STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews the facility failed to ensure that the personal funds account were managed adequate for one (#39) of one resident reviewed for personal funds out of 49 sample residents. Specifically, the facility failed to ensure Resident #39 was aware of personal funds and was able to access his funds on the weekend. Findings include: I. Resident #39 status Resident #39, age 68, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis following a cerebrovascular disease affecting the right dominant side (stroke with right sided weakness), protein calorie malnutrition, cognitive communication deficit and heart disease. The 10/16/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score of 15 out of 15. He required supervision with transfers and was independent for all other activities of daily living (ADLs). II. Resident interview Resident #39 was interviewed on 11/14/22 at 3:06 p.m. He said he was not aware he had his own money. He thought all of his money went to room and board at the facility. He said he had not received a statement that said he had personal funds to spend. Cross referenced F568: the failure to provide the resident with a quarterly bank statement. III. Record review The business office manager (BOM) provided a copy of the banking hours on 11/16/22 at 12:13 p.m. It revealed the current banking hours were Monday through Friday 10:00 a.m. to 12:00 p.m. and 1:00 p.m. to 3:00 p.m. IV. Staff interviews (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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BOM was interviewed on 11/16/22 at 11:50 a.m. She said the facility did not have banking hours on the weekend. The BOM said she had emailed the social services director (SSD) earlier in the week, because Resident #39 needed to spend down his money. She said Resident #39 had too much money in his account, which could put him at risk for losing his Medicaid benefits. The BOM said residents who were on Medicaid services received approximately 91 dollars a month. The SSD was interviewed on 11/16/22 at 12:00 p.m. She said she had received an email earlier in the week regarding residents who needed to spend down their money.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and interviews, the facility failed to establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf for one (#39) of one reviewed for personal funds out of 49 sample residents. Specifically, the facility failed to ensure quarterly statements were provided for Resident #39. Findings include: I. Facility policy The Resident Trust policy and procedure, undated, was provided by the nursing home administrator (NHA) on 11/16/22 at 3:15 p.m. It revealed, in pertinent part, Quarterly statement shall be mailed to the family, resident and or responsible parties on file with the business office and only to those individuals listed on the Patient Trust Agreement form that is maintained in the business office file for each individual resident. II. Resident #39 status Resident #39, age 68, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis following a cerebrovascular disease affecting the right dominant side (stroke with right sided weakness), protein calorie malnutrition, cognitive communication deficit and heart disease. The 10/16/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score of 15 out of 15. He required supervision with transfers and was independent for all other activities of daily living (ADLs). III. Resident interview Resident #39 was interviewed on 11/14/22 at 3:06 p.m. He said he had never received a statement since admitting to the facility over two years ago. He said he had asked several staff members for a copy of his statement including the social services director (SSD) and the business office manager (BOM), but never received one. IV. Record review A request was made for the documentation of when Resident #39 received his quarterly statements on 11/16/22. The facility did not have any documentation to show the resident received quarterly statements. The BOM said she was aware residents were to receive statements quarterly (see interview below). (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V. Staff interviews The BOM was interviewed on 11/16/22 at 11:50 a.m. She said she was responsible for providing residents their quarterly statements. She said she mailed or emailed the statements to resident family members. She said if the resident was their own representative she would hand deliver a copy to them. The BOM said the facility managed the finances for Resident #39. She said Resident #39 should have received a statement quarterly. The BOM said she had not provided Resident #39 with a copy of his statement since she began working at the facility in December 2021 (11 months). The SSD was interviewed on 11/16/22 at 12:00 p.m. She said she had not provided Resident #39 with a copy of his statement. The nursing home administrator (NHA) was interviewed on 11/16/22 at 12:00 p.m. He said all residents whose money was managed by the facility should have received a quarterly statement.

