STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews and record review, the facility failed to ensure one (#1) of three out of eight sample residents had the right to receive visitors. Specifically, the facility failed to ensure the family of Resident #1 were allowed to see the resident for continued compassionate visit. Findings include: I. Professional reference The Colorado Department of Public Health and Environment (CDPHE) COVID-19 Residential Care Facility Comprehensive Mitigation Document Guidance, revised on 3/22/21, revealed Compassionate care visits should be permitted at all times, even during an outbreak. If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask (covering both their nose and mouth) and cleaning their hands before and after contact. II. Facility policy and procedure The Visitation: Universal Guidance and Policy, revised March 24, 2021, was provided by the director of nursing (DON) on 4/22/21 at 10:51 a.m. It revealed, in pertinent part, Fully vaccinated refers to a person who is greater than two weeks following receipt of the second dose in a two dose series, or greater than two weeks following receipt of one dose of a single-dose vaccination, per the CDC ' s public health recommendations for vaccinated persons. Compassionate Care Visitation and visits required under the federal disability rights law should be permitted at all times, for all residents, as needed. Close Contact for Vaccinated Residents: If a resident is fully vaccinated, she/he can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand hygiene before and after. (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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident #1 status Resident #1, age 75, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side and vascular dementia. The 1/19/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of two people with bed mobility and dressing, extensive assistance of one person with personal hygiene and total dependence of two people with toileting. It indicated it was important to the resident to have her family involved in her care. A. Observations Resident #1 was observed on 4/21/21 at 10:30 a.m. She was lying in bed with the blankets pulled up to her mid chest. The over bed table had three cups of beverages within reach of the resident. The television was on. B. Resident representative interview The resident representative was interviewed on 4/19/21 at 3:00 p.m. She said the facility had been allowing her to visit the resident every Monday at a scheduled time, for the past few months, for compassionate visits. She said the resident resided in a private room, so she was able to visit with her in the room, with the appropriate personal protective equipment (PPE). She said 3/29/21, she was informed she was no longer allowed to have compassionate visits with her mother. She said she was told by facility staff, she would only be allowed to visit with her mother for 30 minutes, in the lobby of the facility, when they had an available appointment. She said she never received an explanation of why she was no longer allowed to do a compassionate visit with the resident in her room. She said the resident had dementia and enjoyed their one to one visits. She said both herself and Resident #1 were fully vaccinated. She said she did not understand why she could no longer visit her mother in her private room. C. Record review The activity care plan, initiated on 3/22/19 and revised on 1/19/21, revealed the resident liked to watch television, listening to Spanish music and dogs. It indicated the resident ' s family kept in contact regularly. The interventions included the resident would keep in contact with her family weekly. The resident ' s daughter was involved in discussions about the resident ' s care and visited. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The impaired cognitive function care plan, initiated on 5/31/18 and revised 12/10/19, revealed the resident had impaired cognitive function or impaired thought processes related to dementia and a history of a CVA (cerebral vascular accident). The psychosocial distress care plan, initiated on 3/16/2020, revealed the resident exhibited or had the potential to exhibit psychosocial distress related to limited visitation due to infection prevention practices. The goal included the resident to use alternate means of communication during the period of limited visitation. The DON provided the 3/22/21 to 4/19/21 compassionate and in-person visit schedule on 4/22/21 at 10:51 a. m. The schedule revealed Resident #1 had compassionate visits with her family scheduled on Mondays from 12:00 p.m. to 1:00 p.m. -It indicated the last compassionate visit the resident had with her family was on 3/29/21 at 12:00 p.m. The schedule did not reveal the resident had visited with her family since her last compassionate visit on 3/29/21. -The residents status had not changed to indicate why compassionate visits were no longer allowed. IV. Staff interviews The activity director (AD) was interviewed on 4/22/21 at 12:57 p.m. She said she was responsible for scheduling in-person visitation. She said the facility