/20/24 the facility had Resident #105 escorted from the facility by law enforcement. Resident #105 was crying and begging not to be kicked out of his home.<br><br>The facility failed to provide the resident with a 30-day discharge notice or any form of written discharge notice and failed to provide written notice to the ombudsman of the discharge.<br><br>Cross-reference F623 for failure to provide a written discharge notice to the ombudsman to include the reasons for the discharge.<br><br>Additionally, the facility failed to provide Resident #105 with discharge instructions or his medications.<br><br>Due to the facility's failures, Resident #105 was in and out of the hospital and homeless shelters following the involuntary discharge. Resident #105 suffered psychosocial harm stating he had a lot of confusion and anxiety when he first left and he was crying and begging at discharge not to be kicked out of his home. Resident #105 was angry about how the facility treated him and said it made him feel like he was a big problem and depreciated. Resident #105 said the experience was horrible when he was threatened with either discharging from the facility or going to jail.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Transfer or Discharge, Facility-Initiated policy and procedure, dated October 2022, was provided by the nursing home administrator (NHA) on 7/11/23 at 5:05 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.<br><br>Facility-Initiated transfer or discharge means a transfer or discharge which the resident objects to, and/or is not in alignment with the resident's stated goals for care and preference.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The resident and his or her representative are given a thirty (30)-day advance notice of an impending transfer or discharge from the facility. The resident and representative are notified in writing of the following information:<br><br>-The specific reason for the transfer or discharge, including the basis;<br><br>-The effective date of the transfer or discharge;<br><br>-The specific location to which the resident is being transferred or discharged ; and,<br><br>-An explanation of the resident's rights to appeal the transfer or discharge to the state, including:<br><br>-The name, address, email and telephone number of the entity which receives such appeal hearing requests;<br><br>-Information about how to obtain an appeal form; and,<br><br>-How to get assistance in completing and submitting the appeal hearing request;<br><br>-The notice of facility bed-hold and policies;<br><br>-The name, address, and telephone number of the office of the state long-term care ombudsman;<br><br>-The name, address, email and telephone number of the agency responsible for the protection and advocacy of residents with intellectual and developmental disabilities; and<br><br>-The name, address and telephone number of the state health department agency that has been designated to handle appeals of transfers and discharge notices.<br><br>A copy of the notice is sent to the office of the state long-term care ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.<br><br>Nurses notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge.<br><br>Documentation of facility-initiated transfer or discharge: When a resident is transferred or discharged from the facility, the following information is documented in the medical record:<br><br>-The basis for the transfer or discharge;<br><br>-If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: the specific resident needs that cannot be met; this facility's attempt to meet those needs; and the receiving facility's services that are available to meet those needs;<br><br>-That an appropriate notice was provided to the resident and/or legal representative;<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -The date and time of the transfer or discharge;<br><br>-The new location of the resident;<br><br>-The mode of transportation;<br><br>-A summary of the resident's overall medical, physical, and mental condition;<br><br>-Disposition of personal effects;<br><br>-Disposition of medications;<br><br>-Others as appropriate or as necessary; and,<br><br>-The signature of the person recording the data in the medical record.<br><br>-However the above information was not documented in Resident #105's electronic medical record (EMR) (see record review below), and the resident and/or representative did not receive any written notice of an impending facility-initiated discharge.<br><br>II. Resident #105<br><br>A. Resident status<br><br>Resident #105, age less than 65, was admitted on [DATE] and discharged on [DATE] to a homeless shelter.<br><br>According to the February 2024 computerized physician orders (CPO), diagnoses included rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder and chronic pain.<br><br>The 2/20/24 discharge 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. He was independent for all functional activities of daily living (ADL).<br><br>The assessment documented the resident had no behavioral symptoms including physical, verbal, or other and there was no rejection of care.<br><br>The assessment documented active discharge planning was already occurring for the resident to return to the community and a referral had been made to the local contact agency.<br><br>-Discharge planning according to the residents goals and preferences was to discharge to an ALF. However, the facility suddenly discharged him to a homeless shelter against his wishes (see interviews and record review below).<br><br>B. Resident interview<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident #105 was interviewed via phone on 7/11/24 at 12:28 p.m. Resident #105 said the facility discharged him with no written discharge notice or reason. He said the facility gave him no discharge instructions or his medications. He said the facility called the police on him when he did not want to go and said he would either go to jail or go to a homeless shelter.<br><br>Resident #105 said the facility had retaliated against him because he had filed a complaint that the facility was cold and within a week he was told to leave. He said it was a horrible humiliating experience and made him feel like he was a huge problem and depreciated. He said the experience made him furious. He said he had been cold in the building and so he said something. He said he was not provided assistance by the ombudsman and he was not involved in selecting the new location to discharge to. He said he wanted to go to an assisted living facility and he said he was in the middle of that process when the facility suddenly discharged him without notice or reason.<br><br>Resident #105 said he worked with a psychiatrist and had a lot of confusion and anxiety when he was discharged from the facility. He said he had to go back to the hospital. He said the homeless shelter where he went had put him on a list for housing assistance.<br><br>C. Resident representative interview<br><br>The resident's representative was interviewed via phone on 7/11/24 at 11:38 a.m. The representative said the facility initiated Resident #105's discharge and he was not treated properly. The representative said neither she nor the resident had received a written discharge notice or a reason for the discharge. She said at the time of the discharge, she was on facetime with the resident because she lived out of state and had screen recorded the resident crying and begging for the facility not to kick him out.<br><br>The resident's representative said she was crying as she viewed how the resident was being treated. She said when Resident #105 would not leave, the facility called the police on him and the police forced him out.<br><br>The resident's representative said she thought the facility was retaliating against the resident because he spoke up about things that concerned him during his stay, such as the heat being turned off and being cold in the building and his clothing coming back from the laundry not cleaned or with holes. The resident's representative said the discharge happened right after he said something and the facility forced him to leave without a written discharge notice. The resident's representative said since his discharge from the facility, the resident had been in and out of the hospital and homeless shelters.<br><br>D. Frequent visitor (FV) interview<br><br>A frequent visitor (FV) was interviewed on 7/15/24 at 10:21 a.m. The FV said she did recall Resident #105. She said he was discharged for non payment and he did not want to apply for Medicaid. She said Resident #105 did not call her for assistance. She said she did not see the facility process the required discharge paperwork and no one followed up with her. She said the discharge process just got away. She said the facility was not consistent with their discharge processes and was changing social workers. The FV said she did not receive a written copy of the 30-day discharge notice.<br><br>E. Record review<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The long term care (LTC) care plan, initiated 12/29/23, revealed Resident #105 planned to remain at the facility for LTC and may have needed time to adjust to his new environment. However, he would be asked about his interest in discharging from the facility on a quarterly assessment. Interventions included to assist the resident to activities as needed, and to monitor for signs and symptoms (s/s) of decrease in mood or s/s of depression and inform social services if noticed such as little interest in doing things or number of depressed episodes, or experiencing pain.