STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065429	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont	1960 S Fordham St Longmont, CO 80503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160 Based on observations, record review and interviews the facility failed to ensure the residents' right to make choices about aspects of their lives that were important to them for two (#7 and #2) of five residents reviewed out of 24 sample residents. Specifically, the facility failed to: -Provide assistance scheduling a wound care appointment for Resident #7 at his preferred wound clinic; and, -Provide Resident #2 a shower schedule based on her preferences. Findings include: I. Facility policy and procedure The Residents' Rights policy and procedure, dated August 2022, was provided by the regional nurse consultant (RNC) on 8/29/24 at 4:30 p.m. It read in pertinent part, Staff will abide by and protect resident rights in accordance with state and federal guidelines. The administrator will pursue appropriate action regarding resident rights. II. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included cerebral palsy, multiple sclerosis, sacral pressure ulcer and infection of amputation left lower extremity, The 8/6/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was dependent on two staff members with a hoyer (mechanical) lift for transfers. B. Resident and resident's representative interview (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 was interviewed on 8/26/24 at 11:28 a.m Resident #7's representative was present at the resident's bedside. Resident #7 said he had previously been seen by a facility wound care physician (WCP). He said he would refuse some treatments from the facility WCP because the treatments had been too painful. Resident #7 said he stopped seeing the WCP while he had been on hospice services. He said while on hospice, the hospice nurse performed his wound care. Resident #7 said after coming off hospice services, he did not want to see the facility's WCP because of the painful treatments. He said he wanted to go to a wound care clinic in the outside community. Resident #7 said he was insured by a company that had its own in-network wound care clinics. Resident #7 said the facility began to transport him to a local wound clinic. He said that his representative called to ask why he had gone to the out-of-network wound clinic, because they had received a bill for $2, 500.00. Resident #7 said he did not know the clinic was out-of-network. Resident #7 said he wanted to go to a different outside community wound care clinic that was an in-network wound care clinic. Resident #7 said he had gone to at least four appointments out-of-network. Resident #7 said he was not educated on the out-of-network status or the financial aspect of going to the wound clinic the facility had set up. The resident's representative said when she had tried to discuss the matter with the facility and the provider, the physician had been nasty and belligerent toward her. The representative said the facility told her that Resident #7 made his own decisions and chose the out-of-network wound clinic. The representative said the facility then set up an appointment for wound care at a wound care clinic in another city. The representative said she told the facility to cancel the appointment because it was a 60-mile drive from the facility and there was another wound care clinic that was in-network in a city that was only 15 miles from the facility. The representative said that the transportation process was painful for Resident #7, so driving over an hour to a wound care clinic was not appropriate. C. Record review -Review of Resident #7's electronic medical record (EMR) revealed there was no documentation to indicate a discussion had been conducted or education was completed with Resident #7 regarding his in-network wound clinic options, insurance coverage or financial considerations with using the out-of-network wound care clinic. D. Staff Interviews The wound care nurse (WCN) was interviewed on 8/27/24 at 2:29 p.m. The WCN said Resident #7 had previously been seen by the facility's WCP. She said the resident went on hospice services and refused to see the facility's WCP after coming off hospice services. The WCN said the facility sent him out to a local wound care clinic and the resident's representative got very upset because the clinic was out-of-network and she was billed for the wound care. The WCN said the representative became upset because Resident #7 had a different payor source and now they had to pay all these bills. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The WCN said she had explained the resident's wound care clinic options and Resident #7 understood his options. The WCN said he chose to go to the out-of-network wound clinic. The WCN said she did not get into the financials and had not discussed the out-of-network costs related to going to the local wound clinic with Resident #7. The WCN said Resident #7 had missed wound care last week related to a transportation issue and he would be missing again that week (week of the survey). The WCN said Resident#7 and his representative had asked her to do the wound care, however, the WCN said she could not provide the wound care because the wounds required debridement (removal of dead tissue). The medical director (MD) was interviewed on 8/28/24 at 8:52 a.m. The MD said Resident #7 should have the option to go to a wound care clinic of his choice, within their insurance network if they did not want to see the facility's WCP. The MD said the resident should be educated about options, choices and financial impact. Physician's assistant (PA) #1 was interviewed on 8/29/2024 at 9:40 a.m. PA #1 said Resident #7 would not see the facility's WCP per his choice. PA #1 said Resident #7 went to a local wound care clinic. PA #1 said he had not known that the wound care clinic was out-of-network. PA #1 said someone should have taken the details of the resident's insurance coverage into consideration and discussed that with the resident. The RNC was interviewed on 8/29/24 at 4:30 p.m. The RNC said social services should help facilitate the choice of doctors or wound care clinics and discuss financials with a resident. III. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included Parkinson's disease. The 6/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required moderate assistance of one staff member for transfers. B. Resident interview Resident #2 was interviewed on 8/26/24 at 10:57 a.m. Resident #2 said she preferred three showers per week. She said the facility assigned two shower days per week based on residents' room numbers. Resident #2 said the facility staff never asked her what her preferences for showers were. C. Record review -Review of the residents' shower binder on Resident #2's hallway revealed there were no showers documented for the resident. -Review of Resident #2's EMR revealed there was no documentation related to the resident's shower preferences. D. Staff interviews (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #1 was interviewed on 8/28/24 at 10:10 a.m. CNA #1said she checked the shower schedule for her hallway at the start of her shift after receiving report from the offgoing CNA. CNA #1 said each residents' room number was assigned a shower day of the week. CNA #1 said the shower binder had the schedule for day of the week and whether they were to receive their shower on the day or night shift. The RNC was interviewed on 8/29/24 at 4:30 p.m. The RNC said the facility discussed shower/bath preferences as part of the admission process. The RNC said if a resident preferred a different shower schedule, the facility should accommodate the resident's preference. The RNC said if a resident changed their preference during their admission, the facility should accommodate that.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on record review and interviews, the facility failed to ensure the comprehensive care plan was reviewed and revised timely to include the instructions needed to provide effective and personalized care for one (#27) of one resident out of 24 sample residents. Specifically, the facility failed to revise Resident #27's care plan to address the resident's pattern of repeated refusals of physician-ordered medications and treatments. Findings include: I. Facility policy and procedure The Care Plan Process policy, revised 3/27/23, was provided by the nursing home administrator (NHA) on 8/29/24 at 3:00 p.m. It read in pertinent part, The team directs care planning toward attaining and maintaining the highest optimal physical, psychosocial, functional status. The plan of care identifies the date, problem, measurable and realistic goals, time frames for achievement, discipline-specific service interventions, resolution and discharge option. II. Resident #27 A. Resident status Resident #27, age 70, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Huntington's disease (chronic incurable neurodegenerative disease that damages the brain), dementia, depression, ataxia (loss of muscle coordination), psychosis, and pain in the left hip. The 6/13/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of zero out of 15. She required substantial assistance with toileting and showering. She required moderate assistance with personal hygiene and dressing. She required supervision with oral hygiene. The assessment revealed the resident did not reject care. B. Record review The behavioral change care plan, revised 3/28/24, revealed the resident had Huntington's disease and resisted care at times. Interventions included attempting to anticipate the resident's needs, responding to verbal outbursts as needed, changing the resident's position, decreasing stimulation and involving the resident's responsible party. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospice care plan, revised 3/18/24, revealed the resident had a terminal diagnosis of Huntington's disease. Interventions included encouraging the support system of family and friends and observing the resident closely for signs of pain. The anti-anxiety care plan, revised 6/6/24, revealed the resident had anxiety as evidenced by the resident receiving lorazepam 0.5 milligrams (mg) and one mg. Interventions included administering medication as ordered. The psychotropic drug use care plan, revised 8/12/24, revealed the resident took haloperidol 10 mg three times per day. Interventions included monitoring behavior every shift. The self-care deficit care plan, revised 2/19/24, revealed the resident had limited joint mobility and was dependent on staff for toileting hygiene. She required substantial assistance with oral hygiene and had tremors. Interventions included providing assistance with self care as needed. The elimination care plan, revised 5/22/24, revealed the resident was always incontinent and was usually aware of her toileting needs. Interventions included assisting the resident to the toilet as needed, and checking the resident every two hours for incontinence episodes. -The above care plans failed to document that Resident #27 frequently refused her care and medications and treatments. The August 2024 CPO revealed the following physician orders: Aspercreme 4% topical patch. Apply one patch topically one time per day for pain in the left hip, ordered on 6/11/24. Haloperidol 10 mg tablet. Take one tablet by mouth three times a day due to psychosis, ordered on 8/12/24. Family would like the resident in her chair for meals three times a day, ordered on 4/25/24. A review of Resident #27's August 2024 medication administration record (MAR), from 8/1/24 to 8/28/24, revealed the following: Aspercreme 4% topical patch was not administered on 12 out of 28 days (8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/20/24, 8/21/24, 8/23/24, 8/24/24, 8/25/24, 8/26/24, 8/27/24 and 8/28/24) due to the resident's refusal. Haloperidol 5 mg tablet was not administered due to the resident's refusal on 8/9/24 at 3:00 p.m. and on 8/12/24 at 7:00 p.m. Lorazepam 0.5 mg tablet was administered due to the resident's refusal on 8/9/24 at 6:00 a.m. A review of Resident # 27's August 2024 treatment administration record (TAR), from 8/1/24 to 8/28/24, revealed the following: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #27 was not gotten up to her chair at meal times due to the resident's refusal on the following dates: - 8/1/24 at 7:30 a.m., 11:30 a.m. and 4:30 p.m.; -8/8/24 at 7:30 a.m., 11:30 a.m. and 4:30 p.m.; -8/9/24 at 7:30 a.m. and 11:30 a.m; -8/15/24 at 7:30 a.m. and 11:30 a.m.; -8/22/24 at 7:30 a.m. and 11:30 a.m; -8/23/24 at 7:30 a.m. and 11:30 a.m; -8/24/24 at 7:30 a.m.; -8/25/24 at 7:30 a.m., 11:30 a.m. and 4:30 p.m.; and, -8/28/24 at 7:30 a.m. and 11:30 a.m -There was no documentation in Resident #27's electronic medical record (EMR) to indicate the facility attempted to address the resident's repeated pattern of care and medication and treatment refusals or update the resident's care plan with person-centered interventions to address the repeated refusals. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/29/24 at 2:28 p.m. LPN #2 said if a resident refused care or a medication or a treatment, it was the resident's right to refuse. She said she tried to educate the resident why they should take their medication or treatment or accept the care being offered. She said if she was unable to administer the medications or treatments due to resident refusal, she would find another nurse to see if they would be able to administer the medications or treatments. She said if the resident still refused and a trend was identified, the physician and family should be notified to see if they had another way that encouraged the resident to accept the medications, treatments or care. Primary care provider (PCP) #1 was interviewed on 8/29/24 at 9:30 a.m. PCP #1 said the nurses had talked to him about Resident #27 refusing care. He said some of the nurses were successful in getting the resident to accept her medications and treatments but other nurses did not know how to approach the resident or who to go to ask for help when the resident refused care. The regional nurse consultant (RNC) was interviewed on 8/29/24 at 4:36 p.m. The RNC said if a resident refused medication or treatment, the resident had a right to refuse. The RNC said the nurse should reapproach the resident a couple of times. The RNC said if the resident still refused, the nurse should ask other nurses for help because they might have tips on administering medications and treatments or other care. The RNC said the resident's care plan should identify that the resident refused medications and care and include person-centered interventions to reduce the number of refusals.