had three types of visitation: compassionate care, indoor and outdoor visitation. She said the corporate management had recently made a decision to reduce compassionate visits. She said, as of 3/29/21, the only residents who were allowed to receive compassionate care visitation were those residents who were bed bound or end of life. She said with the new guidance given for indoor visitation, the corporate management decided those residents who were receiving compassionate visits in their room, would now need to visit with their family in the lobby for the scheduled 30 minute indoor visitation. She said there were a lot of families who had been conducting compassionate visits with residents who were upset about the recent change. She said Resident #1 had been receiving compassionate visits in her room for a couple months. She said Resident #1 was fully vaccinated and resided in a private room. She said the nursing home administrator (NHA) was required to approve any compassionate care visit requests with the new guidance. She said Resident #1 was not approved to continue to receive compassionate care visits because she was not considered bed bound. The DON was interviewed on 4/22/21 at 4:29 p.m. She said at the end of March 2021, the facility corporate management had changed the direction for compassionate care visitation. She said compassionate care visits were only approved for bed bound residents. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said she felt the corporate management had limited visitation, when the new guidance from the CDC was attempting to open up visitation. She confirmed Resident #1 was fully vaccinated and resided in a private room. The NHA was interviewed on 4/22/21 at 4:10 p.m. He said he started at the facility three weeks prior. He said with the new guidance from CMS (Centers for Medicare and Medicaid) and CDPHE (Colorado Department of Public Health and Environment), the facility started to allow indoor visitation. He said the facility offered three kinds of visitation: indoor, outdoor and compassionate care. He said the compassionate care visitation guidelines had been recently changed from corporate management. He said compassionate care visitation was now reserved for bed bound residents only. He said he had to approve all compassionate care requests. He said Resident #1 was receiving compassionate care visits in her room. He said he did not know her vaccination status. He said the resident was not bed bound and could come out her room to do a visit with her family in the lobby at a scheduled time. He said many of the resident families had been upset at the recent change to the compassionate care visitation guidance from their corporate management. He said he understood why they were upset, but he had no control over the policy.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43909 Based on observation, record review and interviews, the facility failed to ensure four (#8, #4, #5, and #1) of five residents reviewed for activities of daily living (ADLs) out of eight sample residents were provided appropriate treatment and services to maintain or improve their abilities. Specifically, the facility to ensure Residents #8, #4, #5, and #1 received baths/showers according to the resident plan of care and preference. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADLs) policy, last revised 11/30/2020, was provided by the director of nursing (DON) on 4/22/21 at 4:58 p.m. via email, documented in pertinent parts: Based on the comprehensive assessment of a resident/patient (hereinafter patient) and consistent with the patient ' s needs and choices, the Center must provide the necessary care and services to ensure that a patient ' s activities of daily living (ADL) activities are maintained or improved and do not diminish unless circumstances of the individual ' s clinical condition demonstrate that a change was unavoidable. Activities of daily living (ADLs) include: -Hygiene - bathing, dressing, grooming, and oral care II. Resident #8 A. Resident #8 status Resident #8, age 79, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), the diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus, and chronic kidney disease. The 3/23/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. He required extensive assistance with one person physical assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. He required physical help in part of the bathing activity with one person physical assistance. B. Resident #8 observation and interviews (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/21/21 at 1:15 p.m. Resident #8 was seated in his wheelchair in the atrium. He called out to the surveyor and asked if he would be getting his shower that day. He said he was scheduled to receive showers on Mondays and Wednesdays but no one had given him a shower yet. Registered nurse #1 (RN #1) approached Resident #8 and told him that she would check to see who was scheduled to help him with his shower. Resident #8 was interviewed on 4/22/21 at 10:18 a.m. Resident #8 was seated in his wheelchair in his room eating a cake roll. His shirt was dirty with multiple