<br><br>-The care plan was not updated with a new discharge plan.<br><br>Review of Resident #105's EMR revealed the following progress notes:<br><br>The 1/11/24 care conference note revealed the resident planned to be discharged by the end of January 2024 and social services would meet the resident's discharge plan needs.<br><br>The 1/18/24 psychosocial note revealed the resident would like to be discharged to the community independently or in an ALF. The resident had been made aware (company name) independent living had a short waiting list and had indicated he was interested in completing the application and the application was provided to the resident on 1/17/24.<br><br>The 1/19/24 psychosocial note revealed the writer spoke to the ombudsman regarding the resident's interest in living in an ALF or an independent living facility. The ombudsman recommended (company name) ALF.<br><br>The 1/25/24 psychosocial note revealed the ALF would come to do a resident assessment of Resident #105 on 1/29/24.<br><br>The 1/30/24 psychosocial note revealed the resident would not be attending an assessment for (company name) ALF because the resident would be going to the independent living of (company name). The admission coordinator would be contacting the resident to relay the message to him.<br><br>The 2/1/24 psychosocial note revealed the writer had met with the resident on 1/31/24 and discussed a tour of (company name) ALF. The resident had indicated that he liked the place and was willing to move forward with admission to the ALF. The resident was unsure of the admission to the new facility therefore the writer reached out to the admission coordinator via email and she had indicated that the potential admitted would be in about two weeks (mid-February 2024).<br><br>The 2/9/24 physician discharge visit note revealed the resident was being seen at the request of the facility administrator for a discharge visit. It revealed the resident suffered from chronic pain due to rheumatoid arthritis and spinal stenosis. It revealed the staff had been dealing with issues regarding behaviors with the resident. The police had been called by the NHA after the resident had an outburst and had yelled inappropriate racial statements and also stated he would kill the people sitting here and still get away with it.<br><br>The note further revealed the police said they did not have enough reason to take him on a mental hold since he was not suicidal or homicidal and since he did not have a previous history, they could not detain him. The resident's health improved to the extent that the resident no longer needed the services of the facility and the resident would be discharged to a safe housing/shelter and the facility would provide transportation.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The 2/9/24 CPO revealed the resident may discharge to safe housing/shelter.<br><br>The 2/14/24 psychosocial note revealed the writer visited the resident to discuss his discharge plans and the resident was open to discuss his plans. When talking about the ALF location the resident was interested in going to, the resident stated he was not going there because they continued to ask him about another facility he had never been to. However when speaking to the ALF, the writer spoke with the admission coordinator and she had stated that the executive director had declined Resident #105's admission due to his behaviors. During the visit, the resident stated he was not depressed regarding the situation but continued to visit with his own therapist weekly. The resident's goal was to be cordial with others to meet his goal of being discharged to an ALF or independent living.<br><br>The 2/16/24 psychosocial note revealed the facility met with the resident to discuss discharge plans. The facility offered to discharge him to homeless shelters and he declined this option. The plan was to follow up the following week for any further instructions needed to aid the resident in the discharge transition.<br><br>The 2/17/24 nurses note revealed the police had been called by the resident to report that the facility's heater was turned off and the resident was cold. The police spoke with the resident and left. The nurse asked the resident if he was still cold and needed more blankets and he had said he was fine.<br><br>The 2/20/24 at 7:13 a.m. psychosocial note revealed the writer had spoken with the resident's representative on 2/19/24 to discuss the resident's discharge plan. The representative had stated she would help find a location for the resident. The writer and the resident's representative planned to meet with the resident via computer facetime, and if possible with the resident's therapist, on 2/21/24 to discuss the discharge plan.<br><br>The 2/20/24 at 10:02 a.m. psychosocial note revealed that, during the call on 2/19/24, the resident's representative had asked if the manager of the facility's ownership company could give her a call to understand what was going on at the facility. The writer had spoken to the CEO (chief operating officer) and CFO (chief financial officer) and addressed the concerns of the representative and they planned to call the resident's representative as requested.<br><br>-The resident's representative revealed during her interview on 7/11/24, the company management had never given her a call.<br><br>The 2/20/24 at 3:49 p.m. nurses note revealed at approximately 3:50 p.m. Resident #105 was escorted from the facility accompanied by law enforcement. The resident was cooperative.<br><br>The 2/20/24 at 4:46 p.m. psychosocial note revealed the resident was presented with multiple options when planning to discharge, however, he refused to comply with any option. The resident was discharged that day (2/20/24) and he refused to leave. The writer met with the resident along with a civilian emergency response team, clinicians and the police because of the resident's refusal to leave after being successfully discharged from the facility and the resident was considered to be trespassing. The administrative staff assisted with the process to have the resident transported to a homeless shelter where he would be able to coordinate housing with the shelter's available options.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The 2/21/24 at 8:47 a.m. psychosocial note revealed the ombudsman was contacted on 2/20/24 about an emergency discharge of Resident #105 due to the ombudsman being a part of the discharge planning from the beginning.<br><br>Review of Resident #105's EMR on 7/11/24 at 9:49 a.m. revealed the following:<br><br>-There was no discharge summary or assessment documentation;<br><br>-There were no nurses note documentation of appropriate orientation and preparation of the resident prior to transfer or discharge;<br><br>-There was no reason for the discharge documented in the record; and,<br><br>-There was no written discharge notice documentation.<br><br>III. Staff interviews<br><br>The regional operations consultant (ROC), the NHA, and the social services director (SSD) were interviewed together on 7/11/24 at 3:06 p.m. The NHA said she had started in the NHA position in May 2024 but she was at the facility in other capacities in the month of February 2024. She said the current SSD started in January of 2024. The NHA said the current SSD was fairly new at the time of Resident #105's discharge in February of 2024 but had help from another regional social services consultant who was now no longer with the company.<br><br>The SSD said the facility initiated the discharge of Resident #105.<br><br>The NHA said when the discharge process began, Resident #105 was in favor of discharging but she said, at the very end of the process, the discharge became facility-initiated. The NHA said the facility used a third party organization who worked with the community to assist with the discharge.<br><br>The ROC said there were several factors for why Resident #105 was discharged but the main reason was because the resident was not happy at the facility.<br><br>The NHA said the ombudsman talked to everyone to help the process. The NHA and the ROC said they did not know what the facility's policy was on discharge notification and they could not give a reason why the discharge was facility-initiated.<br><br>The NHA said they did not formally notify Resident #105 regarding the discharge.<br><br>The NHA and the ROC were interviewed again on 7/15/24 at 8:46 a.m. They reiterated that the discharge started as a resident-initiated discharge but they were not sure how or why the discharge became facility-initiated. The NHA and the ROC acknowledged that the progress note documented that it was an emergency discharge and that the police were called but they did not know the reason why the progress note documented that. The NHA and the ROC said they did not know why it was determined that Resident #105 would be discharged on that day (2/20/24) when the resident did not want to be discharged . They said they did not know the reason why the facility discharged the resident or why the facility had not issued a 30-day discharge notice.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The director of nursing (DON) was interviewed on 7/16/24 at 10:10 a.m. The DON said on the day a resident was discharged the nurses made preparations to be sure all the resident's medications were ready. The DON said the social services department would handle the transportation arrangements. The DON said the nurses would go over the medications to make sure the resident understood how and when to take the medications. The DON said the discharging resident could take their medications with them. The DON said the nurses would get discharge orders. The DON said the nurse should document the education provided to the resident prior to the discharge.