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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** 31821 Based on observations, resident and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for residents in 15 of 62 resident rooms and on seven of eight hallways. Specifically, the facility failed to ensure: -Walls, ceilings, floors were repaired, painted and properly maintained; -To ensure oxygen concentrators were plugged into electrical outlet instead of a power strip; and, -Comfortable room temperature levels for all rooms in the facility located in the dementia nitunit and dining rooms. Findings include: I. Resident environment A. Initial observations Observations of the resident living environment, conducted on 11/15/22 at 2:15 p.m., revealed: room [ROOM NUMBER]: The tile in front of the resident's restroom had missing floor tiles approximately 24 inches by 24 inches. room [ROOM NUMBER]: The wall in the restroom had six dime sized holes from removal of the grab bar. The wall had an area approximately five feet by four feet which had been repaired but not completed. Room # 402: The wall next to the restroom had four dime sized holes from the television mount that had been removed. room [ROOM NUMBER]: had a large hole on the ceiling approximately 14 inches by 14 inches covered with plastic. The wall between the residents ' beds had eight large dimes sized holes and a missing electrical box with the wires were visible. room [ROOM NUMBER]: The wood frame underneath the sink had a missing piece of wood approximately 32 inches long. The ceiling in the hall between room [ROOM NUMBER] and #404 had water damage approximately three feet long by two feet wide. room [ROOM NUMBER]: The floor underneath the sink had an area approximately four feet long by 24 inches wide of water damage. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Room # 404: The toilet in the restroom would not flush. The floor in the four hundred hall next to room [ROOM NUMBER] had a section of cement foundation with a gap approximately seven feet long by three inches wide and two inches deep. room [ROOM NUMBER]: The floor next to the restroom had a section approximately five feet by four feet with water damage. There was a missing towel rack next to the sink. The wall in the assisted dining room on hall 700 had a large hole approximately 24 inches by seven inches high, which had been repaired but not completed. Room # 702: The wall in the restroom had sheetrock damage approximately three feet wide by 32 inches long. The carpet in hall 700 outside of room [ROOM NUMBER] had large water stains approximately ten feet wide by 12 feet long. The stains were white in color. room [ROOM NUMBER]: The wall next to the restroom had four dime sized holes from where the television mount had been removed. The sheetrock in hall 200 next to the shower room had an area approximately six feet long and two inches wide from the wheelchairs hitting the wall. room [ROOM NUMBER]: The sheet rock in the restroom had water damage approximately three feet by seven inches long. room [ROOM NUMBER]: The wall next to the resident's bed had eight dime sized holes. room [ROOM NUMBER]: The baseboard cove underneath the sink was peeling away from the wall. The length of the peeling baseboard cove was approximately three feet long by four inches high. The corner piece at the end of hall 200 was missing a corner piece approximately four feet high by two inches wide. C. Environmental tour and staff interview B. Environmental tour and staff interview The environmental tour was conducted with the maintenance director (MTD) and maintenance assistant (MA) on 11/172022 at 12:30 p.m. The above detailed observations were reviewed. The MA documented the environmental concerns. The MTD said he did not have any repair requisition requests for the above-mentioned items from staff. The MTD said the above-mentioned damage should have been repaired and addressed in a timely manner. II. Ensure oxygen concentrators were plugged into electrical outlets instead of a power strip. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Observation On 11/15/22 at 2:15 p.m., Room# 410 had the resident's oxygen concentrators plugged into a regular power strip. It was not a medical grade power surge. On 11/16/22 at approximately 9:12 a.m., oxygen concentrators continued to be plugged into the non-medical power surge. B. Staff Interview The MTD was interviewed on 11/17/22 at 12:30 p.m. The MTD said all staff know that all oxygen concentrators should be plugged into the wall outlets. He said it was to ensure the environment was safe. -At 11:00 a.m. the MA stated the oxygen concentrators had been plugged into the wall and staff were educated again on oxygen concentrators and outlet placement. III. Cold room temperatures A. Observations and resident interviews On 11/14/22 at 8:55 a.m. five residents were sitting next to the nursing station on 400 hall. All residents' had blankets covering themselves. -At 10:30 a.m. a thermometer was placed in the middle of room [ROOM NUMBER]. Another was placed on top of a cart across from the nursing station on the 400 hall. -At 11:09 a.m., Resident #67 was observed sitting in her room in her wheelchair. Resident #67 said, I move over here by the door because the cold comes in from my window. A thermometer placed next to the resident's bed measured the room temperature at 66 degrees F. -At 12:31 p.m., Resident #79 was sitting next to his bed in his wheelchair. Resident #79 said it was always cold in my room. Resident #79 said, It was even worse earlier in the morning. He said he slept under the blankets because My room was so cold. A thermometer placed next to the resident's bed measured the room temperature at 66 degrees F. -At 12:35 p.m. certified nurse aide (CNA) #2 observed a thermometer on the cart on 200 hall and said the the thermometer read 64 degrees F. -At 1:00 p.m., a thermometer was placed next to the resident's bed in room [ROOM NUMBER]. Housekeeper (HSKP) #1 read the thermometer and said it was 60 degrees F. -At 1:40 p.m., CNA #2 observed the thermometer next to the nurses station on the 400 hall, confirmed it read 60 degrees F, and stated, It has been getting colder here. She said she would report the temperatures to the MTD. -At 3:13 p.m. Resident #39 said his room was always cold. He said, I think they leave the air-conditioner on all the time. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 3:27 p.m., Resident #6 was sitting on her bed, which was next to the window. She said, My room is always cold and it is worse at night. On 1/15/22 at 11:15 a.m., two thermometers were placed in the main dining room. -At 11:39 dietary aide (DA) #1 observed the thermometer, confirmed it read 68 degrees F. He said he would report the temperatures to the MTD. B. Staff interviews The MTD was interviewed on 11/14/22 at 1:25 p.m. The above observations were reviewed with him. He said the facility had been having problems with their circulating pump and roof top units. He said the facility was in the process of repairing the boiler and were waiting on a recirculating pump for the baseboard heat. The MTD said he had ordered the circulating pump about two to three weeks ago and he was told it was on backorder. The MTD said, I should have checked on the pump and if it was not coming in I should have checked elsewhere to get a circulating pump. The MTD said the circulating pump should be coming in tonight and he and his assistant would install it immediately. A request for temperature logs was requested. The MTD was interviewed again on 11/15/22 at 9:15 a.m. He said the circulating pump had been installed but it was not aligned correctly so it was not working but MA were able to get it going. The MTD stated the roof unit's breakers were kicking off and that was why they were not working. He said the problem was the building was so old that the voltage that runs through the building was too low in voltage that the breakers were kicking off. He said the facility was continuing to monitor the system to ensure adequate temperatures are reached in the building. The MTD said the temperatures should be at 71 to 81 degrees F in the building.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42193 Based on interviews and record review the facility failed to prevent resident to resident altercations for six (#35, #59, #74, #99, #70 and #21) of six residents out of 49 residents reviewed. Specifically the facility failed to prevent resident to resident physical abuse altercations between: -Resident #35 and Resident #59; -Resident #74 and Resident #99; and, -Resident #21 and Resident #70. Findings include: I. Facility policy and procedure The Abuse policy, modified on 3/9/19, was received from the nursing home administrator (NHA) on 11/14/22 at 11:47 a.m. It read in pertinent part: Our residents have the right to be free from abuse, neglect, misappropriation of property and exploitation. This includes but is not limited to corporal punishment, involuntary seclusion, verbal, mental, sexual and physical abuse. As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including other residents, facility staff, volunteer staff, family members or other individuals. The facility will conduct thorough background checks and develop and implement policies and procedures to aid our facility in protecting our residents from abuse, neglect and mistreatment of our residents. II. Resident to resident physical altercation between Resident #35 and #59 A.Resident #35 (victim) 1. Resident status Resident # 35 age 91 was admitted on [DATE]. The November 2022 computerized physicians orders (CPO) indicated a diagnosis of mental disorders due to known physiological conditions, presence of cardiac and vascular implant, behavioral disturbances of unspecified severity. The 9/9/22 minimum data set (MDS) indicated the resident was severely cognitively impaired and could not understand others nor be understood by others. The resident required supervision with transfers, bed mobility and extensive assistance with assistance with dressing. The resident required extensive assistance with toileting and personal hygiene. The MDS documented the resident was totally dependent on the staff for bathing. The resident had no impairment in range of motion function. The resident wandered daily and had no displays of physical or verbal aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review Resident #35's comprehensive care plan, last revised 9/5/22, revealed the resident had poor safety awareness with a history of wandering. The resident was at risk for injury due to wandering into other residents' rooms and fidgeting with doors. Interventions included:encourage and remind the resident to attend group activities. Post the activity calendar in the resident's room. Monitor for fall risk. The resident may leave the unit with family members or staff. -The interventions failed to address how staff was to provide redirection to the resident when the resident was observed to wander without purpose into potentially unsafe situations B. Resident #59 (assailant) 1. Resident status Resident # 59 age 85 was admitted on [DATE]. The November 2022 CPO revealed a diagnosis of hypertension, personal history of traumatic brain injury, dementia with behavioral disturbances, need for assistance with personal care, history of falling, insomnia and unspecified fracture of facial bones. The 9/4/2022 MDS indicated the resident was severely cognitively impaired with a brief interview of mental status (BIMS) score of four out of 15. The resident required supervision with bathing, dressing,eating, toileting, and transfers. The resident wandered daily and had no displays of physical or verbal aggression towards others. 