white splatter marks visible near the collar of the shirt. His pants were also dirty with visible food crumbs on them. His hair was uncombed. Resident #8 said he did not receive his shower yesterday. He said he often did not get his showers when he was supposed to. He said the staff yesterday told him they would do it today instead. He said that the staff told him they were short staffed yesterday and that is why they were unable to give him a shower on his scheduled shower day. At 1:47 p.m. Resident #8 was observed asleep in his wheelchair in his room. He was wearing clean clothing and appeared to have received a shower. C. Record review Review of the certified nurse aide (CNA) shower/bathing preference sheet revealed Resident #8 was scheduled for bathing on Mondays, Wednesdays, and Fridays during the day shift as of 1/25/21. Resident #8 ' s January through April 2021 bathing records were provided via email by the director of nursing (DON) on 4/22/21 at 3:58 p.m. Review of the bathing records revealed the following: -January 2021, received seven showers out of 13 opportunities; -February 2021, received five showers out of 12 opportunities; -March 2021, received five showers out of 14 opportunities with one opportunity marked as not applicable; and, -April 2021, received two showers out of nine opportunities. -There was no nursing documentation of bathing refusals, explanations of why the resident did not receive the scheduled number of showers, or if alternative bathing options were offered. D. CNA interview CNA #1 was interviewed on 4/22/21 at 1:39 p.m. CNA #1 said that Resident #8 never refused showers. She said that she was scheduled to give him a shower on 4/21/22 but the unit was short staffed so she told him she would give him a shower on 4/22/21 instead and he accepted that response. She said she gave him a shower around noon on 4/22/21. III. Resident #4 A. Resident #4 status (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4, age 77, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), the diagnoses included dementia with behavioral disturbance, delusional disorders, type 2 diabetes mellitus, and chronic kidney disease. The 2/9/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to complete the brief interview for mental status (BIMS). He required extensive assistance with one person physical assistance for bed mobility, dressing, and personal hygiene. He required total dependence and one person physical assistance for toileting. He required physical help in part of the bathing activity with one person physical assistance. B. Resident #4 observations On 4/21/21 at 11:34 a.m. Resident #4 was sleeping in his bed. His bed covers were pulled up to his chin. His hair looked unkempt and unclean. On 4/22/21 at 12:19 p.m. Resident #4 was sleeping in his bed. He was wearing a blue shirt. His hair was again unkempt and unclean. C. Record review Review of the certified nurse aide (CNA) shower/bathing preference sheet revealed Resident #4 was scheduled for bathing on Wednesdays and Saturdays during the day shift as of 2/22/19. Resident #4 ' s January through April 2021 bathing records were provided via email by the director of nursing (DON) on 4/22/21 at 3:58 p.m. Review of the bathing records revealed the following: -January 2021, received one shower and one bath out of nine opportunities; -February 2021, received three baths and one shower out of eight opportunities with two opportunities marked as not applicable; -March 2021, received no showers/baths out of nine opportunities with two opportunities marked as not applicable; and, -April 2021, received no showers/baths out of six opportunities with one opportunity marked as not applicable. -There was no nursing documentation of bathing refusals, explanations of why the resident did not receive the scheduled number of showers, or if alternative bathing options were offered. IV. Staff interview (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #1 was interviewed on 4/22/21 at 1:11 p.m. CNA #1 said CNAs provide showers to the residents. She said usually the CNA who is assigned to a specific hallway would provide the showers for the residents in that hallway. She said they have been short-staffed lately and typically there are four CNAs for the unit but sometimes they only have three and cannot get everything done. She said at one point there was a CNA scheduled to help the unit from 6 a.m. to 10 a.m. and that person would be assigned to do showers but that did not happen often. She said there was a shower schedule book in the nurses station and that book indicated which residents received showers on certain days of the week and on which shift. She said showers were documented in the electronic medical record (EMR). She said if a resident refused a shower, it would be documented in the EMR and a paper sheet would be filled out and signed by the resident to indicate that the resident refused the shower. She said the CNAs sometimes struggle to get showers completed. The DON was interviewed on 4/22/21 at 4:34 p.m. The DON said CNAs were responsible for giving showers and that showers were given two times per week and