<br><br>-However, there was no documentation that Resident #105 was provided with his medications or any education regarding medications or his discharge prior to his involuntary discharge on 2/20/24. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950<br><br>Based on record review and staff interviews, the facility failed to ensure one (#105) of two residents and/or their responsible person and the ombudsman were provided a written discharge notice to include the reasons for the move in a language and manner they would understand out of 31 sample residents.<br><br>Specifically, the facility failed to provide Resident #105 an appropriate written notice of discharge from the facility that included:<br><br>-The reason for transfer or discharge;<br><br>-The effective date of transfer or discharge;<br><br>-The location to which the resident was transferred or discharged ;<br><br>-A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests;<br><br>-Information on how to obtain an appeal form and assistance in completing the form and submitting the appeal-hearing request; and,<br><br>-The name, address (mailing and email) and telephone number of the Office of the State.<br><br>Additionally, the facility failed to provide written notice to the ombudsman of Resident #105's facility-initiated discharge.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Transfer or Discharge, Facility-Initiated policy and procedure, dated October 2022, was provided by the nursing home administrator (NHA) on 7/11/23 at 5:05 p.m. It read in pertinent part, Once admitted to the facility, residents have the right to remain in the facility. Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy.<br><br>Facility-Initiated transfer or discharge means a transfer or discharge which the resident objects to, and/or is not in alignment with the resident's stated goals for care and preference.<br><br>The resident and his or her representative are given a thirty (30)-day advance notice of an impending transfer or discharge from the facility. The resident and representative are notified in writing of the following information:<br><br>-The specific reason for the transfer or discharge, including the basis;<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The effective date of the transfer or discharge;<br><br>-The specific location to which the resident is being transferred or discharged ; and,<br><br>-An explanation of the resident's rights to appeal the transfer or discharge to the state, including:<br><br>-The name, address, email and telephone number of the entity which receives such appeal hearing requests.<br><br>A copy of the notice is sent to the office of the state long-term care ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.<br><br>II. Resident #105<br><br>A. Resident status<br><br>Resident #105, age less than 65, was admitted on [DATE] and discharged on [DATE] to a homeless shelter. According to the February 2024 computerized physician orders (CPO), diagnoses included rheumatoid arthritis, anxiety disorder, depression, attention-deficit hyperactivity disorder, and chronic pain.<br><br>The 2/20/24 discharge 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. He was independent for all functional activities of daily living (ADL).<br><br>The assessment documented the resident had no behavioral symptoms including physical, verbal, or other and there was no rejection of care.<br><br>The assessment documented active discharge planning was already occurring for the resident to return to the community and a referral had been made to the local contact agency.<br><br>-Discharge planning according to the residents goals and preferences was to discharge to an assisted living facility. However the facility suddenly discharged him to a homeless shelter against his wishes (see interviews and record review below).<br><br>III. Record review<br><br>-Record review revealed the facility failed to provide a written notice for the facility initiated discharge to Resident #105, to include his appeal rights, and failed to send a written copy of the notice to a representative of the office of the state long-term care ombudsman.<br><br>-The facility failed to provide a reason for the sudden discharge (cross-reference F622 for transfer and discharge requirements).<br><br>On 7/11/24 at 3:06 p.m documentation of the discharge notice that was provided to the resident and the written notification of the ombudsman were requested from the facility.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -However, the facility failed to provide documentation of the discharge notice and notification to the ombudsman (see interviews below).<br><br>Review of Resident #105's electronic medical record (EMR) revealed the following progress notes:<br><br>The 2/20/24 at 3:49 p.m. nurses note revealed at approximately 3:50 p.m. Resident #105 was escorted from the facility accompanied by law enforcement. The resident was cooperative.<br><br>The 2/20/24 at 4:46 p.m. psychosocial note revealed the resident was presented with multiple options when planning to discharge, however, he refused to comply with any option. The resident was discharged that day (2/20/24) and he refused to leave. The writer met with the resident along with a civilian emergency response team clinicians and the police because of the resident's refusal to leave after being successfully discharged from the facility and the resident was considered to be trespassing. The administrative staff assisted with the process to have the resident transported to a homeless shelter where he would be able to coordinate housing with the shelter's available options.<br><br>The 2/21/24 at 8:47 a.m. psychosocial note revealed the ombudsman was contacted on 2/20/24 about an emergency discharge of Resident #105 due to the ombudsman being a part of the discharge planning from the beginning.<br><br>Review of Resident #105's EMR on 7/11/24 at 9:49 a.m. revealed the following:<br><br>-There was no discharge summary or assessment documentation;<br><br>-There were no nurses note documentation of appropriate orientation and preparation of the resident prior to transfer or discharge;<br><br>-There was no reason for the discharge documented in the record; and,<br><br>-There was no written discharge notice documentation.<br><br>IV. Staff interviews<br><br>The social services director (SSD) was interviewed on 7/11/24 at 3:06 p.m. The SSD said he did not issue a written facility-initiated discharge notice to Resident #105 or the ombudsman.<br><br>The NHA and the regional operations consultant (ROC) were interviewed together on 7/15/24 at 8:46 a.m. The NHA and the ROC said the facility did not issue a facility-initiated discharge notice to Resident #105 or provide written notice to the ombudsman. The NHA and the ROC said they did not know the reason why the facility discharged the resident or why the facility had not issued a 30-day discharge notice. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219<br><br>Based on record review and interviews, the facility failed to develop a comprehensive care plan for services that were to be provided in order to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being for one (#19) of two residents reviewed for care planning out of 31 sample residents.<br><br>Specifically, the facility failed to identify and implement an appropriate care plan in a timely manner for Resident #19's exit seeking behaviors.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Wandering and Elopement policy, revised March 2019, was provided by the nursing home administrator (NHA) on 7/16/24 at 11:45 a.m. It read in pertinent part, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as a risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.<br><br>II. Resident #19<br><br>A. Resident status<br><br>Resident #19, age less than 65, was admitted to the facility on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included dementia and schizophrenia (mental illness that affects a person's mood and behavior).<br><br>The 4/30/24 minimum data assessment (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident required supervision and touching assistance with all activities of daily living.<br><br>B. Record review<br><br>A progress note dated 5/19/24 revealed Resident #19 was found with many stolen items, some of which belonged to a woman in the apartment complex next-door to the facility.<br><br>A physician's note, dated 6/4/24, revealed Resident #19 was interested in leaving the facility and did not want to come back. Resident #19 was sent to the emergency room for further medical and mental health workups.<br><br>A progress note, dated 6/12/24, revealed Resident #19 was crying, upset and said he wanted to leave.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A progress note, dated 6/15/24, revealed Resident #19 shoved a staff member aside while a visitor was entering the facility and walked outside. A certified nurse aide (CNA) attempted to stop Resident #19. The CNA was unable to stop the resident from leaving the facility. The note documented two people nearby, a CNA and the assistant director of nursing (ADON) attempted to redirect the resident back to the facility. Resident #19 was combative with those trying to redirect him and refused to go back into the facility. The paramedics were called to the facility and transported Resident #19 to the hospital for an evaluation. Fifteen minute checks were initiated for Resident #19 upon his return to the facility.