STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065213	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024 Based on observation, document review, and interviews the facility failed to provide a clean, safe, homelike environment for residents on two of three units and in resident common areas. Specifically the facility failed to : -Ensure the privacy curtains were changed on a regular basis; -Ensure the facility was free from urine odors; -Provide clean floors in resident rooms and throughout the facility; -Ensure resident rooms and furnishings were clean, neat, and tidy; -Ensure the heating units in resident rooms were clean and free form dust build up; -Ensure trash cans in resident rooms that contained soiled adult incontinence briefs were emptied timely; -Ensure resident shared medical equipment was in clean condition; -Ensure the shower rooms were cleaned after each use and maintained in good repair free from odors; -Ensure the resident showers were in good repair with safe flooring and functional faucets with easy to control water temperatures; and, -Ensure that facility vents in resident bathrooms; common areas; in in the elevator were cleaned regularly and free from visible dust. I. Facility policy and procedures The Home like Environment policy was requested from the nursing home administrator (NHA) on 11/3/22. The facility did not provide the policy. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Cleaning and Disinfecting of Environmental Surfaces policy, revised June 2009, was received from the NHA on 11/3/22 at 8:30 p.m. It reads in pertinent part: Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection of healthcare facilities. -Housekeeping surfaces will be cleaned on a regular basis, when spills occur and when these surfaces are visibly soiled. -Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. -Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. -Horizontal surfaces will be wet dusted regularly (e.g., daily, three times per week) using clean cloths. II. Observations On 10/31/22 from 10:00 a.m. to 11:33 p.m. resident rooms on the first and second floor were observed. Immediately upon exiting the elevator to the first floor there was a strong odor of urine. Trash bins in the hall were full with soiled incontinent briefs and several resident rooms on the 100 hall had soiled briefs in the resident trash cans causing a strong smell of urine in those resident rooms. Observation of all resident rooms on the 100 had revealed floors that were stained with black marks and dried spilled liquids in several resident rooms. Every resident room flooring was heavily soiled with dark black build up at the point where the floor met the wall. The black soiling extended out from the walls approximately a quarter to a half an inch from the base's board and was highly visible as you entered each of the resident rooms. Resident rooms observations -room [ROOM NUMBER]: The electrical outlet by the sink was covered with a dried light brown substance; the floor was soiled with blackish gray marks; and there was crumpled paper trash on the floor. -room [ROOM NUMBER]: The floor was streaked with a dried brown substance coming out from the resident's bathroom. On the other side of the room there was a large dried pink substance soiling the floor; there was spotting of a dried brown liquid substance on the wall; and the heating unit was dusty and soiled with black matter. -room [ROOM NUMBER]: The divider curtain was heavily soiled with a dark grayish black matter. -In the shared bathroom between resident rooms [ROOM NUMBERS] there was a used urine catheter bag hanging on the grab bar next to the resident toilet. The urine bag was heavily soiled with a thick dark yellow sediment and had the strong smell of urine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER]: The trash cans were overflowing and included soiled incontinent briefs that emitted a strong smell of urine. -room [ROOM NUMBER]: The bathroom floor was heavily soiled around the base of the toilet with a thick black matter covering the cracked caulking. There were used attendants in the trash can causing a urine odor in the room. -room [ROOM NUMBER]: The bathroom toilet had a thick layer of a blacked substance built up at the base, the toiled chrome piles and flushing element at the top back of the toilet was heavily corroded and appeared soiled and unclean. The room heating unit vents were dusty and the unit was soiled with black matter. On 11/1/22 at 10 :30 a.m. resident room [ROOM NUMBER] was observed. The trash can was overflowing with soiled incontinent briefs and a strong odor of urine. There were multiple dirty dishes with dried food from the previous diner and breakfast meals piled up on the resident sink. On 11/1/22 from 11:00 a.m. to 11:50 a.m. the second floor was observed. -The hallway had a strong odor of urine. Several resident rooms had heavily soiled privacy divider curtains that were stained with various colored stains. The floors around many sinks, corners of rest rooms, and rooms had black or brown soil in the corners. The air conditioners, bathroom vents, and baseboards were visibly soiled or dusty. Personal grooming items were not labeled per resident. On 11/3/22 at 3:50 p.m. resident room [ROOM NUMBER] was observed. The bathroom floor had cracks in the tiles, the corners of the room had a black substance stuck on it. The bottom rim of the toilet had a black substance on it. There was dried soup under the head of the resident's bed. Common shared space areas On 10/31/22 the first floor lounge was observed. -There was a bread maker on the counter that had not been cleaned after the last use. The inside of the machine was encrusted with old bread dough and crumbs. The dried matter was whitish and spotted with black matter. -The air conditioner unit was dusty; -The floor was sticky in places and there was trash and debris on the floor. On 11/2/22 it was observed that the main elevator ceiling tiles were heavily coated with dust. Resident shower rooms On 11/1/22 from 4:30 p.m. to 5:05 p.m. the resident shower rooms were observed. First floor resident showere room (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A bag of soiled Attends (adult briefs) was left on the floor causing the room to have a strong odor of feces. There was a large bin of soiled laundry in the walkway just inside of the room before approaching the shower. The laundry container was overflowing with soiled towels, linens and resident clothing. A Second bag of soiled towels was on the floor next to the shower entrance; -The sink contained soiled resident clothing. -The whirlpool tub had a plastic cover bag covering the basin. The plastic was soiled with dried brown substance. The grout on the floor were stained black. The floor baseboards were soiled withblack and tan debris and stains with dried brown and orange stains; -The shower stall had several broken and missing tiles, the tan grout was heavily soiled in most areas with a dark black substance and there were small gnat-like bugs flying around the shower. The tiles surrounding the water control knob were soiled with a brown and yellow substance;. -A table at the entrance to the shower stall had an unlabeled toe nail clipper that appears to have been used; -The water knob was unadjustable and broken making it difficult to adjust the water to a comfortable temperature; and, -The shower curtain was heavily soiled with brown and black stains. Second floor resident shower room -The trash container was overflowing with soiled incontinent briefs; -The soiled linen bin was overflowing with soiled linens and resident clothing; -A chair in the outside of the showerwas soiled with brown spots; The decorative letters on the wall were soiled with dust; -The baseboards in the outer chamber were stained black and tan; -Several flooring tiles around the tub and through the shower room were broken; were broken -The walls and baseboards boards around the shower area were broken or cracked in multiple areas; -The tiles in the shower stall were stained with a dark brown and dark tan matter; -The [NAME] was broken and taped together; and, -The sink beside the shower stall had multiple unlabeled hair brushes lying on it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/3/22 at 9:31 a.m. it was observed that a resident was being transferred into the shower room that had an overflowing linen container and a strong foul odor. Resident hallways on the second floor On 10/31/22 at 10:49 a.m. and 11/1/22 at 1:58 p.m. the second floor resident hallway observations included: -The kick plates and floorboards were coated with dust and debris; -There was shared medical equipment including mechanical lifts and a blood pressure monitor device in the hall that was dirty with dust and debris; -There was a dirty used cup on the handrail and a wheelchair in the hallway with a used nasal cannula hanging from the hand grips without a bag to contain it. -The hallway floor was soiled with dust and debris; and some ceiling tiles were falling down and others were water stained with brown marks. -room [ROOM NUMBER] which had been converted to a small dining room was in disarray. The walls were splashed with brownish fluid that had dried and the floor was soiled with spilled food and debris that had been dried in place. The air conditioning unit was dusty. III. Document review Resident council concern form dated 7/21/22 revealed the resident council complained that trash had not been removed from their rooms for several days in a row. Resident council minutes from 8/18/22 documents the resident's trash is not being picked up on a regular basis. Resident council concern form from 8/18/22 revealed the resident council complained that their trash is not being taken out and was often overflowing in resident rooms and common areas. Resident council minutes from 9/15/22 documents the trash in the building and resident's rooms were not being taken out daily. An individual resident concern form dated 9/26/22 revealed that a resident made a complaint that the floors and surfaces throughout the facility were sticky. IV. Resident group interview On 11/2/22 at 1:00 