documented in the EMR. She said refusals were also documented in the EMR as well as on paper in the shower book that was signed by the resident. She said the facility did not have a shower aide, but sometimes had extra staff assigned to a unit who would become the shower aide. She said staffing had always been a concern at the facility and there had not been a unit manager to supervise the CNAs for a long time. The DON said she tried to do bathing record audits and noticed that documentation was missing or staff marked that the resident refused but did not provide additional documentation of the refusal. She said she did not know why staff would mark a bath/shower as not applicable on their scheduled shower day unless the bath/shower had been completed on a different shower day or a different shift, but that should also be documented in the EMR. She said staff have all been trained on how to document and if they were unable to document by the end of their shift they should have let the nurse know so someone could document if the resident received a shower. 38185 X. Resident #1 status Resident #1, age 75, was admitted on [DATE]. According to the April 2021 CPOs, the diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the right dominant side and vascular dementia. The 1/19/21 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of two people with bed mobility and dressing, extensive assistance of one person with personal hygiene and total dependence of two people with toileting. The resident required extensive assistance with bathing. A. Record review (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities of daily living (ADL) care plan, revised 11/26/18, revealed the resident was dependent on staff for assistance with bathing, grooming, personal hygiene, dressing, transfers and toileting related to the resident's limited range of motion to her upper extremities. The April 2021 CPOs revealed the following physician order: - Ketoconazole Shampoo 2% - apply to the scalp topically every evening shift every Tuesday, Thursday and Saturday. The January 2021 ADL documentation revealed the resident received a shower on 1/11/21 and 1/21/21, two out of eight opportunities. The February 2021 ADL documentation revealed the resident received a shower on 2/18/21, one out of eight opportunities. The March 2021 ADL documentation revealed the resident received a shower on 3/8/21, 3/11/21, 3/22/21 and 3/29/21, four out of nine opportunities. The April 2021 ADL documentation revealed the resident received a shower on 4/1/21, 4/5/21 and 4/8/21, three out of six opportunities. The facility was unable to provide documentation the resident had received her showers in accordance with her shower schedule and plan of care. The resident's medical record did not reveal documentation the resident refused bathing. III. Staff interviews Certified nurse aide (CNA) # was interviewed on 4/22/21 at 1:11 p.m. She said the CNAs were responsible for providing showers to residents on their scheduled shower days. She said the shower book, which was kept at the nursing station, provided a schedule of every resident's shower schedule in that unit. She said the point of care (POC) system alerted the CNA if the resident required a shower on that specific day. She said all shower documentation was completed in POC. She said, if the resident refused a shower, it should be documented in POC and on a refusal sheet. She said the nurse and the resident have to sign the refusal sheet. She said Resident #1 was dependent upon staff for showers. She said she had a history of a stroke and was unable to bathe herself. The director of nursing (DON) was interviewed on 4/22/21 at 4:29 p.m. She said showers should be given to each resident twice per week, on their scheduled showers days. She said showers were documented by the CNAs in the POC system. She said each time a shower was provided to a resident, it should be documented in POC to include either a shower or bath and the level of assistance for the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said if a resident refused a shower, it should be documented in the POC system and signed by the resident and nurse on the refusal shower sheet. She said the CNAs were responsible for providing showers for their assigned residents. She confirmed Resident #1 required assistance from staff with bathing. She confirmed the documentation for Resident #1 did not indicate the residents received showers according to their schedule and plan of care. She said she was unable to locate any further documentation the residents had received their showers according to their plan of care.