<br><br>A progress note, dated 6/18/24, revealed the interdisciplinary team (IDT) reviewed Resident #19 and found that his elopement attempts had decreased. Resident #19's fifteen minute checks were discontinued during this meeting.<br><br>A progress note, dated 6/19/24 at 2:48 p.m., revealed Resident #19 followed a visitor out of the facility. Resident #19 made multiple attempts to leave the facility premises but was prevented from doing so by facility staff members. A registered nurse (RN), the nursing home administrator (NHA) and the social services director (SSD) were able to redirect Resident #19 back into the building with significant difficulty. Fifteen minute checks were restarted by nursing staff for Resident #19.<br><br>A progress note, dated 6/19/24 at 4:47 p.m., revealed Resident #19 was walking in and out of the facility courtyard.<br><br>A progress note, dated 6/19/24 at 11:54 pm., revealed Resident #19 tried to follow a staff member as she left the facility. Resident #19 was redirected back to the common room where he was crying and looking for his father.<br><br>A progress note dated 6/20/24 at 5:53 a.m. revealed Resident #19 was exit seeking and crying throughout the preceding night, and required redirection multiple times.<br><br>A progress note, dated 6/20/24 at 1:18 p.m., revealed Resident #19 required frequent redirection away from the facility exits and continued on fifteen minute checks for safety.<br><br>A progress note, dated 6/27/24 at 7:46 p.m., revealed at 6:10 p.m. that day Resident #19 exited the facility through a fire exit in the dining room. The facility staff followed Resident #19 and attempted to stop him, but Resident #19 ran after a public bus. All available staff were notified and searched the neighborhood for Resident #19 but were unable to find him. The police were called and Resident #19 was reported as a missing at-risk person.<br><br>A progress note, dated 6/28/24 at 3:56 a.m., revealed at 1:45 a.m. that morning Resident #19 was found by the police and escorted back to the facility. The nursing staff continued fifteen minute checks on Resident #19 before sending the resident to the emergency room for evaluation.<br><br>A progress note, dated 6/28/24 at 2:42 p.m., revealed a one-to-one caregiver was assigned to Resident #19 due to his high risk for elopement and poor safety awareness.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The 6/28/24 care plan, revised 7/4/24, revealed Resident #19 was an elopement risk due to impaired safety awareness, refusal of medications, and prior elopement attempts. Pertinent interventions included distracting Resident #19 from wandering by offering pleasant diversions, assessing the resident's needs (initiated 6/28/24 and revised on 7/4/24), one-to-one monitoring (initiated 6/28/24 and revised on 7/4/24) and identifying a pattern in the resident's wandering (initiated 6/28/24).<br><br>-The care plan for elopement risk was not implemented until after Resident #19 returned to the facility after his elopement episode on 6/27/24, despite the resident's numerous attempts to elope prior to 6/27/24.<br><br>The 6/28/24 elopement evaluation revealed Resident #19 was at a high risk for elopement with a score of 21.<br><br>C. Staff interviews<br><br>The SSD was interviewed on 7/15/24 at 11:56 a.m. The SSD said the facility staff usually created a care plan within approximately seven days after a concern had been identified. The SSD said Resident #19 kept to himself when he was first admitted , but started to refuse his medications and escalate in his behaviors. The SSD said Resident #19's exit-seeking behaviors started around his second or third week at the facility and worsened over time. The SSD said Resident #19 started waiting by the main entrance and trying to sneak out the door when visitors were coming and going. The SSD said the facility staff had been able to successfully redirect Resident #19 back inside after his elopement attempts.<br><br>The director of nursing (DON) was interviewed on 7/16/24 at 10:07 a.m. The DON said the nursing staff or the SSD complete elopement evaluations for residents. The DON said Resident #19 would start hanging out near the main entry, at which point the staff knew to keep a close eye on him. The DON said Resident #19 was able to slip out the door one day following behind a staff member, but they were able to redirect him back into the facility by offering to let him make phone calls. The DON said Resident #19 became a missing person after his last elopement, and the facility had since initiated one-on-one monitoring.<br><br>The DON said Resident #19's exit-seeking behaviors started to amplify on 6/4/24. The DON said Resident #19's care plan for elopement behaviors was not initiated until 6/28/24. |

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| F 0730<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observe each nurse aide's job performance and give regular training.<br><br>43950<br><br>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for two of two certified nurse aides (CNA).<br><br>Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for CNA #1 and CNA #3.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The In-Service Training, Nurse Aide policy and procedure, dated August 2022, was provided by the nursing home administrator (NHA) on 7/17/24 at 12:13 p.m. It read in pertinent part, The facility completes a performance review of nurse aides at least every 12 months. In-service training is based on the outcome of the annual performance reviews.<br><br>II. Record review<br><br>Annual performance reviews were requested on 7/15/24 at 8:12 a.m. for CNA #1 and CNA #3.<br><br>The facility was unable to provide annual performance evaluations for 2023/2024 for CNA #1 (hired on 7/4/08) and CNA #3 (hired on 7/1/21).<br><br>The CNA's did not have an annual performance review completed and the CNAs did not have an in-service<br><br>education plan based on the outcome of the review.<br><br>III. Staff interviews<br><br>The director of nursing (DON) was interviewed on 7/16/24 at 12:55 p.m. The DON said the performance evaluations needed to be done. The DON said she was unsure why the annual performance evaluations had not been completed as she was new to the facility. The DON said she believed the competency assessments and performance reviews needed to be done on an annual basis. The DON said she would perform an audit to determine which employees needed a performance review. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350<br><br>Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent.<br><br>Specifically, the facility's medication error rate was 7.14%, or two errors out of 28 opportunities for error.<br><br>Findings include:<br><br>I. Professional reference<br><br>According to [NAME], A., [NAME], L. M. (9/14/23). Nursing Rights of Medication Administration. Stat Pearls. National Library of Medicine. retrieved from https://www.ncbi.nlm.nih.gov/books/NBK560654/ on 7/22/24 at 4:16 p.m.,<br><br>Right time: administering medications at a time that was intended by the prescriber. Often, certain drugs have specific intervals or window periods during which another dose should be given to maintain a therapeutic effect or level.<br><br>Right dose: incorrect dosage, conversion of units, and incorrect substance concentration are prevalent modalities of medication administration error.<br><br>II. Facility policy and procedure<br><br>The Administering Medications policy and procedure, revised April 2019, was provided by the nursing home administrator (NHA) on 7/16/24 at 11:45 a.m. It read in pertinent part,<br><br>Medications are administered in a safe and timely manner and as prescribed.<br><br>Medications are administered in accordance with prescriber orders, including any required time frame.<br><br>III. Medication administration to Resident #52<br><br>On 7/15/24 at 7:39 a.m. licensed practical nurse (LPN) #2 checked Resident #52's order for Empaglifozin (a medication used for glucose control in diabetes) ten milligrams (mg) one tablet by mouth once a day for diabetes mellitus. LPN #2 looked through Resident #52's medication cards and was unable to find the medication.<br><br>LPN #2 proceeded to administer Resident #52's other morning medications.<br><br>-LPN #2 did not administer the Empagliflozin to Resident #52.<br><br>IV. Medication administration to Resident #33<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 7/15/24 at 8:10 a.m. LPN #1 checked Resident #33's order for Sinemet 25/250 mg one tablet once a day for tremors in Parkinson's disease. She looked through Resident #33's medication cards and was unable to find the Sinemet 25/250 mg card.<br><br>LPN #1 proceeded to administer Resident #33's other morning medications.<br><br>-LPN #1 did not administer the Sinemet 25/250 mg to Resident #33.<br><br>V. Staff interviews<br><br>LPN #2 was interviewed on 7/15/24 at 7:40 a.m. LPN #2 said Resident #52's Empagliflozin had been ordered but it had not been received. She said she would check again with the pharmacy to find out when it would be delivered. She said when medications were not available for administration, the provider should be notified and it should be documented on the medication administration record (MAR) and the progress notes why the medication could not be administered.<br><br>LPN #1 was interviewed on 7/15/24 at 8:12 a.m. She said an order had been placed two days prior (7/13/24) for Resident #33's Sinemet 25/250 mg but the medication had not been received and was unavailable for administration. She said the physician needed to be notified and the reason why the medication was not given should be documented.