p.m. Five alert and oriented residents who regularly attended resident council meetings were interviewed in a group. The resident group attendees said the facility housekeepers do not clean well. The floors throughout the facility were remained sticky and they did not empty the trash cans. Trash builds up especially on the weekends. The facility does not control the odor of urine and feces on the units. Odors are made worse when the CNA's leaves soiled incontinent briefs in their trash cans. Additionally, the CNA do not make their beds or change sheets as often as needed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Interviews The housekeeping supervisor (HSKS) was interviewed during a tour of the facility on 11/3/22 at 1:09 p.m The HSKS acknowledged that the floor was stained and that it was on the list of things to take care of. The HSKS said the floors had been waxed in the past and the person who waxed the floor did not properly clean the floors first thus sealing in the dirt. This was hard to remove but the facility had a plan to remedy the situation The HSKS said the facility hired a new floor technician to work on the floors and the facility was working on an action plan to renovate the rooms to fix the floors. The HSKS said that the divider curtains in resident rooms should be changed at least once every two weeks. There was a low inventory of the curtains and they needed to order more. The HSKS said there are only two to four sets of curtains to replace the existing ones. The HSKS said that it is not the responsibility of the housekeepers (HSK) to remove bags of soiled incontinent briefs or other soiled garments from resident rooms or other rooms but they should alert nursing staff if they found these items left in resident rooms. The HSK were responsible for basic cleaning and disinfection in each resident's rooms on a daily basis. The HSKS provided the HSK's daily cleaning task list with an 18 step process to clean the resident rooms which included cleaning and disinfecting all high touch surfaces, dusting, sweeping, mopping regular trash removal and cleaning of the resident's bathroom. The certified nurse aides (CNA) were responsible for removing any items soiled with bodily fluids and tidying up the resident rooms in between daily housekeeping The maintenance director (MTD) was interviewed during a tour of the facility on 11/3/22 at 12:40 p.m. The MTD acknowledged that the floor tiles, baseboard, and surrounding areas, including the floors around the resident toilets, were soiled and needed to be cleaned and in some cases repaired. The MTD said the facility had developed a plan to make repairs but the pandemic put things on hold and the plan had not yet been implemented The MTD said it was possible to replace cracked and soiled caulking and help the housekeeping department with deep cleaning needs The MTD said the facility had started renovations and updates on the third floor but acknowledged the first floor was in need of immediate repairs and updates. The MTD acknowledged that the shower room floor tiles, baseboards and shower stall were soiled and needed to be deep cleaned and tiles needed to be repaired. The MTD acknowledged that the shower faucets were not in good condition and need to be repaired to enable easier temperature controls and prevent water temperatures from getting too hot or too cold. The MTD said he had a temporary fix for the faucet in the first floor shower room and would speak to administration about getting the shower faucets replaced as soon as possible. The MTD demonstrated the temporary faucet fix The faucet fix consisted of the MTD placing orange tape on the handle at the six o'clock and ten o'clock to indicate where the knob should be turned to in order to prevent the water from being too hot or too cold. The plan included providing instruction to the CNA responsible for assisting residents with showering. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 11/3/22 at 5:34 p.m. The DON said that if there was a problem with the trash removal due to limited access to the dumpsters particularly over the overnight and weekend through Monday morning. The CNA will hold trash till morning for disposal because they had to wait for someone to provide a key for access to the dumpster and usually by Monday morning the dumpster was full; the facility shared the dumpster with neighboring buildings. The DON said the housekeepers were not in the building 24 hours seven days a week so it is up to the CNAs to clean anything that is close contact with the residents, including removal of soiled and dirty items. The DON acknowledged there were odors near soiled linen and trash containment areas and it needed to be controlled. The DON said there should be an environmental check up for any particular room that has strong odors. Problematic rooms should be placed on a 15 minute check schedule to manage spills and smells. The DON said leaving soiled laundry linen and incontinent briefs in the shower rooms was not acceptable. The DON said the CNAs needed to make sure the shower rooms were clean before bringing someone in there to use it.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to keep residents safe from accident hazards related to falls and elopement for four (#61, #60, #45, and #218) of six residents reviewed for falls and one (#61) of one resident reviewed for elopement/missing person out of 31 sample residents. Specifically, the facility failed to prevent residents at risk for falls from having repeated falls, falls with injury, and major injury. Resident #60 was admitted to the facility on [DATE]. At the time of admission, the resident was able to walk throughout the facility with staff supervision and weight bearing and balance support. Once the resident was assisted to a standing position with balancing support the resident was able to walk up to 50 feet with a walker assistive device and staff supervision, touch assistance and verbal cuing. The resident did not use a wheelchair for mobility. Resident #60 was assessed to be at low risk for falls upon admission, however the resident started to experience a decline and began to experience repeated falls after admission to the facility. The resident's first fall was on 8/6/22, due to losing balance during a self-transfer out of a chair. The resident had four additional falls while a resident of the facility. Following the first fall, the facility failed to reassess the resident risk for falls, implement an appropriate person centered care plan focus for balance and standing deficits, and implement fall prevention measures with effective interventions against repeated falls. The resident had a second fall on 9/1/22 and fractured the right thighbone, then had three additional falls. The facility's failure to address the resident's balance and gait concerns, consider other medical reasons for the resident's balance deficits, and implement person centered interventions to address a method for staff to ensure the resident received care assistance when needed, for care tasks where the facility assessed the resident needed assistance. These failures led to repeated falls and a fall with a major injury. Resident #45 experienced multiple falls while a resident of the facility. Resident #45 was assessed to have had poor balance, unsteady gait and poor safety awareness. The fall prevention care plan was vague and lacked any specific person centered interventions. After the resident's fall on 8/10/22, the nurse on duty conducted a post fall investigation. It revealed that the interdisciplinary team (IDT) would discuss effectiveness of interventions and possible clinical indications (reasons) for the resident's continued fall and need for additional interventions to prevent future falls and injury from falls. However, the resident's medical record did not document any further assessment or discussion of implementing fall prevention interventions at that time. The facility did not revise the resident's care plan to add a fall prevention focus until 9/21/22; by that time the resident had three additional falls, one with a major injury. The facility's failures led to the resident having continued falls and one fall resulting in a subdural hematoma (bleeding between the brain and skull). Additionally, the facility failed to: -Ensure safe transfers with a mechanical lift and provide the correct size equipment (lift sling) to perform a safe transfer for Resident #60; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Implement person centered detailed fall prevention care plans with individualized interventions for Residents #61, #45 and #218; -Complete a comprehensive post fall assessments following resident falls, for Resident #218; -Ensure that all staff working were made aware that a new resident had been admitted to the secured unit, and ensure that staff working on the secured unit were informed of the newly admitted resident's care needs for Resident #61, -Prevent Resident #61, a newly admitted resident, from eloping out of the secure unit; and -Develop and implement a person centered elopement prevention care plan with individualized interventions for Resident #6. Findings include: I. Resident Falls A. Facility policy and procedure The Fall Clinical Protocol, revised March 2018, was provided by the nursing home administrator (NHA) on 11/3/22 at 8:30 p.m. The protocol read in pertinent part, The physician will help identify individuals with a history of falls and risk factors for falling. While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause. The staff and practitioner will review each resident's risk factors and document them in the medical record. -After the first fall, the staff (and physician, if possible) should watch the individual rise from a chair without using the assistance of his or her arms, walk several paces, and return to sitting. If the individual has difficulty or is unsteady in performing this test additional evaluation should occur. -The physician will identify medical conditions affecting fall risk and risk for significant complications of falls and the risks for significant complications for falls. The staff, with the physician's guidance, will follow up on any falls with associated injury until the resident is stable and delayed complications such as a late fracture or subdural hematoma have been ruled out or resolved. -The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. -If the individual continues to fall, staff and physicians will re-evaluate the situation and reconsider possible reasons for the resident's falling and also reconsider the current interventions. B. Resident #60 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1. Resident status Resident #60, age 75, was admitted on [DATE] and discharged on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, and heart failure. The 8/9/22 admission minimum data set (MDS) assessment revealed the resident had intact cognition and scored 15 out of 15 on the brief interview for mental status (BIMS). The resident showed no signs of delusions or psychosis and had no aggressive behaviors. The resident did not reject care or assistance. According to the MDS assessment the resident, upon admission, was able to complete some activities of daily living with only set up assistance from staff. The resident needed extensive assistance from staff for bed mobility, transferring, toileting, dressing, and with personal hygiene. Once assisted to a standing position the resident was able to walk unassisted with a walker device. The resident was occasionally incontinent of bladder and bowel. The resident did not have a catheter and was not placed on a toileting program. 