2. Record review Resident #59's comprehensive care plan dated 9/17/22 revealed the resident required cues and daily reminders to perform activities of daily living such as grooming, dressing and eating. Resident #59 had aggressive behavioral deficits and could be physically aggressive towards other residents when they invaded her personal space. Interventions included respect for the resident's right to decline participation in activities. Keep a daily consistent routine, monitor for changes in condition, provide redirection when needed during times of confusion. -The interventions failed to provide direction for staff to redirect the resident when the resident engaged in aggress behavioral expressions towards other vulnerable residents C. Resident #59 to Resident #35 physical altercation (10/22/22) Resident #35 and #59 were involved in a resident to resident physical altercation on 10/22/22; when Resident #59 intentionally pushed resident #35 causing resident #35 to lose balance and fall to the floor. Nursing note dated 10/21/22 at 1:00 a.m., documented, Resident #59 told staff that Resident #35 came into her room from his room across the hall and would not leave her room. Resident #59 said she pushed Resident #35 onto the floor because she did not want him in her room. Resident #59 told the staff to tell Resident #35 not to ever come back to her room. Resident #35 sustained no injuries. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Social services director (SSD) follow up note dated 10/25/22 at 10:50 a.m., revealed the SSD educated Resident #59 to ask staff for assistance if someone enters her room rather than reacting and the resident expressed understanding and agreed. Facility investigation Registered nurse (RN) #4's interview investigation statement dated 10/22/22 at 9:00 a.m. revealed that CNA#10 reported to RN#4 that the CNA witnessed Resident #35 was on the floor dragging himself out of Resident #59's room. RN#4 then went to assess the residents. The assessment revealed the resident had no injuries and had no emotional distress. Resident # 59's interview investigation statement dated 10/22/22 at 9:30 a.m. revealed Resident #59 was in her room when Resident #35 entered uninvited. Resident #59 said she asked resident #35 to leave her room but he would not listen so she pushed Resident #35 and told him to never come into her room again. The resident fell to the floor. Resident #35 was interviewed after the altercation but he was unable to explain what happened. The facility unsubstantiated the abuse due to the resident not having fear or remembering the incident. -However, the physical abuse did occur due to the resident's willful action toward the other resident. D. Staff interview Certified nurse aide (CNA) #8 was interviewed on 11/14/22 at 10:27 a.m. CNA #8 said Resident #35 had a habit of wandering into other residents' rooms and fiddling with the door knobs. III. Resident to resident physical altercation between Resident #74 and #99 A. Resident's #74 (victim) 1. Resident status Resident # 74 age 91 was admitted to the facility on [DATE]. The November 2022 CPO indicated a diagnosis unspecified dementia with agitation, muscle weakness, and cognitive communication deficit disorder. The 10/18/22 MDS indicated the resident was severely cognitively impaired with a brief interview of mental status (BIMS) score of four out of 15. The resident required limited assistance with dressing, bathing, grooming, supervision with eating, bed mobility and transferring. The resident did have trouble focusing attention on things and was easily distracted and had trouble remembering what was being said. The resident did not wander and had no displays of physical or verbal aggression during the assessment period. 2. Record review (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #74's comprehensive care plan dated 10/13/22 documented that Resident #74 had impaired communication due to cognitive deficits. The cognitive impairment was evidenced by impaired orientation and distressing hallucinations and delusions. New interventions for the impaired orientation were, explain care to resident before and during, keep daily routine as consistent as possible, reassure the resident as needed if she is confused and reorient the resident to the situation as needed. Nurses note dated 11/6/22 read: At approx 2:15 a.m., yelling was heard coming from a resident room (Resident #99). Upon arrival to the resident's room, this RN found Resident #74 and Resident #99 on the floor in Resident #99's room. Resident #74 stated she tried to use the bathroom and was pushed. Resident #99 stood up from the floor by the bed. Resident #99 complained of right hip pain and right forearm