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43909 Based on observation, record review and interviews, the facility failed to provide treatment and care services in accordance with professional standards of practice for one resident (#3) of three residents reviewed for change of condition out of eight sample residents. The facility failed to ensure timely care and services were provided to Resident #3 following a change of condition. Resident #3 suffered three falls within six days in December 2020 after she recovered from COVID-19 with an increase in behavioral symptoms. The falls occurred during the night shifts on 12/14/2020, 12/16/2020, and 12/19/2020. The resident experienced new pitting edema to the lower left extremity and a noticeable increase in reported pain levels starting 12/21/2020. Although both the facility and medical provider documented the increased edema and resident complaints of leg pain, an x-ray was not ordered until 1/6/21, 18 days after the latest fall and 10 days after the pitting edema started, which revealed the resident sustained a fracture of the left tibia and fibula. This contributed to the resident suffering unnecessarily from associated increased leg swelling and increased pain levels due to the delay in treatment and discovery of the fracture. Findings include: I. Facility policies and procedures The Falls Management policy, last revised 2/18/2020, was provided by the director of nursing (DON) on 4/22/21 at 4:58 p.m. via email, documented in pertinent part: Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Patients experiencing a fall will receive appropriate care and investigation of the cause. The Notification of Change in Condition policy, last revised 11/30/2020, was provided by the DON on 4/22/21 at 4:58 p.m. via email, documented in pertinent part: A center must immediately inform the resident/patient (hereinafter patient), consult with the patient's physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker (HCDM), where there is: -An accident involving the patient which results in injury and has the potential for requiring physician intervention (refer to); -A significant change in the patient's physical mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); -A need to alter treatment significantly (that is, a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or -A decision to transfer or discharge the patient from the Center. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	When making notification of above, the Center must ensure that all pertinent information is available and provided upon request to the physician. II. Resident status Resident #3, age 83, was admitted on [DATE]. According to the April 2021 computerized physician orders (CPO), the diagnoses included dementia with behavioral disturbance, fracture of the left tibia/fibula (onset date of 1/6/21), type 2 diabetes mellitus, and COVID-19. The 1/14/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of seven out of 15. She required extensive assistance with two person physical assistance with bed mobility, dressing, and toileting. She required extensive assistance with one person physical assistance for personal hygiene. She was totally dependent and required two person physical assistance for transfers. She was independent and required set up help only for eating. III. Resident observations On 4/21/21 at 10:20 a.m. Resident #3 was observed seated in her wheelchair in the atrium. She had her feet elevated on foot pedals and a blanket was placed over her lap and legs. She was socializing with another resident. -At 2:39 p.m. Resident #3 was again observed seated in her wheelchair in the atrium. She was drinking a soda. Her feet were elevated on foot pedals and she had a blanket covering the majority of her legs. There was a soft backing behind the foot pedals. No edema was observed in her right leg, however, the left leg was completely covered by the blanket. On 4/22/21 at 10:29 a.m. Resident #3 was observed in the atrium seated in her wheelchair. Registered nurse #1 (RN #1) lifted the blanket on the resident's legs which revealed the resident was wearing thrombo-embolic deterrent (TED) hose on her right leg and a controlled ankle motion (CAM) boot to the left leg. There were towels placed underneath the left foot in the CAM boot. IV. Record review A. Care plans The resident's behavioral care plan, last revised 1/14/21 revealed Resident #3 was resistive to care related to cognitive loss/dementia, would often refuse incontinence care when offered, would get upset stating she had not received incontinence care, would call family crying about not receiving incontinence care, would yell and bang on items when in bed, and was noted to have increased verbal behaviors after she had COVID-19. Pertinent interventions included: -Allow time for expression of feelings; provide empathy, encouragement, and reassurance; -Contact daughter to speak with the resident after behavior/during behavior episodes; -Provide a calm, quiet, well-lit environment; (continued on next page)