2. Record review Review of the resident medical record revealed Resident #60 had five falls while a resident of the facility from 8/1/22 through 10/19/22 when the resident was discharged from the facility due to a decline in health condition. The resident's repeated falls started on 8/6/22, five days after admission (see below for details). On 8/6/22 at 11:55 p.m., Resident #60 had an unwitnessed fall in the dining room; the resident lost balance and fell while getting up from a chair. The resident did not appear to be injured other than some discoloration to the skin to the abdomen below the belly button. There were no recommended interventions. Facility progress notes dated 8/6/22 at 11:54 p.m., revealed the resident told the nurse who assessed the resident post fall a chair where I sat is broken while I was getting up and that's why I fell . There was no documentation to verify if the chair the resident sat in was or was not broken. Facility progress notes dated 8/7/22 at 3:41 a.m., read in part: Resident required Hoyer (mechanical lift) to get up off floor, he is on neurological checks from a fall yesterday morning. He refuses to call staff for assistance, will not wear shoes, after he is Hoyered (lifted) into bed he gets up again immediately. Resident does seem to have good strength as he can lift his lower body up off the bed when supine and can get in a sitting position as well when supine, but he offers no effort during these falling episodes. On 9/1/22 at 7:50 p.m., Resident #60 had an unwitnessed fall in the resident's room while transferring to bed. The resident was assessed to be in severe pain at a level of 10 out of 10 (excruciating pain) and was not able to move the right leg. Deformity of the right knee was noted. Contributing factors included water on the floor and having bare feet. The resident was sent to the hospital emergency room for assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility progress notes dated 9/1/22 at 7:50 p.m., read in part: Post fall evaluation: Resident stated to nurse that he felt his right knee pop when he landed on floor. Resident stated pain was a 10 and was not able to move right leg. Floor mat was on the floor: No footwear at time of fall: Bare feet. Resident was not using a walker as instructed. Resident was wearing oxygen as prescribed at the time of fall. Bathroom call light on when resident was found: No. Physical Findings: Change in diagnosis status: No. Actioned clinical suggestions: (none listed). Resident #60's comprehensive care plan documented initiation of a fall prevention focus on 9/2/22, after two falls in the facility where one of the falls resulted in a major injury sustaining a fracture to the right thighbone. After the resident had experienced two falls while a resident of the facility (see below). The care focus revealed the resident had actual falls related to repeated unsafe decision making for self-transfers. Interventions included: -Resident choose not to ask for assistance with ambulation, transfers. The resident is able to make needs known, staff will do frequent checks on the resident for assistance offering. -Resident was non-compliant with asking for assistance with ambulation, transfers. Resident was able to make needs known, staff will do frequent checks on the resident for assistance offering. Additionally, the nursing assessment of the resident's physical function and other physiological factors revealed the resident had a decline in function and ability to complete activities of daily living (ADLs) independently. The resident was assessed to need assistance with self-care including transfers and mobility. The resident assessment revealed the resident did not reject or refuse care. Care planned interventions revealed the resident needed two staff to assist the resident with transfers and standing to walk, toileting and bed mobility. The care plan had no person-centered interventions to address the resident's reluctance to call for staff assistance. Hospital treatment notes dated 9/7/22 revealed Resident #60 was admitted on [DATE] and remained in-patient for five days. X-ray assessment of the resident's injuries confirmed a right femur (thighbone) fracture with adjacent soft tissue injury. X-ray right knee results showed pronounced right knee degenerative changes without displaced fracture, although the hospital could not exclude mild impacted fracture of the medial tibial plateau (the flat area of the larger of the two bones of the leg just below the knee). While in care of the hospital, the resident received surgical intervention to treat a right femur shaft (thighbone between the hip and knee) fracture after a fall. The after visit note revealed the resident could walk on the fractured leg post-surgery as tolerated. The facility Safe Resident Handling and Mobility Objective Transfer assessment dated [DATE] revealed Resident #60 could not bear any weight and was not able to follow instructions due to confusion. -The assessment did not address any related risk factors or recommendations to address the assessment findings. On 9/10/22 at 12:22 p.m., nursing notes revealed Resident #60 had an unwitnessed fall possibly while transferring to bed. The resident said he slid off the bed. The resident was not injured in the fall. Contributing factors listed included poor safety awareness. The facility placed a floor mat at bedside and educated the resident to use the call light for staff assistance to prevent future falls. (continued on next page)

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	065213	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Facility progress notes dated 9/11/22 at 3:53 p.m., read: Resident constantly using call light through the night, saying I want to walk to the bathroom, I lost my television (TV) control, I am not able to see TV in this position. Resident was repositioned many times; offered a bed pan that he declined. Resident dropped the bedside table on the floor; his bed sheets were moved on the floor many times. Resident denied any pain and kept saying I want to walk to the bathroom. Explained to the resident that it is not safe for him to walk and there was only one nurse and one CNA on the floor and we are not able to support him with walking. Resident keeps saying nobody cares. Bed is in a low position, floor mattress in place. Facility progress notes dated 9/18/22 at 6:59 p.m., read: Resident never received any non-slip strips or any other product to provide floor traction. He fell in his room and fractured his femur. -The interventions still did not address the resident's reluctance to use the call light. The comprehensive care plan revised on 9/24/22 documented new fall prevention interventions which included: -Educated the family about the barriers to care and coordination with partnering services for assistance; placing the resident bed in the low position; -Place a fall mat next to the resident's bed; provide outpatient services for PT/OT (physical and occupational therapy); -Resident had repeated falls since admission to the facility, August 2022. Staff goes into the room each time the resident uses the call light for assistance and frequently each shift while the resident is awake. The resident had a history of asking staff to go get water refilled or some other request then after staff leaves the room and resident will attempt to ambulate and transfer alone because of previous functioning. Resident is having a hard time with asking for help with transfers of any kind and will state that he did not think he needed help with that. -Social Services to evaluate the resident for current BIMS for ability to make decisions. -Therapy notes from (provider name) for PT/OT aftercare updates if any. -Provide frequent toileting check and change. -Ensure oxygen tubing, cords and clutter in the room is kept neat. -Coordination of care between services will be communicated and coordinated with the facility for continued care with the resident, including barriers to resident acceptance for needing increased help with transfers, toileting/peri care. -Although there were new interventions, some lacked individualized personalized approaches. The care plan documented the resident was reluctant to call for staff assistance; however, the care plan did not offer any specific approaches staff should take to ensure all needs were met prior to staff leaving the resident's room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Additionally, a review of progress notes from 9/12/22 through 10/19/22 (date of discharge), revealed the resident was experiencing increased episodes of restlessness, increased attempts to get out of bed, increased complaints