pain. Resident #74 was not taken to the hospital. B. Resident's #99 (assailant) 1. Resident status Resident #99 age 90 was admitted on [DATE].The November 2022 CPO revealed a diagnosis of heart disease,contusion of right wrist, unspecified dementia with behavioral disturbances, major depressive disorder, and a lack of cognitive function and awareness. The 10/18/22 MDS revealed Resident #99 was severely cognitively impaired with a brief interview of mental status score of three out of 15. The resident required limited assistance with dressing, bathing, toilet use, personal hygiene and occasional behaviors in which the resident was aggressive towards other residents. According to the MDS assessment, Resident #99 exhibited experienced delusions; but did not wander or display physical or verbal aggression during the assessment period. 2. Record review Resident #99's comprehensive care plan dated 10/14/22 documented the resident can become verbally demanding towards other residents telling them what to do and ordering them around. This behavior could lead to unsafe situations for the resident and other residents on the unit. Intervention included for staff to provide redirection and explinton that other residents have the right to make their own decisions. If Resident #99 responded with more aggression, staff were to give the resident space to allow the resident to calm then reapproach; unless it was not safe for other residents' well being to do so. A second care focus revealed Resident #99 engaged in daily and aimless wandering with a tendency to become aggressive towards peers. Intervention-included providing the resident a safe place when displaying signs of aggression and unsafe wandering. Nurses note dated 11/7/2022 at 6:05 a.m., read: Resident #99 was monitored for resident to resident altercation. No injuries noted, neurological checks (neuro) checks done for residents. Resident was not fearful of anyone and did not remember the altercation occurred. Resident (#99) was quiet through the night. Nursed note dated 11/7/22 at 10:46 a.m., read: Resident #99 was monitored for resident to resident altercation. Diagnosis of dementia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Root cause of the altercation was that another resident came out of her bathroom. Intervention: A stop sign was placed on the door of Resident 99's room and the care plan was updated. C. Resident #99 to Resident #74 physical altercation (11/6/22) Resident #74 and #99 were involved in a resident to resident physical altercation on 11/6/22; when Resident #99 intentionally pushed Resident #74 causing Resident #74 to lose balance and fall to the floor. Facility investigation Resident #99 interview investigation statements dated 11/7/22 at 11:00 a.m., revealed Resident #99 did not recall the incident with Resident #74 and had no concerns about any of the residents on the unit. Resident #74 interview investigation statements dated 11/7/22 at 1:00 a.m. Resident #74 said she tried to use the restroom in Resident #99's room but when she did so she was pushed down to the floor by Resident #99. When Resident #74 was reinterviewed on 11/7/22 at 11:30 a.m. The resident said she did not recall the incident. The facility unsubstantiated the abuse due to the resident not having fear or remembering the incident. -However, the physical abuse did occur due to the resident's willful action toward the other resident. IV. Other staff interviews The director of nursing (DON) was interviewed on 11/16/22 at 10:00 a.m. The DON said residents with dementia often exhibit behaviors towards one another and the staff. The DON said the behaviors can sometimes be controlled with psychotropic medications or by the use of redirection. The DON said she would provide inservice training to all staff about behaviors with dementia. The memory care coordinator (MCC) was interviewed on 11/15/22 at 10:42 a.m. The MCC said that the resident to resident altercations have decreased in the last 30 days. She said there had been no altercations between Resident #59 and Resident #99 in the last 72 hours. The MCC said the staff had been monitoring the residents more closely. 31821 V. Resident to resident altercation involving Resident #21 and Resident #70 A. Resident #21 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #21, age 65, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included diabetes mellitus, end stage renal failure, dependence on renal dialysis, congestive heart failure, schizophrenia, and bipolar. According to the 10/20/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had no behavioral symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. The resident was receiving dialysis. Two person assist transfers. 