STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065411	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottonwood Rehabilitation and Healthcare Center	450 Prospector Ave Durango, CO 81301

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31229 Based on record review and interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for one (#14) of three residents reviewed for behavioral and emotional status out of 22 sample residents. Specifically, the facility failed to coordinate timely necessary behavioral, mental and emotional health care and services for Resident #14. Findings include: I. Resident #14 A. Resident status Resident #14, age 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included Arnold Chiari Syndrome with hydrocephalus (a condition where the lower part of the brain protrudes into the spinal canal causing a blockage in the flow of cerebrospinal fluid and leading to a buildup of fluid in the brain), anxiety disorder, depression, insomnia, other complicated headache syndrome, cognitive communication deficit, unspecified dementia, severe, with mood disturbance and malignant neoplasm of prostate. The 9/17/24 minimum data set (MDS) assessment revealed the resident's cognition was severely impaired with a brief interview for mental status (BIMS) score of four out of 15. Verbal behavioral symptoms directed towards others were present during the assessment. He used a wheelchair for mobility and required partial moderate assistance with toileting hygiene, substantial/maximal assist with bathing and partial/moderate assist with transfers. He was prescribed antianxiety and antidepressant medications. B. Record review (continued on next page)

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

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the comprehensive care plan, initiated on 11/14/23 and revised on 11/20/24, revealed Resident #14 had a history of depression and insomnia and was taking two antidepressant medications (Trazodone and Lexapro) due to sleep disturbances, withdrawal from activities and refusals of care. He received Ativan for anxiety as evidenced by restlessness and leg movements, pacing, increases in complaints, agitation, obsession about clothing and temperature changes, false accusations against staff, and playing with a suprapubic urinary catheter. Resident #14 was prescribed and administered an antipsychotic medication (Seroquel) related to auditory hallucinations, increased agitation and anxiety. Interventions included referral to a psychologist/psychiatrist as needed. Review of Resident #14's behavior care plan, initiated on 5/16/24 and revised on 11/18/24, revealed the resident had behaviors related to his dementia diagnosis and often made false allegations and statements. The resident yelled and cussed at staff, residents and imaginary individuals and often had auditory hallucinations. He was withdrawn from group activities and stayed in his room most of the day. He had depression at times that caused him to have difficulty sleeping as evidenced by sleep disturbances and restless leg movements. Interventions included administering medications per the physician's order, approaching the resident in a calm manner to avoid frustration and behavior escalation, attempting to redirect the resident when he was exhibiting behaviors, monitoring and documenting episodes of inappropriate behaviors, monitoring the resident's behavior episodes and attempting to determine the underlying cause of the behavior, including considering location, time of day, persons involved and situations, observing and reporting any changes in mental status caused by situational stressors and offering psychologist/psychiatrist services as needed. Review of Resident #14's November 2024 CPO revealed the following physician's orders: Trazodone HCl oral tablet 50 milligrams (mg). Give 25 mg by mouth at bedtime for insomnia and depression, ordered 11/23/23. Cymbalta oral capsule delayed release particles 20 mg (Duloxetine HCl). Give one capsule by mouth one time a day for depression, ordered 11/4/23 and discontinued on 10/31/24. Escitalopram Oxalate (Lexapro tablet 20 mg). Give one tablet by mouth one time a day for depression, ordered 11/1/24. Ativan (Lorazepam) oral tablet 1 mg. Give one tablet by mouth at bedtime related to generalized anxiety, ordered 5/7/24. Quetiapine Fumarate Oral Tablet 25 mg. Give one tablet by mouth three times a day for unspecified dementia, severe, with mood disturbance, ordered 11/14/24. A nurse progress note dated 4/7/24 documented Resident #14 had been angry that he was not served breakfast immediately when entering the dining room. The resident was reminded that the cooking staff did not arrive to work until 6:00 a.m., therefore they were unable to serve him at 5:00 a.m The resident was yelling at his neighbor to 'shut-up', because his neighbor was whistling songs while getting ready for the day. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse progress note dated 4/9/24 documented the interdisciplinary team (IDT) met to review resident's psychotropic medication usage. The resident had no adverse side effects to the medications and no changes were made to the current medications per the power of attorney's (POA) and the resident's request. A risk versus benefit form was completed and the IDT would continue to review quarterly or PRN (as needed). A nurse progress note dated 4/16/24 documented Resident #14 had repeatedly set his call light off while laying in bed. When asked upon entering each time, what the nurse could do to assist him, he said his neighbor slammed the bathroom door, his sheet was coming off or he did not call. Upon the nurse entering his room the last time, the resident had thrown a dish from the kitchen on the floor and it shattered. Resident #14 had changed his shirt at least six times this morning (4/16/24). A nurse progress note dated 5/9/24 documented Resident #14 was upset that his neighbor shut