of pain, and increased agitation which were not address as potential factors in the resident's increased falls. On 10/2/22 at Resident #60 had an unwitnessed fall from bed after trying to reach something on the floor. The post fall evaluation documented Contributing factors note: resident is anxious and exhibiting poor safety awareness. The resident complained of pain to the right hip and knee at a level of 3 out of 10. -There were no clinical suggestions. Facility skilled evaluation notes dated 10/2/22 at 3:17 p.m., read in pertinent part: Safety concerns: Yes. Safety concerns - note: when using the Hoyer lift exercising caution when transferring. -There was no more detailed explanation about the nature of the safety reference to use caution when using the Hoyer lift in the note written above. There was an allegation that staff performed an improper transfer with the mechanical lift and the lift tipped during the transfer onto the staff performing the transfer, and staff had to lower the resident to the floor. The director of nursing (DON) acknowledged this did occur and attributed it to staff using the incorrect size Hoyer sling (see interview below). On 10/4/22 at 6:50 a.m., Resident #60 was found lying on the floor at the bedside. The resident had no injuries. The resident said he was trying to reposition himself in the bed and did not want to have to rely on others. Implementation of a floor mattress was listed as the recommended intervention, but the fall mat should have already been in place since 9/24/22 (see care plan revision above). -The resident's medical record did not document a review of the effectiveness of fall prevention interventions for effectiveness. On 10/5/22 at 5:58 p.m. at 3:00 p.m., Resident #60 was found lying on the floor at the bedside. -The resident's medical record revealed there were no new interventions implemented and no assessment of the existing fall prevention interventions. On 10/19/22 at 3:38 p.m., Resident #60 was found on the floor at bedside during nursing rounds. The resident told nursing staff he rolled out of bed. -There was a progress note documenting the event but no post fall assessment in the resident's medical record. 3. Staff interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 11/3/22 at 5:23 p.m. The DON said IDT reviewed any resident after a fall and investigated the predisposing factors of the fall in order to develop appropriate fall prevention interventions. This process can take approximately two to three days to complete, sometimes longer if the resident was experiencing repeated falls. Once the assessment was complete, the care plan will be updated and interventions will be implemented. The DON said Resident #60 was experiencing repeated falls and declining health with increasing episodes of being confused. The facility was having trouble communicating with the physician provider, getting physician orders timely and getting lab results. Meanwhile the resident was slowly declining in his ability to perform ADLs and less active with social activities. The DON acknowledged that the resident was in a Hoyer transfer accident and ended up on the floor with no injury. The DON said staff used the incorrect Hoyer sling to transfer the resident out of bed to the wheelchair. The sling was too small for the resident and the resident was improperly placed into the sling. Once the resident was lifted up off the bed and the staff moved the Hoyer towards the resident wheelchair the resident slid out of the sling and the lift tipped. Staff performing the lift had to lower the resident to the floor. The resident was not injured in the process. After investigation, the facility obtained the correct size Hoyer sling for the resident to use in all future Hoyer transfers. 47024 C. Resident #15 1. Resident status Resident #45, under age 75, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses include chronic obstructive pulmonary disease (COPD), history of falling, generalized anxiety disorder, cerebral infarction (stroke), unsteadiness on feet, muscle weakness, and difficulty walking. The 9/9/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental health status score of 11 out of 15. According to the MDS assessment the resident required extensive assistance from two people with bed mobility, transfers, toileting and one person assistance with walking in the room, corridor, on and off the unit, personal hygiene, and dressing. The resident was unsteady while moving from seated to standing position, surface to surface transfers, walking, turning around, and moving on and off the toilet. The resident has a manual wheelchair that requires substantial to maximum assistance, the helper does more than half of the assistance. 2. Resident interview and observation Resident #45 was interviewed on 11/1/22 at 10:41 a.m. The resident said that he had fallen once about four months ago, right after he started using the walker. The resident said he was trying to get up and the floor was slick, then his legs gave out and he slipped and fell off the bed. The resident said that he used the walker when he was walking in the hallways, used a manual wheelchair when he was going to the shower room, and did not use any assistive devices while walking in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident said the only fall prevention intervention the facility provided was to move him closer to the nurses station in order to monitor his movements. The resident was observed on 11/1/22 at 10:41 a.m. The resident was in bed; the bed was in the lowest position. The resident did not have non-skid slip strips or fall mat on the floor at the bedside, while he was in bed. 3. Record review The comprehensive care plan, implemented on 7/11/22, documented the resident had an actual fall in the facility, poor balance, poor communication, poor comprehension, and unsteady gait. The goal was to resume usual activities without further incident. Interventions included to continue the interventions on the at-risk plan, determine and address the causative factors of the fall, monitor and report changes in mental status, use a urine leg bag while awake, and resident room moved closer to the nurses station for more frequent checks every shift. -The care plan did not explain what the actual interventions were, or provide details of the fall at-risk prevention plan for Resident #45. The comprehensive care plan documented generic interventions, to continue to follow the intervention on the at-risk plan, and determine and address the cause of falls, but failed to document individualized person centered approaches and interventions. On 8/10/22 at 6:45 a.m., Resident #45 had an unwitnessed fall in his room and sustained a skin tear to the right elbow. No treatment of the skin tear was documented. The resident was found sitting on the floor next to the bed facing the television with the walker behind him. -No new interventions were put into place. The post fall investigation reports documented that the IDT and resident physician would discuss the effectiveness of interventions, with possible clinical indications (reasons) for the resident's continued falls, or need for additional interventions to prevent future falls and injury from falls. On 8/12/22 at 5:00 a.m., Resident #45 had an unwitnessed fall in his room.The nurse responded to a loud noise from the resident room and found the resident lying face down on the floor with blood coming from the resident's forehead, the resident's walker was nearby. The resident sustained a laceration on his forehead that required four stitches. Interventions included encouraging the resident to use the call light for help -The facility failed to document the size or appearance of the laceration. The resident went to the hospital emergency room for further assessment (see hospital note below). Upon the resident's return to the facility, there was no documentation or monitoring of the wound for signs of infection or healing The hospital note dated 8/12/22 revealed the resident was admitted to the emergency room for assessment after a fall with injury and head trauma after tripping over oxygen tubing and hitting his head on the floor. Based on hospital evaluation the resident was found to have suffered a right frontal subdural hematoma (occurs when a blood vessel in the space between the skull and the brain the subdural space is damaged following a trauma to the head), resulting from the resident's fall in the facility. The resident received four stitches to the forehead. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Computerized tomography notes dated 8/12/22, revealed the resident sustained a right frontal lobe injury 3-4 millimeter hyperdense collection (a small area of pool blood or fluid within the skull, but outside the brain), consistent with a small acute subdural hematoma. On 8/17/22 at 1:50 p.m., Resident #45 had an unwitnessed fall. The resident was found on the floor on his knees and lying partly across the bed. The resident did not sustain an injury. Interventions included removing the wheelchair from the room to discourage the resident from attempting to transfer himself without help. This intervention included removing the resident wheelchair from his room to discourage the resident from self transferring to the wheelchair unassisted. -This intervention was not implemented consistently, as the resident's wheelchair was observed at bedside during an observation on 11/1/22 at 10:41 while the resident was lying in bed resting. On 8/31/22 at 9:30 a.m., Resident #45 had an unwitnessed fall in his room; the resident was not injured. The resident was found sitting on the floor with his back to the dresser. The resident told the nurse that he fell out of his wheelchair. Interventions included moving the resident to a new room closer to the nurses station. The resident's room was moved. -No other new interventions were put into place. The 9/18/22 fall risk assessment documented the resident had a history of three or more falls in the past three months with three or more predisposing diagnoses for falls, indicating the resident was at risk for falls. The resident's gait and balance were unsteady, and the resident required assistive devices for mobility including a wheelchair or walker. The fall care plan revised on 9/21/22, documented the resident had several falls without injury. The care focus revealed Resident #45 had poor balance, poor communication and poor comprehension skills. Interventions included moving the resident to a room closer to the nursing station for more frequent monitoring, and to assess and determine the causative factors of the fall. -No other new interventions were put into place. 