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Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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F 0684 Level of Harm - Actual harm Residents Affected - Few	General progress note dated 1/1/21 at 3:12 p.m. documented that the resident's feet were especially edematous and shiny. -At 9:20 p.m. the resident refused to lay down and her legs were swollen and hurting. The medical provider note dated 1/4/21 documented the resident was positive for edema with +2 edema of the left and right pretibial, +3 of the left ankle and left pedal, +2 edema of the right ankle and pedal; this indicated that the left side showed more edema than the right side. General progress note dated 1/4/21 at 9:20 p.m. documented staff educated the resident on how important it was to rest her legs as they were causing her pain and were swollen with +3 pitting edema. General progress note dated 1/5/21 at 9:37 p.m. documented the resident was in bed and some of the leg swelling had gone down. The resident's legs were still swollen and the resident complained of pain when she moved her legs. The medical provider note dated 1/6/21 documented the resident was positive for edema with +3 edema of the left ankle and +2 edema of the right ankle; this indicated that the left side showed more edema than the right. The medical provider note dated 1/7/21 documented the resident was positive for edema with +3 edema to the left pedal and +2 edema to the right ankle and pedal. -According to progress notes and confirmed with interviews the resident had a history of edema. She did not have a history of pitting edema until after her fall, which would indicate a change in condition for her baseline status to her lower legs. The facility failed to identify pitting edema as a change for the resident and lower extremity pitting edema is not mentioned in the resident's progress notes between September 2020 and December 2020. It is not mentioned until 12/27/2020 which is after the resident sustained multiple falls. D. Pain levels Review of the December 2020 and January 2021 MARs revealed the resident had an order for pain monitoring. The resident was asked, Are you free of pain or hurting? every shift. The reported pain levels prior to and after the falls were as follows: 1.Before falls -12/1/2020 pain level of 2 on all three shifts; -12/2/2020 through 12/20/2020 pain level of zero on all shifts; 2. After falls -12/21/2020 pain level of 5 on all three shifts; -12/22/2020 pain level of 5 on afternoon shift; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-1/6/21 pain level 5 V. Hospital documentation The 1/6/21 summarization of encounter note from the hospital revealed Resident #3 sustained a fall during transferring. She was diagnosed with a closed displaced comminuted fracture of the shaft of the left tibia and fibula. The hospital physician recommended a closed treatment with splint application followed by cast application in clinic with close radiographic followup in one week. The procedure and plan was fully reviewed with the patient and her daughter. VI. Interviews Registered nurse (RN) #1 was interviewed on 4/22/21 at 10:29 a.m. RN #1 said she was familiar with Resident #3. She said that lower extremity edema had been an ongoing concern for Resident #3 and she had been off and on diuretics and potassium supplements several times. She said she was not present when Resident #3 suffered multiple falls in December 2020 as those occurred on a different shift, however, she did state that the resident's lower extremity edema was significantly more noticeable after her falls. She said the resident had been combative with nursing staff after her falls and refused to lie down in bed or elevate her legs. The medical provider was interviewed via telephone on 4/22/21 at 11:57 a.m. She said she would not answer any questions about Resident #3 until after she spoke with her manager. She said she would call back after speaking with her manager. The medical provider called back on 4/22/21 at 12:37 p.m. The medical provider said Resident #3 had been one of her patients for a long time. She said Resident #3 had always had lower extremity edema, however, it was not pitting and seemed to be fairly well controlled without medication. She said she had recommended having the resident wear compression stockings but the resident did not always tolerate them. She said the resident's edema did get worse after her falls in December 2020. She said she only knew what was reported to her and everything could be found in her notes. She confirmed that she did order an x-ray on 1/6/21 because a nurse suggested the resident may have a fracture. She said she was not aware of any other injuries Resident #3 may have suffered outside of the multiple falls. RN #1 was interviewed again on 4/22/21 at 1:22 p.m. RN #1 said when a change of condition occured for a resident, the nurse notified the medical provider and family right away, vital signs are taken, and a change of condition was initiated. She said with regards to Resident #3, she had a history of swelling and pain in her legs but facility staff continued notifying the medical provider of the increased swelling after the multiple falls. She said she did not know of any other injury Resident #3 may have sustained that would have caused her left tibia/fibula fracture other than one of her falls. She said she did not know how it was ultimately determined that the resident may have had a fracture. RN #2, the nurse who suggested to the medical provider that Resident #3 may have had a fracture, was called on 4/22/21 at 3:02 p.m. A voicemail was left but no return call was received. (continued on next page)

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