<br><br>The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 716/24 at 12:30 p.m. The DON said residents'medications needed to be reordered from the pharmacy eight days before the medication was to run out. She said it was the nurses responsibility every shift to make sure medications were ordered timely so they did not run out. She said the pharmacy was only dispensing a three day supply of Resident #52's Empagliflozin because his insurance was only allowing a three day supply at a time. She said the facility was working with the provider to change the resident to another medication so that the facility did not run out of the medication.<br><br>The DON said Resident #33's Sinemet 25/250 mg was not reordered in a timely manner because the nursing staff did not pull the old card out of the medication cart to get it reordered.<br><br>The ADON said the facility obtained a physician's order for a one time dose of Sinemet 25/100 mg for the morning to cover until the facility received the resident's correct dose of Sinemet 25/250 mg. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>50219<br><br>Based on observations and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the kitchen.<br><br>Specifically, the facility failed to:<br><br>-Ensure kitchen staff handled ready-to-eat foods in an appropriate sanitary manner to prevent cross contamination; and,<br><br>-Ensure safe holding temperatures for food items were maintained.<br><br>Findings include:<br><br>I. Inappropriate handling of ready-to-eat foods<br><br>A. Professional reference<br><br>The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 7/17/24 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<br><br>ready-to-eat food or with raw animal food, used for no other purpose, and<br><br>discarded when damaged or soiled, or when interruptions occur in the operation.<br><br>B. Facility policy<br><br>The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy, revised November 2022, was provided by the nursing home administrator (NHA) on 7/16/24 at 11:45 a.m. It read in pertinent part, Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced between handling soiled and clean dishes.<br><br>Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent foodborne illness.<br><br>C. Observations<br><br>On 6/25/24 the lunch meal service was observed during a continuous observation, beginning at 10:30 a.m. and ending at 12:10 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 - Some | At 11:16 a.m. cook (CK) #1 began preparing a side salad for dinner service. CK #1 donned (put on) a pair of gloves and tore open the plastic packaging using both hands for a bag of lettuce.<br><br>-CK #1 did not change his gloves after touching the outside of the lettuce bag.<br><br>-CK #1 chopped the lettuce and used the knife to scoop the lettuce into his gloved hand using the same pair of gloves before placing it into a metal bin. CK #1 grabbed a cucumber and diced it, then used the knife to scoop into his gloved hand using the same pair of gloves before placing it into the metal bin.<br><br>-Using the same gloves, CK #1 touched the outside of a bag of shredded cabbage, ripped the bag open, reached in and grabbed a handful of cabbage, then sprinkled it on top of the salad mixture in the metal bin.<br><br>-At several points during the lunch service, dietary aide (DA) #1's name tag and apron strings rested on top of and dragged across the surface of the plates that were then used to serve lunch to the residents while DA #1 was reaching over the steam table to scoop food out.<br><br>D. Staff interview<br><br>The dietary manager (DM) was interviewed on 7/15/24 at 12:40 p.m. The DM said ready-to-eat foods should be handled with gloves. The DM said dietary staff should wash their hands before putting gloves on and only handle one ready-to-eat food at a time. The DM said dietary staff should change their gloves in between handling packaging and handling ready-to-eat foods.<br><br>CK #1 was interviewed on 7/16/24 at 1:00 p.m. CK #1 said he had been told he was supposed to change gloves after touching the salad bag and before touching the salad. CK #1 said he did not know he was supposed to do that.<br><br>II. Maintain safe holding temperatures for food items<br><br>A. Professional reference<br><br>The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 7/17/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Stored frozen foods shall be maintained frozen.<br><br>Time/temperature control for safe food cold holding shall be maintained at 5 (five) degrees Celsius (C) (41 degrees Fahrenheit) or less.<br><br>According to the product guidelines for MedPass Fortified Nutritional Shake, retrieved on 7/17/24 from https://www.hormelhealthlabs.com/resources/for-healthcare-professionals/product-protocols/med-pass-fortified-nutritional-shake-medication-pass-program/,<br><br>MedPass products can safely remain on a medication cart as long as it is kept at refrigerated temperature range 34 to 40 degrees Fahrenheit (F).<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 - Some | Cover, label and refrigerate opened containers of MedPass products and discard after four days as long as the product has been kept at the proper refrigerated temperature range.<br><br>B. Facility policy<br><br>The Food Receiving and Storage policy, revised November 2022, was provided by the NHA on 7/16/24 at 11:45 a.m. It read in pertinent part, Frozen foods are maintained at a temperature to keep the food frozen solid.<br><br>All food items to be kept at or below 41 degrees Fahrenheit (F) are placed in the refrigerator located at the nurses'station and labeled with a'use by'date.<br><br>C. Observations<br><br>On 7/10/24 at 9:18 a.m. an initial tour of the kitchen was conducted. The following was found in the main kitchen walk-in refrigerator:<br><br>-An opened bag of vegetarian chorizo crumbles was found in the walk-in refrigerator. The refrigerator temperature was 40 degrees F.<br><br>-On the vegetarian chorizo crumble bag, there were instructions indicating to keep the product frozen until time of use.<br><br>At 12:09 p.m. two cartons of MedPass Shake were on a nurse's medication cart in a plastic bin without a lid. The plastic bin had ice in it that reached approximately one-quarter to one-third the height of the MedPass Shake bottle.<br><br>On 7/15/24 at 10:25 a.m. a carton of MedPass Shake was on a nurse's medication cart in a plastic bin without a lid. The plastic bin had mostly melted ice and water in it that reached approximately 1.5 inches up the MedPass Shake carton.<br><br>At 12:50 p.m. on the medication cart there was a container of MedPass nutritional supplement that measured 58 degrees F. The carton of MedPass Shake was on a nurse's medication cart in a plastic bin without a lid. The plastic bin had fresh ice in it that reached approximately one-quarter to one-third the height of the MedPass Shake carton.<br><br>-The temperature of this nutritional supplement was above the safe temperature parameter for cold foods of 41 degrees F or less.<br><br>E. Staff interviews<br><br>The DM was interviewed on 7/10/24 at 9:28 a.m. The DM said the chorizo crumbles could be kept refrigerated. The DM said she read the bag and it indicated to keep the product frozen. The DM said she would throw the product away because it had not been used in a while.<br><br>The DM was interviewed again on 7/15/24 at 12:40 p.m. The DM said the ideal holding temperatures for cold food items was below 40 degrees F. The DM said the dietary department supplied the MedPass Shakes but did not prepare or maintain the supply on the nurses'carts. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted 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 maintain medical records in accordance with accepted professional standards and practices for one (#7) of one resident out of 31 sample residents.<br><br>Specifically, the facility failed to ensure Resident #7's medical record was consistently accurate regarding the pressure injury to the resident's left heel.<br><br>Findings include:<br><br>I. Resident #7<br><br>A. Resident status<br><br>Resident #7, age 66, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included traumatic brain injury, muscle weakness, muscle wasting and atrophy, and type 2 diabetes.<br><br>The 5/17/24 minimum data set (MDS) assessment revealed Resident #7 was significantly cognitively impaired with a brief interview for mental status (BIMS) score of zero out of 15. Resident #7 was dependent on staff for all care, hygiene and mobility. The assessment indicated Resident #7 was at risk of developing pressure ulcers/injuries and that the resident did not reject care.<br><br>B. Observations<br><br>On 7/15/24 at 1:45 p.m. Resident #7's left heel wound was observed with the assistant director of nursing (ADON). When Resident #7's pressure relieving boot and dressing were removed, a small open area, which was approximately 0.5 centimeters (cm) in diameter, was observed. The old dressing contained moderate serosanguinous (wound discharge that contains both blood and blood serum which is light pink to red in color) drainage. The wound bed was difficult to visualize due to the slough (creamy or yellow-white dead tissue) in the wound bed.<br><br>C. Record review<br><br>The June 2024 CPO revealed the following physician's orders:<br><br>Right heel wound: apply iodine and leave open to air daily and as needed, ordered 6/26/24 and discontinued 6/28/24.<br><br>-The physician's order documented the wound care was to be provided to Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 wound physician (WP) note below).