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for one (#134) of five residents reviewed for ADLs out of 24 sample residents. Specifically, the facility failed to ensure Resident #134 received showers per her preference Findings include: I. Facility policy and procedure The Bathing policy and procedure, revised 2/12/2020, was provided by the nursing home administrator (NHA) on 8/29/24 at 3:00 p.m. It revealed in pertinent part, Staff will provide bathing services for residents within standard practice guidelines. Residents have the right to choose if they want to be bathed at certain times and with certain methods in accordance with the care plan. II. Resident #134 A. Resident status Resident #134, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician order (CPO), diagnoses included multiple sclerosis (chronic disease damaging the protective coating around nerve cells in the brain and spinal cord), bipolar disease, cachexia (involuntary weight loss and muscle wasting), suicidal ideations and urinary tract infections. The 8/24/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. She required substantial assistance with toileting and was dependent on staff for showering and dressing, The MDS assessment revealed it was very important to the resident to choose between a tub bath, shower and sponge bath. B. Resident interview and observation Resident #134 was interviewed on 8/26/24 at 11:15 a.m. Resident #134 said she had not received a shower in over a week. Resident #134 was lying in her bed. The resident's hair was tied up in a ponytail and was greasy in appearance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #134 was interviewed again on 8/28/24 at 3:10 p.m. She said she had not received a shower since she was admitted to the facility on [DATE]. The resident was lying in her bed. The resident's hair was tied up in a ponytail and was greasy in appearance. Her fingernails were long. The resident had red nail polish on her fingernails that was chipping off and covered approximately one-quarter of each nail. Resident #134 was observed on 8/29/24 at 1:17 p.m. in the activities area. She was eating her lunch. Her hair was in a ponytail and was greasy in appearance. C. Record review The self care deficit care plan, revised 8/18/24, revealed the resident would have bathing and hygiene on a daily basis. The resident preferred a bath in the morning. The 8/18/24 nurse admission assessment revealed the resident wanted to take baths in the morning. A request was made for shower records for Resident #134. A functional abilities record was provided by the NHA on 8/29/24 at 9:00 a.m. -A review of the resident's electronic medical record (EMR) revealed there was no documentation to indicate the resident was offered a bath or shower since her admission on 8/18/24. A 8/22/24 grievance form revealed Resident #134 told MDS coordinator (MDSC) #1 she had been admitted to the facility for five days and she had not received a shower. MDSC #1 told the resident her shower days were Tuesday and Friday in the evening. -There was no documentation that the resident was offered a shower after the grievance was filed. III. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/27/24 at 4:06 p.m. LPN #1 presented a shower record book which revealed the shower schedule. The shower book contained blank and completed shower record forms. It revealed the room Resident #134 resided in was scheduled for showers on Tuesday and Friday in the evening. -The shower record book did not indicate Resident #134 had received a shower since her admission to the facility. LPN #1 said the residents were asked their shower preference at the time of admission. LPN #1 said the admitting nurse showed the resident the shower schedule so the resident knew which days of the week showers were offered. LPN #1 said the resident chose if they wanted a shower in the morning or evening. LPN #1 said showers were documented by the CNAs on a paper shower form and by the nurse when a skin assessment was completed. LPN #1 said if a resident refused a shower, the CNA told the nurse so the nurse could reapproach the resident. He said if the resident said no to the nurse, the nurse documented the refusal in a progress note. LPN #1 said he did not know the frequency of showers for residents and where it was documented. LPN #1 said he did not know if Resident #134 had received a shower since her admission. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #3 was interviewed on 8/29/24 at 11:06 a.m. CNA #3 said she knew when a resident should be offered a shower based on the schedule that was posted in the clean linen closet and in the shower binder. CNA# 3 said the shower schedule was based on the residents' room numbers and not on the residents' preferences. CNA #3 said the shower schedule indicated Resident #134's room was to receive showers in the evening on Tuesdays and Fridays. CNA #3 said residents were not offered baths. CNA #3 said there was one bath tub in the spa room and it was not used. She said the spa room was used for storage. CNA #3 said she documented if a shower was offered in the CNA task list in the EMR and on the paper shower form. CNA #3 said did not know if Resident #134 had had a shower since she was admitted to the facility. The regional nurse consultant (RNC) was interviewed on 8/29/24 at 4:36 p.m. The RNC said showers were scheduled by resident room number. She said the CNAs knew when a resident needed a shower based on the CNA tasks in the EMR. She said the admitting nurse told the resident the shower schedule for their room upon admission. The RNC said a resident should be offered a shower within 24 to 48 hours from when the resident was admitted to the facility. The RNC said showers were documented in the EMR by the CNA and the nurse and CNAs also documented shower completion on the paper shower record. The RNC was aware Resident #134 had a grievance regarding not receiving a shower. The RNC said the resident should have been offered a shower. The RNC said it was important to have timely showers so residents felt clean.