4. Staff Interview The director of nursing (DON) was interviewed on 11/3/22 at 5:34 p.m. The DON said the floor nurse assessed Resident #45's risk for falls and the interdisciplinary team (IDT) discussed the need and implemented interventions for fall prevention. Interventions for Resident #45 included moving him closer to the nurses station in order to better monitor his mobility. The DON said Resident #45 should have been on a toileting schedule with hourly rounds to ensure the resident was offered assistance with care needs. 44949 D. Resident #218 1. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #218, age 81, was admitted on [DATE]. According to the November 2022 computerized physician orders, diagnoses included Alzheimer's disease, hypertension, fracture of clavicle and insomnia. The 10/25/22 minimum data set (MDS) assessment indicated the resident had a severe cognitive impairment with a brief interview of mental status score of zero out of 15. It indicated the resident required extensive, two person assistance with activities of daily living. It indicated the resident had at least two falls since admission with no injuries. 2. Resident representative interview Resident #218's representative was interviewed on 11/1/22 at 10:03 a.m. She said the resident had multiple falls since admission. She said she was called at least four times but was unsure how many falls the resident actually had. She said she found the resident on the floor when she went to visit him shortly after he was admitted . She said she could hear him calling for help as she approached his room. She said the resident had dried feces on him and it was upsetting to her to find him like that. She said she did not believe his call light was working and the nurse told her they did not use call lights on the secure unit. She said staff told her they would try to move the resident to a different floor since he was not ambulatory and did not need to be on the secure unit. She said when the staff moved him they would make sure he was close to the nurses' station because his current room was far away from the nurses' station. 3. Observation On 10/31/22 at 11:50 a.m. Resident #218 was observed in the dining room in his wheelchair. Resident was eating lunch and a hospice nurse was sitting next to him. Resident #218 began to slide out of his wheelchair and attempted to grab the table for support. Licensed practical nurse (LPN) #2 went over to the resident and with the assistance of the hospice nurse, repositioned the resident upright in his wheelchair. 4. Record review The fall care plan, initiated 11/1/22, indicated Resident #218 had falls with no injuries. Interventions included assistance with toileting prior to going to bed, bed in lowest position, fall mat in place near bed, and flat call light. -The resident did not have a flat call light based on observation and interview with staff. Progress notes from 10/19/22-11/2/22 revealed the following: -On 10/19/22 a post fall evaluation was completed and indicated the resident had a fall in his room on 10/19/22. It indicated the resident said he did not fall but was on the floor because he was crawling to the bathroom and was found by his wife. The evaluation indicated the resident had small scrapes to his knees. -On 10/19/22 a fall progress note was completed that provided additional fall details. It indicated the resident's wife found the resident on the floor of his room. The resident was assisted to bed ten minutes prior but the resident wanted to use the bathroom and was on the floor to crawl to the bathroom. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-On 10/21/22 a fall progress note was completed that indicated the resident had a fall on 10/20/22. A CNA reported they found the resident on the floor of his room near the fall mat. An intervention of frequent checks was added post fall. -On 10/27/22 a fall progress note was completed that indicated the resident had a fall on 10/26/22 in his room. It indicated staff heard the resident calling for help and he was found on the floor near his bathroom. It indicated a new intervention of frequent checks and possible room move to be closer to the nurses station. -On 10/29/22 a post fall evaluation was completed that indicated the resident had a fall in his room on 10/29/22. It indicated the resident was found on his fall mat and did not indicate any injuries. -On 11/2/22 a post fall evaluation was completed that indicated the resident had a fall in his room on 11/2/22. It indicated the resident said he did not fall and instead rolled out of bed. The note indicated the resident was found on the floor mat and his call light was on. -There were no post fall evaluations for the falls on 10/21/22 and 10/27/22. 5. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 11/2/22 at 1:36 p.m. She said Resident #218 had a few falls since he was admitted to the facility. She said interventions included having the resident sit in the television room near staff, a fall mat on the floor beside his bed, and a new wheelchair through hospice. She said the resident was able to use his call light. CNA #2 was interviewed on 11/2/22 at 1:45 p.m. She said when a call light was activated the nurse's phone was paged. She said a light outside of the resident's door would not illuminate. She said Resident #218 was able to use his call light and he had a pointed call light, not a flat button. Registered nurse (RN) #1 was interviewed on 11/3/22 at 9:48 a.m. She said Resident #218 had a few falls that occurred in his room at night or early morning. She said interventions included a floor mat that was placed beside his bed, the bed in a low position, and hourly rounding. She said his room was far away from the nurses station and it could be safer if he was closer. She said he was able to use his call light but needed reminders. The director of nursing (DON) was interviewed on 11/3/22 at 5:34 p.m.[TRUNCATED]

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, staff interviews, and record review, the facility failed to consistently provide catheter care, treatment and services to minimize the risk of urinary tract infections for two (#60 and #62) of two residents reviewed for catheter care, out of 31 sample residents. Resident #60 admitted to the facility on [DATE] without having a catheter in place. The resident did not have a medical diagnosis to provide clinical indication (reason) for the need for a catheter. While in the care of the facility, the resident fell and fractured a hip and required surgical intervention. The resident returned to the facility on [DATE] with the indwelling catheter. The facility failed to ensure Resident #60 had orders for the use of an indwelling catheter to assist the resident with bladder function. The facility failed to conduct a comprehensive assessment to determine if the indwelling catheter was clinically indicated. The facility failed to have order for routine catheter care to maintain a healthy bladder and prevent catheter associated urinary tract infections to the extent possible. Once the catheter was in place, the facility failed to continually assess the resident's catheter for possible removal to aid the resident in maintaining and/or restoring bladder continence to the resident's best optimal ability. Additionally, the facility failed to ensure proper maintenance and care of the resident's indwelling catheter and the resident's bladder health declined, the resident became increasingly confused and was in a weakened condition, leading the facility to send the resident to the hospital where the resident was assessed and diagnosed with a significant urinary tract infection with sepsis requiring antibiotic treatment and intravenous fluids. The resident required intravenous (IV) antibiotic therapy and hospital care to treat a catheter associated urinary tract infection (CAUTI). In addition, the facility failed to: -Ensure Resident #62 was provided appropriate catheter care assistance using acceptable standards of nursing care, to ensure the resident's catheter was draining to gravity and not backing up into the resident's bladder; -Ensure orders for catheter care and maintenance; and, -Ensure Resident #62's leg bag was emptied timely and not bulging full of urine. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G. , et.al. Fundamentals of Nursing, ninth ed., 2017, pp. 1121: (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Routine catheter care: Patients with indwelling catheters require regular perineal hygiene, especially after a bowel movement, to reduce the risk for catheter-associated urinary tract infections (UTI) and catheter associated UTI (CAUTI). -In many institutions, patients receive catheter care every 8 hours as the minimal standard of care. -Empty the drainage bags when half full. An overfull drainage bag can create tension and pulling on the catheter, resulting in trauma to the urethra (the duct by which urine is moved out of the body from the bladder) and/or urinary meatus (the opening in the body from which the urine leaves the body), and increase risk for CAUTI. -Expect continuous drainage of urine into the drainage bag. In the presence of no urine drainage, first check to make sure that there are no kinks or obvious occlusion of the drainage tubing or catheter. Preventing catheter-associated infection (CAUTI): A critical part of routine catheter care is reducing the risk for CAUTI. -A key intervention to prevent infection is maintaining a closed urinary drainage system. Another key intervention is prevention of urine backflow from the tubing and bag into the bladder. The nurse should monitor the system to prevent pooling of urine within the tubing and to keep the drainage bag below the level of the bladder. II. Facility policy and procedure The Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing policy and procedure, revised September 2017, was provided by the nursing home administrator (NHA) on 11/3/22 at 8:30 p.m. It read in pertinent part: It is the responsibility of the interdisciplinary team to maintain vigilant practices to prevent CAUTI and to recognize and report early indications that a UTI may be developing. Facility-wide surveillance of infections is collected as part of the infection control program. The following CAUTI prevention strategies have been adopted and are to be followed: -Insert catheters only for indications deemed appropriate for urinary catheter insertion, and as ordered. -Leave catheters in place only as long as needed. Conduct ongoing assessment and monitoring of residents with indwelling catheters to establish continued need. Document every 24 hours or per facility protocol. -Do not insert or maintain a urinary catheter unless you have been properly trained and demonstrated competency in this area. -Always practice vigilant hand hygiene and standard precautions when handling catheter systems. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-After aseptic insertion, maintain a sterile closed drainage system. -Maintain unobstructed urine flow. -Perform daily meatal hygiene with soap and water for residents with an indwelling catheter. Document: The continued need for the resident's indwelling catheter; and any signs or symptoms of urinary tract infection. III. Resident #60 A. Resident status Resident #60, age 75, was admitted on [DATE] and discharged on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), diabetes, and heart failure. The 8/9/22 admission minimum data set (MDS) assessment revealed the resident had intact cognition and scored a 15 out of 15 on the brief interview for mental status (BIMS). The resident showed no signs of delusions or psychosis and had no aggressive behaviors. The resident did not reject care or assistance. The resident upon admission was able to complete some activities of daily living with only set up assistance from staff. The resident needed extensive assistance from staff for bed mobility, transferring, toileting, dressing, and with personal hygiene. Once assisted to a standing position the resident was able to walk unassisted with a walker device. The resident was occasionally incontinent of bladder and bowel. The resident did not have a catheter and was not placed on a toileting program. C. Record review Review of the resident's medical record revealed the resident was admitted on [DATE] without an indwelling catheter. At the time of admission the resident needed minimal assistance setting up the task from staff to walk and perform activities of daily living including using the bathroom. While the resident had occasional episodes of bladder incontinence there was no documentation that the resident was having difficulty emptying the bladder. There was no documentation that the resident was having problems emptying the bladder. The resident had a fall on 9/1/22 and fractured a hip. Following the fall the facility provided the resident an indwelling catheter. The record failed to document a clinical indication or an assessment of need for the catheter. Review of the resident's October 2022 physician's orders, medication and treatment administration record (MAR/TAR) and comprehensive care plan revealed: -No orders for placement of the indwelling catheter and no clinical indication (reason) of why the catheter was placed; -No orders for routine catheter care, maintenance or monitoring of the resident catheter; and (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-No care interventions to promote a healthy bladder, to maintain bladder continence or restore bladder continence and/or function as possible. Facility progress notes failed to show the date and time the resident was provided with the indwelling catheter, as per the admission MDS the resident admitted on [DATE] without an indwelling catheter (see above). The first progress notes to document the resident's catheter were on 9/12/22 and 9/14/22. -A progress note: Spiritual care note, dated 9/12/22 at 9:59 a.m., read in part: Resident #60 complained that his Foley is painful sometimes. (Resident) says he prefers to use his wheelchair to move around and be able to use the bathroom. -Progress note dated 9/14/22 at 2:54 a.m. read in part: Towards the night time on 9/13/22, this nurse observed that urine in resident Foley catheter bags appears to be dark with spotted patterns of blood clots in the bag and drainage tube. Foley catheter bag emptied and subsequent urine return continues to come out with dark blood stained urine with strings of blood clots .This nurse notified the on-call (physician provider office). The on-call provider gave orders to send the resident to the hospital for further evaluation. -Progress note dated 9/14/22 at 3:27 p.m. read in part: Resident returned to facility at 9:05 a.m. from the hospital emergency room , hospital discharge papers indicate all labs performed at the hospital were within normal (limits). Foley catheter was also changed with 16 fr (French)/ 10 cc (cubic centimeter) balloon. Denies any spasms, Foley is draining dark amber urine. -A progress note dated 9/26/22 at 11:41 a.m. read in part: Resident complained of burning and pain and having the urge to urinate. The Foley catheter was intact and draining well. Complaining of lower abdominal pain with palpation. Foley catheter changed, with 16fr and 10cc; immediate output was 200cc, of cloudy, thick and concentrated urine. -A skilled evaluation note dated 9/27/22 at 1:40 a.m. read in part: Genitourinary: Cloudy in appearance. Complaint of urinary urgency. Complaint of urinary burning. Urine sample collected due to milky urine, (physician office) notified awaiting physician instructions. -A progress note dated 10/5/22 at 5:58 p.m. read in part: Resident is lying on the floor in his room. Resident Foley catheter was out with the balloon intact. Foley catheter 18 fr changed today. Catheter in place due to urinary retention. Prior to the 10/5/22 note, the resident was provided a 16 fr Foley catheter (see notes above). Additionally, there was no documentation about the results of the resident's urinalysis done on 9/27/22 or resolution of the resident's documented symptoms (see notes above). -A progress note dated 10/19/22 at 9:48 a.m. read: Early this morning, right after, the resident was noted to be sleepy, tired and poorly aroused. Resident appeared to be lethargic, and gasping for air. Upon further assessment the resident revealed low blood pressure. Physician notified and urged to send the resident out to the hospital for further evaluation. (See hospital notes above.) (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Hospital emergency room treatment records dated 10/19/22 revealed the resident was admitted from the facility for a change in mental condition, increased shortness of breath, increased fatigue and hypotension (low blood pressure). The resident's Foley catheter appeared cloudy. The hospital performed a urinalysis and found the resident's urine showed pyuria (the presence of pus in the urine, typically from bacterial infection) and hematuria (presence of blood). Diagnosis, assessment /plan: -Acute complicated cystitis - urine with pyuria and hematuria. Likely secondary to chronic indwelling Foley catheter. -Benign prostatic hyperplasia (BPH) (enlarged prostate gland) with chronic Foley catheter - Uncertain if chronic Foley is due to chronic urinary retention. Consider a void trial while here. The resident was admitted to the hospital on 10/20/22 for further treatment. Hospital admission notes dated 10/20/22 documented, Intensive care unit (ICU) consulted after (patient) had to be intubated in the emergency room . (Diagnoses included): -Severe sepsis with septic shock. SIRS (a serious condition in which there is inflammation throughout the whole body) criteria: Hypoxemia (lack of oxygen in the blood), leukocytosis (high white blood cell count; indicating the body is fighting and infection), tachycardia (elevated heart rate), tachypnea (rapid breathing) Source: Urinary tract infection. Treatment of infection as below; -Urinary tract infection: On cefepime and Vancomycin; adjust these antibiotics based on (urine) cultures -Acute on chronic renal failure: IV (intravenous) fluids given for sepsis. Renally dose (adjust medications based on renal function) all meds, hold nephrotoxins (substances damaging to the kidneys), and monitor ins and outs (urine intake and output); and, -BPH with chronic Foley catheter: monitor urine cultures. D. Staff interview The director of nursing (DON) was interviewed on 11/3/22 at 5:34 p.m. The DON said the facility ensures nurses and certified nurse aides are competent with catheter care before they provide service for a resident with a catheter. In order to ensure the resident's catheter is maintained properly, nursing staff tracks the date the catheter was changed and monitors catheter function daily. A resident's catheter should be changed once a month and as needed. Between changes, nursing staff were expected to monitor the catheter for leaks. If there are no orders for the resident to continue with the catheter the nurse on duty will contact the resident's physician for an order to maintain and change the resident's catheter once a month. Upon receipt of a physician's order for a resident to use an indwelling catheter the nurse receiving the order will enter the orders for the catheter. A full set of treatment orders for catheter care will auto-populate once the nurse entered the catheter order. The DON should confirm the resident's catheter orders are entered into the resident's TAR. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The DON said Resident #60 received physician services from an outside physician provider and with that particular provider, it can be challenging to get physician treatment notes and orders timely. The physician did provide verbal direction that it was better for the resident to keep the catheter in place so the resident would not have to be changed a lot while the resident was in the healing process after recent hip surgery. The DON said Resident #60 had ongoing issues with the indwelling catheter. The physician ordered lab tests on the resident's urine and results were delayed because they were sent to the wrong facility. Because of catheter complications, the resident was sent to the hospital twice for medical assessment and treatment. The resident's condition was progressively declining, being less likely to participate in activities of daily living and other social activities. 47536 III. Resident #62 A. Resident status Resident #62 , under the age of 65, was admitted on [DATE]. According to the computerized physician's orders, diagnosis included schizoaffective disorder, bipolar type, pressure ulcer stage 4, dementia, insulin dependent diabetes mellitus. According to the 9/9/22 minimum data set assessment (MDS) the resident had severely impaired cognition as evidenced by a score of five out of 15 on the brief interview for mental status (BIMS). The resident required extensive assistance from one staff member for transfers, bed mobility, toilet use, hygiene, and was totally dependent on staff for bathing. The Resident was always incontinent of bowel, and had an indwelling catheter in place. B. Resident observations and interview On 10/31/22 at 10:18 a.m., Resident #62 was observed. Resident #62 was observed sitting on the side of her bed. The resident's Foley catheter drainage tube was exiting upwards over the top of the resident's waistband of her pants then extended downward towards the floor. The tubing was then looped upward from the drainage bag which was then attached to her walker assistive device at a height above her bladder. -This placement of the catheter bag and tubing promotes urine to drain properly. When the drainage tube is placed below the level of the resident's bladder it will flow out of the bladder with gravity and prevent the urine from flowing backwards into the bladder. When urine flows back into the bladder once it has left the body the individual risks infections and other bladder complications. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 10/31/22 at 12:20 p.m., Resident #62 was observed exiting the lunchroom with the Foley catheter drainage tubing running up the resident leg above the bladder and exiting the top of the resident's pants over the waistband, causing the urine flow to flow out of the resident's bladder against gravity risking that the expelled urine may flow back into the resident's bladder. The catheter drainage tubing was long and was dragging on the floor. The urine in the tube was clearly visible and was observed to be cloudy, milky in color with stringy mucus present. A CNA approached and said this is not right and asked the resident if she would walk to the bathroom so the catheter tubing could be readjusted correctly. On 11/1/22 at 10:30 a.m. Resident #62 Foley catheter leg bag was observed. The leg bag was over full and bulging out with cloudy yellow urine. Resident #62 was interviewed on 11/2/22 at 11:30 a.m. Resident #62 was unable to describe how the nurses took care of her catheter or understand the reason the nurses changed the overnight bag to the leg bag in the daytime while awake. C. Record Review The resident's October 2022 CPO was reviewed. Orders pertinent to the catheter revealed: -Indwelling Foley catheter, change each month on the 24 of the month, with 16 French, 30 cubic centimeters (CC) bulb inflation. The CPO did not document the reason for the catheter placement,orders for routine catheter care, maintenance to ensure proper function, placement of tubing or use of a leg bag during waking hours. D. Staff interviews Registered nurse #3 was interviewed on11/3/22 at 1:15 p.m. RN #3 reviewed the resident's CPO and confirmed the resident did not have orders for Foley catheter care, monitoring and assessment. RN #2 and RN #4 were interviewed on 11/3/22 at 2:10 p.m. RN #4 said when a patient was admitted with a Foley catheter the admitting nurse conducts an assessment to determine why the catheter was in place, including whether or not the catheter is new or had been in place for a significant amount of time. The nurse should also consider why the catheter is in place, is a trial removal to be performed. If a catheter is in place at admission, the admitting nurse will use a collaborative practice order to initiate nursing care for the catheter. The DON was interviewed on.11/3/22 at 5:34 p.m. The DON stated that the facility had a check off process regarding who can perform catheter care and when. The DON said that nurses should be checking for drainage tube leaks, and monitor positioning of the drainage tube daily. The DON said Resident #62 drainage tubing. should have been draining to gravity and not draining upward over the resident's pants waistband. The DON said that catheter orders are considered treatment orders and the order set should be activated by a nurse when a resident was admitted or ordered to have a Foley catheter placed. IV. Facility follow-up (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 11/3/22 at 8:00 p.m, the facility obtained orders for catheter care, assessment, and use of leg bag and entered the order into the resident's treatment administration records.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 44949 Based on record review and interviews, the facility failed to ensure certified nurse aides (CNAs) were able to demonstrate competencies in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Specifically, the facility failed to ensure CNA staff had completed competencies prior to providing resident care for four (#3, #4, #5 and #6) out of five CNAs reviewed for competencies. Findings include: I. Facility policy The Competency of Nursing Staff policy and procedure, revised October 2017, was provided by the nursing home administrator (NHA) on 11/3/22 at 8:30 p.m. It read, in pertinent part, All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements. Licensed nurses and nursing assistants employed by the facility will participate in a facility specific, competency-based staff development and training program and will demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. II. Record review The facility assessment was provided by the NHA on 10/31/22 at 12:00 p.m. It revealed facility staff would complete required competency classes upon hire, annually, and as needed. Employee files were reviewed for four CNAs and one registered nurse (RN). CNAs #3, #4, #5, #6 were found to not have competency records for CNA skills. III. Interviews The staff development coordinator (SDC) and NHA were interviewed on 11/3/22 at 3:30 p.m. The SDC said the facility did not conduct routine competency assessments of nursing practice. The SDC said if a concern about resident care arose, an assessment of the staff members' skills and competencies would be conducted with training provided, if needed. The NHA said there were no competencies completed for the four CNAs that were reviewed. The director of nursing (DON) was interviewed on 11/3/22 at 5:34 p.m. The DON said the facility did not complete competencies with staff. He said during the pandemic the competency training was lost in the shuffle and he was aware that competency training would need to be completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47024 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases for two out of three units. Specifically, the facility failed to: -Ensure housekeeping staff cleaned all high-touch surfaces in resident rooms and followed manufacturer surface contact time during routine daily cleaning; -Ensure housekeeping staff followed the appropriate procedure when cleaning resident rooms and bathrooms; -Ensure houskeeping staff implemented appropriate hand hygiene with glove changes when moving form handling soiled linens and trash to providing resident care and services; and, -Ensure residents were offered hand hygiene prior to eating meals. Cross referenced to F584 failure to maintain a clean sanitary homelike environment. Findings include: I. Housekeeping services A. Professional standards The Centers for Disease Control and Prevention (2020) Preparing for COVID-19 in Nursing Homes, updated 11/15/21, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html/ , on 11/9/22revealed in part: For environmental cleaning and disinfection: develop a schedule for regular cleaning and disinfection of shared equipment, frequently touch surfaces in resident rooms and common areas. Clean high-touch surfaces at least once a day or as often as determined is necessary. Examples of high-touch surfaces include: pens, counters, shopping carts, tables, doorknobs, light switches, handles, stair rails, elevator buttons, desks, keyboards, phones, toilets, faucets, and sinks. B. Facility policy and procedures The cleaning and disinfecting residents rooms policy was received from the nursing home administrator on 11/3/22 at 8:30 p.m. It read in pertinent part: Housekeeping surfaces (e.g, floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (e.g., daily, three times per week) and when surfaces are visibly soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manufacturer's instructions will be followed for proper use of disinfecting (or detergent) products including safe use and disposal. Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled. The Cleaning Procedures checklist was provided by the NHA on 11/3/22 at 8:30 p.m. The checklist read: -Change cleaning cloths when they become soiled. -Clean horizontal surfaces daily. -Clean personal use items at least twice weekly. -Clean curtains, window blinds, and walls when they are visibly soiled or dusty. -Clean all high touch furniture items with disinfectant solution. -Clean all high touch personal items (e.g., bedside tables, call bells, phones, bed rails, etc.) with disinfectant solution. C. Observations On 11/2/22 from 11:22 a.m. to 11:30 a.m. housekeeping services were observed. Housekeeper (HSK) #1 was observed cleaning resident room [ROOM NUMBER] . The HSK washed her hands and put on gloves to start cleaning services. The HSK swept the floor, under the dresser, around the resident, under the bed, under the trash can, under the second bed, and under the sink. She swept the debris into a dust pan and disposed of it. HSK #1 failed to sweep sufficiently under the furniture to collect all the debris, failed to empty the trash bin, failed to spray and disinfect the bedside table, bed rails, call button, dresser surfaces, or other high touch surfaces in the resident room. HSK #1 sprayed the door handle then wiped the handle immediately after spraying the disinfectant on the surface, then sprayed the sink then wiped it down immediately, then sprayed the paper towel dispenser and wiped it down immediately. The HSK used one cloth to clean all surfaces and did not wait the minimum two minute dwell time to ensure effective disinfection of surfaces that would destroy potential infectious pathogens. HSK#1 used the same cloth to clean all surfaces and failed to clean the bathroom including toilet, fixtures, and floor. On 11/2/22 at 11:43 a.m. to 12:03 p.m. housekeeping services were observed. HSK #2 was observed cleaning resident room [ROOM NUMBER]. The HSK sanitized her hands and put on clean gloves and entered the room. HSK #2 sprayed surfaces and fixtures but failed to spray the bed rails and call button for disinfection. D. Staff interviews (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/2/22 at 11:30 a.m. HSK#1 was interviewed. HSK#1 said that the process that had been used in cleaning the room was all that needed to be done. The process included sweeping and mopping the floor, spraying and wiping down the fixtures. On 11/2/22 at 12:02 HSK#2 was interviewed. HSK #2 said the facility used Sunburst No-Bac disinfectant as the cleaning and disinfection agent. The dwell time for the product was two minutes to disinfect and kill germs. The product was to be applied and was to remain wet for at least two minutes before being wiped off. The housekeeping supervisor (HSKS) was interviewed on 11/3/22 at 1:09 p.m. The HSKS said the minimum dwell time for disinfection is two minutes and up to ten minutes per manufacturer's instructions. The HSKS said the HSK's should clean all high touch surfaces, work from high to low, change gloves frequently, and empty the trash bin in every room. The HSKS acknowledged that there is a step by step process on the HSK's cart that should be followed in each room and that HSK #1 did not follow the steps as listed. The DON was interviewed on 11/3/22 at 5:34 p.m. The DON said the CNA's were to empty trash and linen bins that contained soiled adult briefs, soiled linen, or items that have close contact with the residents and may promote cross contamination of germs. The DON acknowledged that it is unacceptable to leave these items in resident rooms. 47536 II. Hand hygiene A. Professional reference According to the Centers for Disease Control (CDC), Hand Hygiene in Healthcare settings, last updated 1/30/20, retrieved from https://www.cdc.gov/handhygiene/providers/guideline.html, on 11/7/22. Health care professionals (HCP) should perform hand hygiene immediately before touching a patient, before performing an aseptic task, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated surfaces, immediately after glove removal. Perform hand hygiene after removing personal protective equipment (PPE) is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. According to CDC, Clean Hands Count for Patients, last reviewed 3/15/16, retrieved fromhttps://www.cdc.gov/handhygiene/patients/index.html on 11/7/22. Clean your hands. before preparing or eating food; Before touching your eyes, nose, or mouth; Before and after changing wound dressings or bandages; after using the restroom; After blowing your nose, coughing, or sneezing; After touching hospital surfaces such as bed rails, bedside tables, doorknobs, remote controls, or the phone. B. Facility policies and procedures The Handwashing policy, undated, was provided by the nursing home administrator (NHA) on 11/03/22 at 8:30 p.m., revealed in pertinent part: Staff will wash hands frequently as needed throughout the day following proper hand washing procedure. Hand washing facilities should be readily accessible and equipped with paper towels and soap. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Clean hands and exposed portions of arms immediately before engaging in food preparation including working with exposed food. When to wash hands: -After touching bare human body parts other that clean hands and clean, exposed portions of arms; -After using the restroom -After caring for or handling service animals or aquatic animals -After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating or drinking -After handling soiled equipment or utensils -During food preparations, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks -When switching between working with raw food and working with ready to eat food -Before donning gloves for working with food -After engaging in other activities that contaminate the hands. The Laundry and Bedding, Soiled, Infection Control Policy and Procedure, revised July 2009 was provided by the NHA on 11/3/22 at 8:30 p.m. It revealed in pertinent part: Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. Soiled laundry and bedding (e.g., personal clothing, uniforms, scrub suits, gowns, bedsheets, blankets, towels, etc.) contaminated with blood or other potentially infectious materials must be handled as little as possible and with a minimum of agitation. Place and transport contaminated laundry in bags or containers in accordance with established policies governing the handling and disposal of contaminated items. Anyone who handles soiled laundry must wear protective gloves and other appropriate protective equipment (e.g., gowns if soiling of clothing is likely). C. Observations 1. Staff hand hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/1/22 at 10:07 a.m., registered nurse (RN) #6 was observed in the hallway removing the full dirty linen bags for the hallway laundry bins in order to transport the soiled linens to the laundry room. RN #6 wore examination gloves while handling the soiled laundry then without removing the used gloves and performing hand hygiene move to the nurses medication cart and assisted the nurse with the medication pass handling items form within the medication cart. After assisting the unit nurse with medication pass RN #6 went to the desk, while still wearing the same gloves the nurse used to handle the soiled laundry in order to answer the first floor video alert doorbell to buzz a visitor into the building. RN #6 then returned to the soiled laundry bags and moved the bags to the elevator waiting area. RN #6 still had not preformed hand hygiene or changed the soiled gloves. As RN #6 waited for the elevator, the RN removed the soiled gloves, rolled them and held the gloves in hand. Resident #62 approached RN #6; RN #6 helped the resident to pull up her pants. RN #6 returned to the soiled laundry bags and left the floor on the elevator. -Through the full observation RN #6 never performed any type of hand hygiene and had touched numerous surfaces and a resident potentially contaminating each surface with whatever pathogen was on the soiled laundry. 2. Resident hand hygiene On 10/31/22 at 11:20 a.m., lunch service on the third floor was observed. The residents gathered for the meal, staff started to serve drinks and then delivered the resident meals. None of the residents were offered any type of hand hygiene before the residents started to eat their meals. At 12:04 p.m., lunch services in the second floor dining room was observed. The servers began passing drinks to the residents; however, they did not offer hand hygiene to the residents before they got their meals and started eating. One resident blew his nose at his table with the cloth napkins and sat the napkin down on the table, it was not removed or replaced. The server was present when this occurred but did not take the dirty napkin, offer the resident a clean napkin, or offer hand hygiene to this resident. On 11/2/22 at 11:30 a.m, lunch service in the second floor dining room was observed. The servers began passing drinks to the residents; however, none of the residents in the dining room were offered hand hygiene before the meal. At 4:34 p.m., dinner service in the second floor dining room was observed. The residents arrived at their tables for dinner service. The servers brought out drinks to the residents as they arrived at their tables; however, the residents were not offered hand hygiene before their meal was served to them. D. Staff interviews The dining service manager (DSM) was interviewed on 10/31/22 at 1:00 p.m. The DSM said it was the CNAs responsibility to provide hand hygiene to the residents before their meal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065213	A. Building B. Wing	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Health Center at Franklin Park	1535 Park Ave Denver, CO 80218

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The infection preventionist (IP) was interviewed on 11/2/22 at 3:00 p.m. The IP said proper hand hygiene for staff and residents was the most important method to prevent disease transmission. The IP said the facility had sanitizing wipes that were to be placed on all resident meal trays and the staff should offer residents reminders and assistance if needed to use the hand sanitizing wipes prior to meal service. The director of nursing (DON) was interviewed on 11/12/22 at 5:04 p.m. The DON said hand hygiene should be performed in between tasks, after removing gloves and frequently when working with residents and performing tasks throughout the facility. The DON said the facility had hand sanitizer dispensers everywhere throughout the facility and staff are expected to use it regularly; prior to moving to a new task; in between tasks if hands came in contact with soiled contaminated items; and before starting to assist a resident. The DON acknowledged staff could spread infectious matter when they did not wash their hands between tasks and frequently. 44949 42193