<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Left heel wound: apply iodine and leave open to air daily and as needed, ordered 6/29/24 and discontinued 7/2/24.<br><br>The July 2024 CPO revealed the following physician's orders:<br><br>Right heel wound: clean wound with wound cleanser, pat dry, apply medihoney alginate to wound bed and cover with bordered gauze daily and as needed, ordered 7/10/24 and discontinued 7/11/24.<br><br>-The physician's order documented the wound care was to be provided to Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 WP note below).<br><br>Right heel wound: clean wound with wound cleanser, pat dry, apply medihoney alginate to wound be, and cover with bordered gauze daily and as needed, ordered 7/9/24 and discontinued 7/11/24.<br><br>-The physician's order documented the wound care was to be provided to Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 WP note below).<br><br>Left heel wound: clean wound with wound cleanser, pat dry, apply medihoney alginate to wound bed and cover with bordered gauze daily and as needed, ordered 7/11/24.<br><br>The 6/11/24 weekly skin assessment revealed Resident #7 had a pressure injury to the left heel.<br><br>The 6/18/24 weekly wound assessment revealed Resident #7 had a facility-acquired pressure/deep tissue injury on the right heel. Preventative measures that were in place included offloading, elevation, air mattress, and pressure-relieving boots. The wound was entirely epithelial tissue and measured 6.9 cm long by 4.4 cm wide. Treatment included iodine soaked gauze and kerlix daily and as needed.<br><br>-The wound assessment incorrectly documented the wound was on Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 WP note below).<br><br>The 6/25/24 weekly wound assessment revealed Resident #7 had a facility-acquired pressure/deep tissue injury on the right heel. The wound was entirely epithelial tissue and measured 6.8 cm long by 3.6 cm wide. The assessment revealed the wound was improving. Treatment course was changed to iodine and being open to air daily and as needed.<br><br>-The wound assessment incorrectly documented the wound was on Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 WP note below).<br><br>The 7/2/24 weekly wound assessment revealed Resident #7 had a facility-acquired pressure/deep tissue injury on the right heel. The wound consisted of granulation (new healthy tissue on the surface of a wound) and necrotic tissue (dead tissue). The wound was 40% (percent) slough and 60% eschar (tan, brown or black dry, dead tissue in a wound) and measured 6.7 cm long by 3.5 cm wide and 0.1 cm deep. The assessment revealed the wound was improving. The wound was debrided (removal of damaged tissue ) to the subcutaneous tissue (deepest layer of skin), and the treatment course was changed to medihoney, gauze pad and kerlix daily and as needed.<br><br>(continued on next page) |

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| | 065387 | A. Building<br>B. Wing | 07/16/2024 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The wound assessment incorrectly documented the wound was on Resident #7's right heel, however, the wound was on the resident's left heel (see wound observation above and 7/16/24 WP note below).<br><br>The 7/9/24 weekly wound assessment revealed Resident #7 had a facility-acquired pressure/deep tissue injury on the left heel. The wound consisted of granulation, slough, and necrotic tissue. The wound was 40% slough, 30% granulation, and 30% eschar and measured 5.6 cm long by 3.4 cm wide and 0.1 cm deep. The assessment revealed the wound was improving. The wound was debrided to the subcutaneous tissue, and the treatment course was changed to honey alginate, gauze, and dry dressing daily and as needed.<br><br>A 7/16/24 wound care assessment revealed a note from the wound physician (WP) that the left heel wound was an unavoidable injury. The note revealed Resident #7 was very non-adherent with proper offloading and dressing changes and frequently refused care from nursing staff. The WP documented Resident #7 developed the wound despite proper measures taken by the facility staff.<br><br>E. Staff interviews<br><br>The director of nursing (DON) and assistant director of nursing (ADON) were interviewed on 7/16/24 at 10:24 a.m. The ADON said the facility found the left heel wound while assessing Resident #7's buttock wounds. The ADON said Resident #7's wound prevention interventions included pressure-relieving boots, an air mattress, and repositioning in bed.<br><br>The WP was interviewed on 7/16/24 at 11:14 a.m. The WP said Resident #7 needed help transferring and was incontinent, and had issues due to lack of mobility that resulted in skin breakdown. The WP said Resident #7 had a pressure wound on his right heel. The WP said the pressure injury for Resident #7 was unavoidable, as the facility used reasonable measures to try to avoid it.<br><br>-During the interview, the WP incorrectly described the wound as being on Resident #7's right heel when it was on the resident's left heel (see wound observation and 7/16/24 WP note above. |

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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** 50219<br><br>Based on record review and interviews, the facility failed to ensure that the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for one (#27) of two residents reviewed for hospice services out of 31 sample residents.<br><br>Specifically, the facility failed to maintain written communication records with the hospice providers for Resident #27.<br><br>Findings include:<br><br>I. Facility policy<br><br>The Hospice Program policy, revised July 2017, was provided by the nursing home administrator (NHA) on 7/17/24 at 12:11 p.m. It read in pertinent part, Ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents.<br><br>II. Resident #27<br><br>A. Resident status<br><br>Resident #27, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cerebrovascular disease, dementia, and hypertension.<br><br>The 4/30/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. He required substantial to maximal assistance with almost all activities of daily living.<br><br>The assessment documented the resident was receiving hospice services.<br><br>B. Record review<br><br>The 4/16/24 care plan, revised 5/17/24, revealed Resident #27 was receiving hospice services care due to senile degeneration of the brain. Pertinent interventions included checking with Resident #27 to see if he wanted clergy visits, hospice care to be provided by the hospice agency of the resident's choice and having social services provide support to the resident as needed.<br><br>The July 2024 CPO revealed a physician's order from 4/18/24 that documented Resident #27 had been admitted to hospice services.<br><br>An additional physician's order dated 4/19/24 revealed the hospice certified nurse aide (CNA) would offer showers to Resident #27.<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 | Resident #27's hospice binder was reviewed on 7/15/24 at 1:08 p.m. The hospice binder contained communication notes from the hospice CNA and hospice providers.<br><br>-There were no hospice communication notes in Resident #27's hospice binder between the dates of 4/22/24 and 7/15/24.<br><br>-Resident #27's electronic medical record (EMR) did not reveal any documentation of communication from the hospice staff regarding the care they had provided to the resident.<br><br>C. Staff interviews<br><br>The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed together on 7/16/24 at 10:07 a.m. The DON said the contracted hospice provider would come to the facility to perform an evaluation and create an initial care plan for the resident so the facility could coordinate care with the hospice provider. The DON said any hospice CNA services would be coordinated with the facility.<br><br>The DON said hospice communication records were kept in a binder at the nurses' station, and might also be in Resident #27's EMR.<br><br>-However, there were no hospice communication records in Resident #27's EMR (see record review above).<br><br>The DON said the hospice CNAs came to the facility twice a week, filled out a shower sheet, and provided the shower sheet to the facility nurse. The DON said the hospice binder was where the hospice providers documented the services they provided and the facility nurses should check the binders routinely.<br><br>When reviewing Resident #27's hospice binder, the DON said the documentation included in the binder was not what she expected to see. The DON said the most recent communication in the binder was from 4/22/24. The DON said the facility had previously used communication sheets to have the hospice providers document what was done at each visit.<br><br>The ADON said the most recent documentation from the hospice provider she could find was an updated hospice care plan dated 5/10/24.<br><br>The DON said the care plan was an overview of any changes made by the hospice provider to Resident #27's ongoing care. She said the hospice care plan did not include information regarding what care was being provided for Resident #27 at each visit by the hospice providers. |