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37166 Based on record review and interviews, the facility failed to designate a registered nurse (RN) to serve as the director of nursing (DON) on a full-time basis. Specifically, the facility did not designate an RN to serve as the DON on a full-time basis, after the former DON resigned. Findings include: I. Record review The review of the facility staffing list and facility assessment on 8/27/24 revealed there was no full time DON in the building. II. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/29/24 at 4:30 p.m. LPN #2 said the facility did not have a DON and there was no charge nurse on duty. She said all questions were deferred to the wound care nurse (WCN) and the minimum data set (MDS) nurse. She said both nurses were LPNs, but since they had worked in the building for a long time they were a good resource. The MDS coordinator (MDSC) was interviewed on 8/29/24 at 4:45 p.m. The MDSC said the staff asked her for assistance in different nursing matters because she was available and had worked in the building for some time. She said she was not a charge nurse, not a unit manager and she did not manage DON duties. She said she helped the nurses where and when she could but she was not in a management position. The nursing home administrator (NHA) was interviewed on 8/29/24 at 5:30 p.m. The NHA said the facility had been looking for a full-time DON since the previous DON resigned from the position. The NHA said the building had two nurse managers who were able to manage the DON duties while the position was open. The NHA said both of the nurse managers were LPNs and not RNs. The NHA said the corporate leadership provided support in person when possible. He said specifically, the regional clinical support person, who was a RN, was currently in the building. He said the plan was for corporate support to stay in the building until the DON position could be filled.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51160 Based on observations, record review and interviews, the facility failed to ensure all drugs and biologicals were properly stored according to professional standards of practice in one of one medication storage rooms and two of two medication carts. Specifically, the facility failed to: -Ensure multi-dose medications were dated when they were first opened; -Ensure medications were stored in clean and sanitary conditions; -Maintain medications in a way that the medications were accessible only to designated staff; -Dispose of unused, wasted or damaged medication in a way to prevent diversion or accidental exposure; and, -Maintain sanitary conditions in the medication storage room. Findings include: I. Facility policy and procedure The Medication Storage policy and procedure, revised January 2020, was provided by the regional nurse consultant (RNC) on 8/29/24 at 4:30 p.m. It documented in pertinent part, Staff will store medications in accordance with standard practice guidelines. II. Manufacturer's guidelines According to the Anoro Ellipta manufacturer's guidelines, retrieved on 9/10/24 from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Anoro_Ellipta/pdf/ANORO-ELLIPTA-PI-PIL-IFU.PDF, Anoro Ellipta should be stored inside the unopened moisture-protective foil tray and only removed from the tray immediately before initial use. Discard Anoro Ellipta 6 (six) weeks after opening the foil tray or when the counter reads 0 (after all blisters have been used), whichever comes first. According to the Latanoprost manufacturer's guidelines, retrieved on 9/10/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf, Once a bottle is opened for use, it may be stored at room temperature up to 25 C (degrees celsius) or 77 F (degrees fahrenheit) for 6 (six) weeks. (continued on next page)

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	065429	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont	1960 S Fordham St Longmont, CO 80503

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the SoloStar insulin pen manufacturer's guidelines, retrieved on9/10/24 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021081s072lbl.pdf, Once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86 degrees fahrenheit (F). Do not use it after this time. III. Medication cart failures A. Observations On 8/29/24 at 11:11 a.m. medication cart #1 was observed in the presence of licensed practical nurse (LPN) # 2. The following items were found: An Anoro ellipta 100 microgram (mcg) inhaler was not labeled with the date it was opened. On 8/29/24 at 11:18 a.m. medication cart #2 was observed in the presence of LPN #5. The following items were found: A bottle of Latanoprost 0.005% eye drops was not labeled with the date it was opened. A Solostar 100 unit/milliliter (ml) insulin pen was not dated with the date it was opened. Additionally, a resident's