his bathroom door loudly. The resident attempted twice to throw ice water into his neighbor's room and was very angry and difficult to redirect. A nurse progress note dated 5/13/24 documented Resident #14 said he was going to throw water at another resident's face. He was asked what made him so upset and he reported his neighbor was in the bathroom, slammed the doors and woke him up. The CNA (certified nurse aide) informed the resident it was his neighbor's shower and he was not creating excess noise on purpose. The resident said he was still going to throw water in his face. The CNA then asked the resident to give them 20 minutes, which he agreed to. No more threats had been made since and he was now in a pleasant mood. A nurse progress note dated 7/24/24 documented the IDT met to review Resident #14's psychotropic medication usage. The resident had had no adverse side effects to the medications and no changes were being made to the resident's current medications. The IDT would continue to review quarterly at the psychotropic committee meeting or PRN and plan GDRs (gradual dose reduction) as appropriate. Resident #14 and his POA requested that no changes be made to his medications because the medications were working for the resident. -The progress note did not indicate the facility offered a psychologist or psychiatrist consultation to the resident to help with the resident's behaviors. A nurse progress note dated 10/6/24 documented the staff was to monitor the resident for the following behaviors related to the use of Ativan as evidenced by an increase in complaints, obsession about clothing and temperature changes, false accusations against staff, playing with his catheter and refusals of care. -The progress note failed to identify interventions that were to be used with the resident to help the resident with the distressing behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note documented by the DON on 10/23/24 DON revealed Resident #14 pressed his call light five times in one minute. The resident was complaining his ears were ringing and he was not able to hear. He was given some eardrops but persisted in fixating on the concern and pressed his call light repeatedly for the same reason. He was requesting to have the physician come in and look in his ears. The note documented the resident had his television (TV) volume extremely loud and, though he claimed he could not hear, he was able to understand everything the DON and the CNAs were saying to him. The DON suggested he turn his TV volume down which could potentially help with his complaint of not being able to hear but the resident refused. Redirection continued without success and the DON notified the physician of the resident's request to look in his ears. A nurse progress note dated 10/24/24 documented Resident # 14 was agitated during the shift and asked to use the bathroom four times in 30 minutes. Staff would assist him to the bathroom every time, for him to sit down, stand right back up and say he was done. The resident was fixating on certain other residents being in the dining room and refusing to eat because they were in there. The resident had to be redirected to the dining room five times during the shift, after being placed at a table per his request, then stating 'that resident is down here' and turning around and leaving the dining room. The resident was difficult to redirect. A nurse progress note dated 10/28/24 documented the resident was yelling out at neighbors and staff to stop slamming the doors. Staff were mindful about closing the doors softly and he continued to yell when doors around him were shut as quietly as possible. Resident #14 was assured everyone was trying to keep the environment quiet, he was given fresh water and his medications at his preferred time. He continued to yell out after any sounds were made in the hall or neighboring rooms until he fell asleep. A nurse progress note dated 10/30/24 documented the resident was yelling loudly about people slamming doors. The nurse watched the resident's neighbor's door be shut with no slamming. The resident had continually used his call light when he was upset about loud noises and cold coffee. A nurse progress note dated 11/1/24 documented Resident #14 was repeatedly screaming 'be quiet' at the top of his lungs, as well as putting his call light on. The nurse informed the resident they would be as quiet as they could and he verbalized understanding. A nurse progress note dated 11/12/24 documented the resident had been yelling over any noise throughout the night. He yelled at another resident to shut up who was talking in the hallway on the way back to their room. Resident #14 was offered food and drink, efforts to keep his environment quiet and reassurance that no one was being noisy on purpose. The resident voiced his understanding, however the resident continued to yell at neighboring residents and staff from his room. A progress note documented by the DON on 11/14/24 documented Resident #14 had been extremely agitated, more so than his normal. He was yelling at his next door neighbor even though the resident was not in his room next door. Resident #14 had pushed his call light three times in five minutes and was yelling and agitated. He then pressed his call light another two times and when the CNA entered the room, he was yelling that the lady next door kept slamming the door, however, there was no lady next door. The physician was notified. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note documented by the DON on 11/15/24 documented the DON called the resident's family member to let her know the physician ordered Seroquel for the resident and to obtain consent for the medication. The family member gave consent for the medication. A nurse progress note dated 11/15/24 documented the resident was agitated, yelling, and cursing during the shift and refused a catheter change. The note documented the resident had begun taking Seroquel and was offered a quiet environment, food and drink and lotion was applied to his abdomen as requested for itchiness. A nurse progress note dated 11/19/24 documented the resident was yelling profanities from his room regarding another resident slamming her door, however, there were no residents slamming their doors. A nurse progress note dated 11/20/24 documented Resident #14 was again yelling and screaming about a resident slamming her door. There were no noises heard by staff who were outside his door being mindful of providing a quiet environment for the resident. The nurse apologized and told the resident the staff did not hear any loud noises or door slamming, but they would be more cautious of making noise. Resident #14 indicated the unoccupied room next to him was where the noise was coming from. A progress note documented by the social services director (SSD) on 11/21/24 (during the survey) documented a physician's order for a referral to behavioral psychiatric services for Resident #14 had been obtained. The resident's POA was contacted and agreed with the referral. The SSD attempted to schedule an appointment with a behavioral health services provider. -The progress note failed to indicate if the SSD was able to schedule a behavioral health services appointment. -Review of the progress notes from 4/7/24 through 11/21/24 revealed there was no documentation to indicate the facility assessed the underlying causes and potential triggers for Resident #14's expressions of distress. -There was no documentation in the resident's electronic medical record (EMR) to indicate the facility offered a psychologist or psychiatrist consultation for Resident #14 in order to assist the resident with his distressing behaviors until 11/21/24, despite several months of documentation related to the resident's behaviors (see progress notes above). II. Staff interviews Registered nurse (RN) #2 and CNA #1 were interviewed together on 11/18/24 at 2:01 p.m. RN #2 and CNA #1 said Resident #14 had exhibited his agitation and aggressive verbal behaviors towards staff and other residents for the past several months. RN #2 said Resident #14's behaviors were disturbing to other residents who were on the unit for skilled rehabilitation services and were going back to the community. RN #2 and CNA #1 said Resident #14 was not offered and had not received any psychological or psychiatric health care consultation or services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN#1 was interviewed on 11/21/24 at 8:45 a.m. RN #1 said Resident #14's behaviors were consistent in the past few weeks and very disturbing to him and other residents. She said his behaviors were not specifically directed. She said the staff offered non-pharmacological interventions such as distractions, TV shows/sports, activities and offered to take the resident outside. She said the resident was not receiving any mental health services for his behaviors. The DON was interviewed on 11/21/24 at 11:10 a.m. The DON said Resident #14's behaviors had escalated within the last few weeks and she said the resident did not feel good in his own skin. She said she communicated with the resident's POA, as well as his physician, regarding recent psychotropic medications changes. She said the physician wanted to try medications first. She said the facility did not consider a behavioral health consultation for the resident during the most recent psychotropic medications review with the medical director and the pharmacist. The DON said she would reach out to the resident's POA for an approval for a mental health consultation for the resident.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47536 Based on interviews and record review, the facility failed to employ an infection preventionist (IP) who had completed specialized training in infection prevention and control which had the potential to affect all residents residing in the facility at the time of the survey. Specifically, the facility failed to have a qualified IP involved with the facility's infection prevention and control program. Findings include: I. Facility policy and procedure The Infection Preventionist policy, revised September 2022, was provided by the nursing home administrator (NHA) on 11/21/24 at 8:25 a.m. The policy read in pertinent part, The IP is professionally trained in nursing, medical technology, microbiology, epidemiology, or other related field with at least the following professional training: -A nurse must have earned a certificate/diploma in nursing; and, -A medical technologist must have earned at least an associate's degree in medical technology or clinical laboratory science. The IP is employed on site and at least part time; and, -The IP is scheduled with enough time to properly assess, develop, implement, monitor, and manage the infection control program, address the training requirements, and participate in required committees. II. Record review A request was made for the IP's infection control certificate on 11/20/24 at 2:30 p.m. The director of nursing (DON) was unable to locate the IP certificate of completion. III. Staff interviews The DON was interviewed on 11/20/24 at 2:10 p.m. The DON said she had worked at the facility as a full time DON. She said she completed the required education in 2024 to obtain the infection control certificate but was unable to locate the certificate of completion. The DON said she worked in the facility as a full time DON but also functioned as the facility IP. The DON said she collected infection statistics but had not analyzed the information to ensure the infection control program was effective. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON said she was unaware of the requirement for the facility to have a qualified infection preventionist that worked as an IP at least half time. The DON said the facility will review the requirement for the IP position and discuss the requirement with the NHA.