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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** 47350<br><br>Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection on one of two units.<br><br>Specifically, the facility failed to:<br><br>-Ensure residents' rooms were cleaned in a sanitary manner; and,<br><br>-Ensure staff and residents performed hand hygiene during mealtime.<br><br>Findings include:<br><br>I. Failure to clean resident rooms in a sanitary manner<br><br>A. Professional reference<br><br>The Centers for Disease Control and Prevention (CDC), Environment Cleaning Procedures (5/4/23), was retrieved on 7/18/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part,<br><br>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms.<br><br>Clean patient areas (patient zones) before patient toilets.<br><br>Proceed from high to low to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas.<br><br>B. Manufacturer's recommendations<br><br>According to the Bright Solutions HP202 #7 (hydrogen peroxide) manufacturer guidelines, reviewed 2024, retrieved on 7/23/24 from https://mybrightsolutions.com/wp-content/uploads/046200BSL_Lit.pdf,<br><br>For Use as a One Step Cleaner/Disinfectant.<br><br>Spray 6-8 (six to eight) inches from the surface, making sure to wet surfaces thoroughly. All surfaces must remain visibly wet for 10 minutes.<br><br>For use as a Virucide. All surfaces must remain visibly wet for 5 (five) minutes. A one minute contact time is required for HIV (human immunodeficiency virus, the virus that causes AIDS), Influenza Virus type A, SARS Coronavirus 2 (the virus that causes COVID-19).<br><br>C. Facility policy and procedure<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 | The Cleaning and Disinfection of Environmental Surfaces policy and procedure, revised August 2019, was provided by the nursing home administrator (NHA) on 7/17/24 at 1:25 p.m. It read in pertinent part,<br><br>Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) standard.<br><br>D. Observations<br><br>On 7/16/24 at 10:30 a.m. the maintenance assistant (MA), who helped the housekeeping staff, was observed cleaning room [ROOM NUMBER].<br><br>The MA put on gloves. He sprayed the bathroom sink, toilet, rails and soap dispenser with Bright Solutions HP202 #7 and placed the bottle on the floor. He proceeded to wipe the outside of the sink, top of the toilet tank, around the outside of the toilet lid, the toilet seat, underneath the toilet seat (which had visible brown material on it), the top of the toilet bowl and down the side of the toilet bowl. After wiping all of the surfaces, the MA disposed of the rag.<br><br>Without changing gloves or performing hand hygiene, the MA obtained a new rag from the housekeeping cart and wiped the rails next to the toilet and the rails in the shower.<br><br>-The MA failed to ensure the surfaces remained visibly wet for the five minute virucidal time and the ten minute total disinfection time specified by the manufacturer's guidelines (see guidelines above).<br><br>-The MA failed to ensure the bottle of disinfectant/cleaning solution was kept sanitary by keeping it off the floor in the bathroom.<br><br>-The MA failed to change gloves, perform hand hygiene or obtain a clean rag after cleaning the dirty toilet seat and before cleaning the toilet bowl.<br><br>-The MA failed to change gloves and perform hand hygiene after cleaning the toilet and before touching clean supplies on the housekeeping cart.<br><br>The MA proceeded to spray and clean the mirror in the bathroom and again placed the disinfectant bottle on the floor. He sprayed and scrubbed the inside of the toilet bowl with a toilet brush. He returned the supplies back to the housekeeping cart. He then got a new rag and proceeded to clean the top of the television (TV) in the room.<br><br>-The MA again failed to ensure the bottle of disinfectant/cleaning solution was kept sanitary by keeping it off the floor in the bathroom.<br><br>-The MA failed to change gloves or perform hand hygiene after cleaning the toilet and touching clean supplies on the housekeeping cart and before cleaning the resident's room.<br><br>-The MA failed to clean the resident's room before cleaning the bathroom and toilet.<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 | The MA obtained a reusable mop head, which was soaking in the disinfectant solution on the housekeeping cart. He started in the bathroom and proceeded into the resident room with the same mop head.<br><br>-The MA failed to mop the resident's room before mopping the bathroom.<br><br>E. Staff interviews<br><br>The MA was interviewed on 7/16/24 at 10:45 a.m. He said rooms should be cleaned from top to bottom and clean to dirty. He said rooms should be cleaned in a methodical manner and in a circular fashion around the room. He said he liked to clean the bathroom first so he could get it out of the way before he cleaned the residents' rooms. He said he should have cleaned the resident's room first before the resident's bathroom. He said he should have changed gloves and performed hand hygiene after touching a dirty area and before touching a clean area.<br><br>The regional maintenance supervisor (RMS), who oversaw the housekeeping staff, was interviewed on 7/16/24 at 10:50 a.m. The RMS said the residents' rooms should be cleaned before the bathrooms and rooms should always be cleaned from clean areas to dirty areas. He said the mop head should be changed out after cleaning the bathroom. He said hand hygiene should be performed and gloves should be changed after touching something dirty and before touching clean supplies on the housekeeping cart.<br><br>II. Hand hygiene<br><br>A. Professional reference<br><br>The Centers for Disease Control and Prevention (CDC). Clean Hands: About Handwashing 2/16/24), was retrieved on 7/23/24 from https://www.cdc.gov/clean-hands/about/index.html. It read in pertinent part,<br><br>Many diseases and conditions are spread by not washing hands with soap and clean, running water. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands.<br><br>Key times to wash hands: before, during and after preparing food and before and after eating food.<br><br>B. Observations<br><br>On 7/10/24 during a continuous observation of the lunch meal, beginning at 11:30 a.m. and ending at 12:30 p.m., the following was observed:<br><br>Ambulatory and wheelchair bound residents were observed entering the dining room and sitting at tables.<br><br>-Hand hygiene was not offered to ambulatory or wheelchair bound residents.<br><br>-Dependent residents were not offered or assisted with hand hygiene before the meal.<br><br>-Canisters of hand wipes were observed on two tables, however, they were not used by residents before or after the meal.<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 | Staff was observed bringing lunch plates on trays from the kitchen to the residents and then returning to the kitchen for another lunch plate. Hand sanitizing dispensers were observed on the wall next to the doors to the kitchen.<br><br>-Staff did not use the hand sanitizer dispensers upon exiting or entering the kitchen area.<br><br>On 7/26/24 during a continuous observation of the lunch meal, beginning at 11:30 a.m. and ending at 12:15 p.m., the following was observed:<br><br>Ambulatory and wheelchair bound residents were observed entering the dining room and sitting at tables.<br><br>-Hand hygiene was not offered to ambulatory or wheelchair bound residents.<br><br>-Dependent residents were not offered or assisted with hand hygiene before the meal.<br><br>-Canisters of hand wipes were observed on two tables, however, they were not used by residents before or after the meal.<br><br>Staff was observed bringing lunch plates on trays from the kitchen to the residents and then returning to the kitchen for another plate. Hand sanitizing dispensers were observed on the wall next to the doors to the kitchen.<br><br>-Staff did not use the hand sanitizing dispensers upon exiting or entering the kitchen area.<br><br>C. Staff interviews<br><br>The DON and ADON were interviewed together on 7/16/24 at 12:30 p.m. The DON said ambulatory residents should be encouraged to wash their hands before leaving their room and going to the dining room. She said dependent and wheelchair bound residents should be offered hand hygiene when they entered the dining area. She said staff should be performing hand hygiene when serving food to residents in the communal dining area. The DON said education on hand hygiene was done quarterly and as necessary. She said a future skills fair for all staff was planned and hand hygiene was a topic that would be discussed. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<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 provide an effective pest control program to ensure the facility was free of pests.<br><br>Specifically, the facility failed to effectively implement and reassess their pest control program.<br><br>Findings include:<br><br>I. Professional reference<br><br>According to the Center for Disease Control (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities, revised July 2019, retrieved on 7/18/24 from https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html,<br><br>Cockroaches, flies, and mice are among the typical pest populations found in health-care facilities. Insects and rodents can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by passing pathogens from one source to another. Insects and rodents should be kept out of all areas of a health-care facility, especially any areas where immunosuppressed patients are located.<br><br>From a public health and hygiene perspective, pests should be eradicated from all indoor environments. Approaches to institutional pest management should focus on:<br><br>-Eliminating food sources, indoor habitats, and other conditions that attract pests;<br><br>-Excluding pests from entering the indoor environments; and,<br><br>-Applying pesticides as needed.<br><br>Rodents can transmit viruses such as Lymphocytic choriomeningitis, bacteria such as Campylobacteriosis, Leptospirosis, Plague, Salmonellosis, Tularemia, Yersiniosis, and fungi such as Dermatophytosis.