open and used metered dose inhaler with a spacer (attachment used to help deliver the medication effectively) attached to it was stored in the medication administration cart wrapped in a tissue in a drawer surrounded by medication bottles and packages. B. Staff interview LPN #5 was interviewed on 8/29/24 at 11:18 a.m. LPN #5 said the resident ' s used inhaler was being stored in a tissue because the cap for the mouthpiece had been missing. IV. Failure to maintain medications in a way that the medications were accessible only to designated staff A. Observation On 8/28/24, during a medication administration observation, LPN #2 walked away from the medication administration cart at 9:42 a.m., leaving the keys seated in the lock on the cart. LPN #2 returned to the medication administration cart at 9:47 a.m., retrieved the keys from the lock. -The medications in the cart were unsecured for five minutes when LPN #2 left the cart unattended with the keys inserted in the lock mechanism of the cart. V. Failure to dispose of unused, wasted or damaged medication in a way to prevent diversion or accidental exposure A. Observations (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 8:48 a.m., during a medication administration observation, LPN #1 split a pill with a pill cutter and disposed of the unused half in the trash can attached to the medication cart. -The medication cart had a drugbuster bottle (a medication disposal system quickly turns most non-hazardous medications into a non-toxic slurry that can be safely put in the trash) readily available in the bottom drawer. However, LPN #1 failed to use the drugbuster bottle to dispose of the unused half of the pill. On 8/27/24 at 8:48 a.m., during a medication administration observation, Resident #140 refused a liquid, oral medication. -LPN #1 disposed of the medication in the resident's trash can instead of the drugbuster bottle. On 8/28/24 at 9:23 a.m. LPN #6 was standing at medication cart #2. A staff member walking down the hallway stopped and picked up a pill off the floor near the medication cart. LPN #6 took the pill from the staff member and threw it into a trash can attached to the medication cart. -The medication cart had a drugbuster bottle readily available in the bottom drawer. However, LPN #6 failed to use the drugbuster bottle to dispose of the pill. VI. Medication storage room failure A. Observation On 8/29/24 at 11:30 a.m. the medication storage room was observed in the presence of the MDS coordinator (MDSC). The medication storage room was cluttered. The counter had copious amounts of expired medications and discharged residents' medications in ziploc bags. The refrigerator in the medication storage room had a dried brown liquid covering the bottom shelf. VII. Additional staff interviews LPN #2 was interviewed on 8/28/24 at 10:00 a.m. LPN #2 said if a medication was split, dropped or damaged it was disposed of in the med buster liquid container available in the bottom drawer of each medication cart or in the medication room. The MDSC was interviewed on 8/29/24 at 11:26 a.m. The MDSC said she did not know who had the responsibility of cleaning the refrigerator. The MDSC said she was not sure of the policy for the disposal of medications and someone should be cleaning up the clutter in the medication storage room. The regional nurse consultant (RNC) was interviewed on 8/29/24 at 4:30 p.m. The RNC said unused or damaged medications should be disposed of in the sharps container. The RNC said the counter in the medication storage room was a mess. The RNC said nurses should document and destroy discontinued medications or medications from discharged residents. The RNC said it would be the responsibility of the director of nursing (DON) or a nurse manager to follow up on the medications. The RNC said it was a night shift nurse duty to clean the medication storage refrigerator.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interviews, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented in order to facilitate improvement in the lives of nursing home residents through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life and quality of care. Findings include: I. Facility policy and procedure The facility's QAPI policy was requested from the nursing home administrator (NHA) on [DATE] at 6:10 p.m. -The policy was not received by the end of the survey on [DATE]. II. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QAPI program in a manner to prevent repeat deficiencies. F759 Medication administration error rate above five (%) percent During a recertification survey on [DATE], F759 was cited at an E level scope and severity, pattern, no actual harm with potential for more than minimal harm, pattern. F 880 Infection control During a recertification survey on [DATE], F880 was cited at an E level scope and severity, pattern, no actual harm with potential for more than minimal harm, pattern. III. Cross-referenced citations Cross-reference F686: The facility failed to ensure pressure injuries were assessed and interventions were implemented timely to prevent worsening of the wounds and infection. The facility failed to ensure wound treatment was implemented as ordered for a resident who developed a wound infection with sepsis. The facility's failure to assess and treat pressure injuries created an immediate jeopardy (IJ) situation with actual serious harm. Cross-reference F727: The facility failed to employ a full time director of nursing (DON), resulting in a F level citation, no actual harm with potential for more than minimal harm, widespread. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Interviews The medical director (MD) was interviewed on [DATE] at 9:57 a.m. The MD said she was not aware that Resident #85 was hospitalized due to her infected wounds. She said pressure injuries were avoidable injuries when all necessary precautions were in place. She said the fact that residents developed pressure injuries indicated that appropriate interventions were not implemented. The NHA was interviewed on [DATE] at 5:30 p.m. The NHA said he was new to the building and he had participated in one QAPI meeting since he started the position. He said he was not aware of the pressure injury, medications administration and medication storage concerns that were identified at the time of the survey. He said he was not able to locate any investigations or notes completed by the previous administrator, however he would continue to look and provide anything that was relevant. V. Facility follow up On [DATE] at 6:47 a.m. the NHA submitted additional documentation via email. Specifically, the NHA provided a QAPI plan of correction for the identified medication error concerns identified at the time of the survey. According to the plan of correction, the date the problem was identified by the facility was [DATE]. Listed interventions included education to all nurses and audits for expired, discontinued or missing medications were to be completed monthly for the next two months (through [DATE]). -However, the NHA did not provide documentation that education had been provided to nursing staff regarding expired, discontinued or missing medications. -Additionally, the NHA did not provide documentation of the audits that were to have been conducted for expired, discontinued or missing medications.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48112 Based on record review and interviews, the facility failed to develop, implement and maintain an effective training program for staff based on the facility assessment and resident population for two of five certified nurse aides (CNA) reviewed. Specifically, the facility failed to: -Ensure CNA #1 and CNA #2 received training in abuse, dementia management, behavioral health management, infection control, communication, quality assurance and quality improvement (QAPI), compliance and ethics, and resident rights; and, -Ensure CNA #1 and CNA #2 received at least 12 hours of annual in-service training. Findings include: I. Record review A request for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training from the past 12 months and the 12 hours of in-service training was made on 8/27/24 for CNA #1 and CNA #2. CNA #1 was hired on 2/28/23. The facility was unable to provide documentation indicating CNA #1 had completed training for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training in the past 12 months and attended at least 12 hours of in-service training. CNA #2 was hired on 11/29/22. The facility was unable to provide documentation indicating CNA #1 had completed training for abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training in the past 12 months and attended at least 12 hours of in-service training. II. Staff interviews The human resources director (HRD) was interviewed on 8/29/24 at 4:28 p.m. The HRD said abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training was completed when the CNAs were first hired and then annually through an electronic learning management program. She said CNA #1 and CNA #2 did not complete abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training in the past 12 months. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The HRD said there was an annual skills clinic training completed in May 2024 that was approximately six hours of training. The HRD said she was unable to locate any documentation that CNA #1 and CNA #2 attended the May 2024 skills clinic training. The HRD said there were monthly hour-long staff meetings that included training. She was unable to locate the agendas for what was covered in the staff meetings and could not say if CNA #1 and CNA #2 attended the staff meetings. The HRD said she was unable to confirm and show documentation CNA #1 and CNA #2 had completed the required annual trainings and 12 hours of inservice. The regional nurse consultant (RNC) was interviewed on 8/29/24 at 4:36 p.m. The RNC said annual training was completed through an online training system. She said CNA #1 and CNA #2 did not complete abuse, dementia management, behavioral health management, infection control, communication, QAPI, compliance and ethics and resident rights training in the past 12 months. The RNC said it was difficult to have staff complete the required annual training.