<br><br>II. Facility policy and procedure<br><br>The Pest Control policy, revised May 2008, was received from the nursing home administrator (NHA) on 7/16/24 at 11:45 a.m. It read in pertinent part, This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents.<br><br>Maintenance services assist, when appropriate and necessary, in providing pest control services.<br><br>III. Observations<br><br>On 7/10/24 at 10:26 a.m. several house flies and gnats were observed flying in the main hallway near the common area.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/15/24 at 8:15 a.m. small gnats/flies were flying around the medication cart while medications were being administered in the memory care unit.<br><br>On 7/15/24 at 12:21 p.m. a glue trap was observed under the resident snack refrigerator in the main wing of the facility. Several cockroaches were stuck to the trap, along with a cockroach egg sac and its hatchlings.<br><br>On 7/16/24 at 10:04 a.m. the same glue trap was observed under the resident snack refrigerator in the main wing of the facility. Several cockroaches were stuck to the trap, along with a cockroach egg sac and its hatchlings.<br><br>At 12:14 p.m. daylight was visible at the bottom of the fire exit door near room [ROOM NUMBER]. Daylight was visible in a gap between the main entrance doors. Daylight was visible at the bottom of the door leading to the courtyard from the living area/activities room. Several house flies were observed flying around the main hallway outside of the resident rooms.<br><br>IV. Resident group interview<br><br>Seven residents (#20, #18, #33, #34, #35, #41 and #31) who frequently attended the monthly resident council meetings and were identified as alert and oriented by facility and assessment were interviewed on 7/11/24 at 3:13 p.m. All residents in attendance said they had seen pests in the facility.<br><br>Residents #31, #33 and #41 said they had seen mice in the facility and a squirrel in the dining room.<br><br>Residents #31, #33 and #41 said the pests in the facility bothered them.<br><br>Resident #41 said he had seen mice running around his room.<br><br>Resident #33 said the insects in the facility were very bad and he thought he was getting bit by them.<br><br>V. Record review<br><br>On 7/16/24 at 9:12 a.m. the NHA provided the pest control service records on 7/16/24 at 9:12 a.m. for 1/10/24, 2/15/24, 2/27/24, 3/13/24, 4/10/24, 5/8/24, 6/12/24 and 7/15/24. The invoices revealed the following:<br><br>On 1/10/24 the kitchen and employee break room were treated for German cockroaches.<br><br>From February 2024 through May 2024 only the kitchen was treated for German cockroaches.<br><br>In June 2024 and July 2024 the entire facility underwent treatment for German cockroaches.<br><br>The entire facility underwent treatments for house mice each month from February 2024 through July 2024.<br><br>-None of the invoices documented the facility was treated for house flies and/or gnats.<br><br>(continued on next page) |

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|---|---|---|---|
| | 065387 | A. Building<br>B. Wing | 07/16/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Forest Street Compassionate Care Center | 3345 Forest St<br>Denver, CO 80207 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The quality improvement plan, dated 6/24/24, was received by the NHA on 7/16/24 at 12:40 p.m. The goal of the plan was to eliminate pest issues and educate staff on deep cleaning. A staff inservice was completed on 6/30/24 regarding deep cleaning schedules and proper deep cleaning procedures. Other tasks were marked as ongoing and included resident and family education, obtaining quotes from other pest control companies, and staff education on cleaning procedures.<br><br>-The quality improvement plan failed to address the multiple points throughout the facility in which daylight was visible and pests could potentially enter the facility.<br><br>V. Staff interviews<br><br>The dietary director (DM) was interviewed on 7/10/24 at 9:18 a.m. The DM said the facility did not have an issue with pests in the kitchen but she said she had found a mouse in the dining room.<br><br>The NHA and the regional operations consultant (ROC) were interviewed on 7/16/24 at 11:59 a.m. The NHA said a few of the residents at the facility had complained about seeing mice more frequently and the facility had responded by creating a quality improvement plan for the issue.<br><br>-However, the quality improvement plan failed to address the multiple points throughout the facility in which daylight was visible and pests could potentially enter the facility (see record review above).<br><br>The NHA said the facility had an increase of pests in the facility the week of 6/24/24 and a regional team came to do a deep cleaning of the facility and train staff on pest control measures. The NHA said the regional team worked with the facility to identify possible entry points for pests and repaired them.<br><br>-However, there were still multiple points observed throughout the facility in which daylight was visible and pests could potentially enter the facility.<br><br>The ROC said the facility identified they were falling behind on their deep cleaning schedule. The ROC said the facility's pest control company had traps, glue traps and bait boxes set out along the perimeter and within the facility and the pest control company sprayed pesticide around the perimeter.<br><br>-However, cockroaches, flies and gnats were observed present in the facility on several occasions during the survey (see observations above).<br><br>The NHA said the facility was still working on eliminating the roaches but that they had a plan in place. The NHA said they had identified that residents were putting food in their drawers, and the facility had given sealed containers to the residents that often had food brought in by their families for better food storage.<br><br>Regarding flies, the NHA said the facility identified one room in particular as being an issue due to the resident's family bringing in a great deal of fruit. The NHA said the facility was able to eliminate the fruit flies by working with the resident and their family. The NHA said the issue was not really widespread but was more of a one-off incident.<br><br>(continued on next page) |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -However, there were several observations throughout the survey of houseflies and gnats flying around residential areas (see observations above).<br><br>The NHA said the facility was looking into switching pest control companies and she was waiting to hear back from another pest control vendor. |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>43950<br><br>Based on record review and interviews, the facility failed to ensure in-service training for certified nurse aides (CNA) consisted of annual training for dementia management and/or annual abuse training for three out of three CNAs reviewed.<br><br>Specifically, the facility failed to:<br><br>-Ensure a system was in place to track the CNAs training to ensure they met the annual training requirements;<br><br>-Ensure CNA #1 and CNA #3 received the required 12 hours of training per year; and,<br><br>-Ensure CNA #2 received abuse and dementia training upon hire.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The In-Service Training, Nurse Aide policy and procedure, dated August 2022, was provided by the nursing home administrator (NHA) on 7/17/23 at 12:13 p.m. It read in pertinent part, All nurse aide personnel participate in regular in-service education. Annual in-services: are no less than 12 hours per employment year; include training in dementia management and resident abuse prevention. Nurse aide participation in training is documented by the staff development coordinator, or his or her designee and includes: the date and time of the training; the topic of the training; the method used for training; a summary of the competency assessment; and the hours of training completed.<br><br>II. Record review<br><br>A review of the CNA training records was completed on 7/16/24 at 12:48 p.m.<br><br>-CNA #1 was hired on 7/4/08. The training records revealed the hours of training in the previous calendar year were not documented.<br><br>-CNA #2 was hired on 6/3/24. Her training records did not reveal she had received abuse or dementia training upon hire.<br><br>-CNA #3 was hired on 7/1/21. The training records revealed the hours of training in the previous calendar year were not documented.<br><br>III. Staff interviews<br><br>(continued on next page) |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The director of nursing (DON) was interviewed on 7/16/24 at 12:55 p.m. The DON said they did not have a staff development coordinator (SDC) but she and the assistant director of nursing (ADON) had been handling those tasks. The DON said she started working in the facility in May 2024 and the ADON was also new. The DON said she planned to have a skills fair so that she could complete a lot of staff training. The DON said she wanted to be sure the CNAs had the 12 hours of required minimum training.<br><br>The DON said she had not implemented a record keeping system yet, but she would implement a spreadsheet and every staff member would be added to keep track of the hours. The DON said the CNAs needed to complete certain training at hire such as dementia and abuse training before working with the residents. The DON said she was going to complete an audit of the staff so she would know which employees needed training. |