2. Record review The care plan, initiated 6/27/22 and revised 10/20/22, identified the resident was at risk for increased behaviors, directed at self/others related to schizophrenia. Interventions included encourage the resident to be patient with other residents. Maintain a safe environment with minimal stimulation. Social service director (SSD) note dated 11/16/22 at 5:02 p.m. revealed in part: SSD follow up reported incident by resident on 11/10/22. Resident #21 states this incident happened on 11/9/22 and he states that nobody witnessed the altercation. Resident reported he was attempted to wheel by another resident when he accidentally wheeled over another resident's foot and the other resident reacted by hitting him with a closed fist 10 times on the right arm. Resident was scared that he was going to get in trouble. SSD informed Resident #21 that an investigation will be opened and reassured resident that this is for safety reasons, Resident #21 expressed understanding and agreed. Resident #21 denies fear and no signs or symptoms of psychosocial distress noted. A written request for abuse investigation for Resident #21 and Resident #70 was given to the nursing home administrator on 11/16/22 at 2:07 p.m., and again on 11/16/22 at 4:26 p.m. B. Resident #70 1. Resident status Resident #70, age 68, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), major depression, anxiety and dementia. According to the 11/11/22 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident had no behavioral symptoms. She required supervision for bed mobility, transfers, grooming and toilet use. 2. Record review The care plan, initiated 3/31/21 and revised 11/11/22, identified the resident had impaired communication due to: confused, short term memory loss, and long term memory loss. Interventions include answering resident ' s questions as needed and repeat as necessary. Use simple and direct communication to promote understanding. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated 3/31/21 and revised 11/11/22, identified the resident was on a psychotropic medication related to dementia with behaviors. Interventions include monitor and record of target behaviors, increased agitation, and paranoia. Provide medications as ordered by physician and evaluate for effectiveness. The care plan, initiated 3/31/21 and revised 11/11/22, identified the resident sometimes had behaviors which include refusing to move for others. Interventions include staff to encourage residents to create an open pathway. Social service director (SSD) note dated 11/16/22 at 5:40 p.m. revealed in part: SSD follow up reported incident by resident on 11/10/22. Resident #70 states she does not recall anyone wheeling over her foot nor ever hitting anyone, states she has no pain on her foot. Resident #70 denies fear, no signs or symptoms of psychosocial distress noted. C. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 11/16/22 at 3:48 p.m. He said Resident #70 did not like to move when other residents were going through the halls if she was there. He said he had heard about the incident but did not witness it. The director of nursing was interviewed on 11/17/22 at 10:52 a.m. She said the incident on 11/9/22 was substantiated. She said Resident #70 would get in the way of other residents as they would go down the hall. She said staff would monitor Resident #70 to ensure she would allow residents to go past her in the hall. The DON said she could not speak about the investigation but she would share the information as soon as she received it. The nursing home administrator was interviewed on 11/17/22 at 11:00 a.m. He said he was working on completing the abuse investigations and would provide it as soon as possible. -At the time of exit on 11/17/22, the facility did not provide the abuse investigation between Resident #21 and Resident #70.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to coordinate the appropriate relocation following facility-initiated transfer and discharge for one (#106) of two residents reviewed for discharge out of 49 sample residents. Specifically, the facility failed to ensure Resident #106 was provided: -An updated comprehensive care plan and discharge plan, when the facility issued a facility initiated discharge notice; and, -An effective discharge planning process that focused on the resident's discharge goals. The facility further failed to: -Consider the availability or lack of caregiver/support; and the resident's capacity and capability to perform required care, as part of the identification of discharge needs; -Ensure the resident was discharged to a safe location; -Involve the resident representative medical durable power of attorney (MDPOA) in the development of the discharge plan from the start of the facility-initiated discharge to the final plan for discharge; -Document the resident's interest in returning to the community, and provision of referrals to local contact agencies or other appropriate entities made for this purpose; -Provide an appropriate and safe discharge to a respite facility, as ordered by the resident's physician; -Provide the resident with education about health self-care practices and medication practices in a manner the resident could understand and with sufficient time to permit the resident time to ask questions and prepare for taking over self-medication administration practices; -Assess the resident's ability for self-care needs and prove an accurate assessment of self-care ability to the adult protection services agency so the agency could follow the resident post discharge as needed; and, -Ensure appropriate and timely notification for a facility initiated discharge to ensure the resident could exercise their right to appeal the discharge decision (cross-reference F623 for discharge notice). Findings include: I. Facility policy (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Discharge, Preparing a Resident for Transfer policy, undated, was provided by the director of nursing (DON) on 11/17/22 at 6:05 p.m. It read in pertinent part: Residents will be prepared in advance for discharge. When a resident is scheduled for transfer or discharge, the interdisciplinary team (IDT) or designee will notify nursing services of the transfer or discharge so that appropriate procedures can be implemented. -A post-discharge plan is developed for each resident prior to his or her transfer or discharge. This plan will be reviewed with the resident, and/or his or her family, at least twenty-four (24) hours before the resident's discharge or transfer from the facility. -Nursing services is responsible for: Obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment; Preparing the discharge summary and post-discharge plan; Preparing the medications to be discharged with the resident; Providing the resident or representative (sponsor) with required documents (Discharge Summary and Plan). The Discharging the Resident policy, undated, was provided by the nursing home administrator (NHA) on 11/16/22 at 3:15 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for the discharge process. -The resident should be consulted about the discharge. -Discharges can be frightening to the resident. Approach the discharge in a positive manner. -Reassure the resident that all his or her personal effects will be taken to his or her place of residence. -Assess and document resident's condition at discharge, including skin assessment, if medical condition allows. The Discharge Summary policy, undated, was provided by the director of nursing (DON) on 11/17/22 at 6:05 p.m. It read in pertinent part, When the facility anticipates a resident's discharge to a private residence, another nursing care facility a discharge summary and a a post-discharge plan will be developed which will assist the resident to adjust to his or her new living environment. -The discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident's current diagnosis; Medical history; Course of illness, treatment and/or therapy; Laboratory, radiology, consultation, and diagnostic test results as applicable; physical and mental functional status; ability to perform activities of daily living; sensory and physical impairments; nutritional status and requirements; discharge potential; rehabilitation potential; cognitive status; and medication therapy. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident' s post-discharge medications. -Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge care plan. II. Resident #106 A. Resident status Resident #106, under the age of 65, was admitted on [DATE] and discharged on [DATE]. According to the November 2022 computerized physician order (CPO), diagnoses included acute respiratory failure, diabetes, end stage renal failure, and anxiety. The 10/27/22 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The MDS documented the resident presented with physical and verbally aggressive behaviors directed towards others. The resident did not reject care assistance. The resident needed limited assistance where the resident was highly involved in the activity and staff provided guided maneuvering of limbs or other non-weight-bearing assistance with bed mobility, dressing and personal hygiene. The resident needed supervision/assistance in the form of oversight, cuing and touching assistance while using the bathroom and walking. The resident was occasionally incontinent of urine and frequently incontinent of bowel. The resident was using a manual wheelchair and was able to walk and get up and down one step with supervision and/or touch assistance. B. Non-staff interviews The resident family MDPOA was interviewed on 11/9/22 at 10:35 a.m. The MDPOA said she was never notified of any care-planning meeting to discuss Resident #106's potential discharge, and was not provided the facility initiated discharge notice until one week before the resident was discharged from the facility. The MDPOA acknowledged the resident had mental health issues and was using marijuana, and said as the MDPOA she asked the facility to provide additional mental health services, which she felt were not provided. Additionally, the MDPOA said she and the primary MDPOA had asked the physician for a psychiatric evaluation to determine the resident's competency but that was not followed through on. The MDPOA felt the resident was not able to read the discharge notice well enough to understand his rights for the appeal process because the resident had cataracts and his vision was impaired at the time of the facility-initiated discharge. The MDPOA said the resident was discharged without any community support services being set up in advance of the discharge and the resident was left without the needed care assistance to complete hygiene tasks and oversight to take medications and seek medical care when needed. These were the varying things that led to Resident #106's admission to a nursing facility in the first place. Prior to admission, the resident was admitted to a local hospital due to self-neglect, not being able to take care of himself, and going out for the day covered in his own feces. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A frequent visitor (FV) to the facility was interviewed on 11/15/22 at 1:50 p.m. The FV said the facility had made notification they were going to issue a 30-day discharge letter to the resident but did not provide the official discharge notice. Resident #106 got in contact with the FV two days prior to the discharge date . That was when the FV reached out to the facility social worker for more details about the discharge. The FV said the administrator in training (AIT) told her the facility had not set up any transportation to the resident dialysis center because the resident was capable of doing that, and if the resident could not set up transportation, the medial clinic which they would provide to the resident as a resource would assist the resident with arranging transport to dialysis. Additionally, the AIT said the resident would not talk to him or the facility social worker about the discharge when the discharge notice was served. The FV said she spoke with the resident, who told the FV he did not go through the appeals process because he was not provided the 30-day discharge notice until two weeks prior to the stated discharge date , and that he could not read the notice due to impaired eyesight resulting from cataracts in his eyes. C. Record review The comprehensive care plan documented the resident had a discharge care focus, last revised on 8/16/22. The care focus revealed the resident expressed interest in discharging to the community with the assistance of a community transition worker. Interventions included: assist Resident #106 with making room a homelike environment; encourage res (resident) to participate in activities; establish a comfortable routine for resident; and provide resident with resources in the community. -None of the interventions promoted steps or actions for the resident to move closer and preparing Resident #106 to meet the goal of discharging to the community. Additionally, Resident #106's care plan was not revised with appropriate interventions for discharge when the facility talked to the resident about issuing the resident a 30-day facility initiated discharge notice for failure to pay his portion of the bill for care and services on 9/14/22. Nor did the facility revise the discharge care plan when the resident was issued a 30-day facility initiated discharge notice on 10/14/22 for failure to follow the facility's non-smoking policy (see below). Other care needs addressed in the comprehensive care plan included Resident #106 had care needs for: -Alterations in kidney function. Interventions included dialysis three times a week; dietary restrictions; monitor for bleeding, edema, chest pains, elevated blood pressure, and shortness of breath; post dialysis side effects; and patience of the dialysis catheter for adequate blood flow and signs and symptoms of infection; -Alterations in respiratory status. Interventions included the need for oxygen at bedtime and for nursing assessment of oxygen saturation levels; - Alteration in blood glucose. Interventions included weekly skin assessment of skin and foot condition by licensed nurse; (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Altered nutrition, malnutrition, and fluid restriction requirements related to end stage renal disease, dialysis and need for a renal diet. Intervention needs included encouragement for compliance, monitoring; -Adjustment issues related to changes in environment and situation. Interventions included counseling; -Impaired physical mobility related to dialysis. Interventions included restorative nursing services for walking and active range of motion program; -Ankle pain. Interventions included pain medication; and educate and encourage non-pharmaceutical pain management methods; -Potential for complications related to atrial fibrillation (A-fib). Interventions assess for signs of reduced cardiac output; teach and encourage stress management behaviors; -Potential for abnormal bleeding related to anticoagulant use. Interventions include education to avoid trauma or massage of any area of suspected thrombus formation in order to decrease risk of pulmonary embolism; follow recommended diet to avoid foods high in vitamin K; follow recommended positioning and movement activities/avoidance; -Potential for complication hypo-hyper-glycaemia (low or high blood glucose) related to diabetes mellitus. Interventions included monitor blood glucose levels for potential negative effects of values out of normal range; -Risk for falls and injury. The intervention included encourage non slip socks; -Potential for altered tissue perfusion (passage of fluid through the circulatory system or lymphatic system to an organ or a tissue) related to hypertension (high blood pressure); -Interventions included monitor for high blood pressure; and evaluate resident reports or evidence of extreme fatigue, intolerance for activity, sudden or progressive weight gain, swelling of extremities, and progressive shortness of breath; -Potential for complications related to hyperkalemia (high levels of potassium in the blood). Interventions included educate on the importance of avoiding foods high in potassium to prevent or control hyperkalemia; and monitor for signs and symptoms of hyperkalemia; -Potential for complications related to utilizing antidepressant and antianxiety medication. Interventions included monitoring for potential medication side effects; track target behaviors; keep in close contact with family regarding increased behaviors. The November 2022 CPO revealed the resident was prescribed the following medications: Medications prescribed for routine administration: -Apixaban tablet 5 milligrams (mg); give 5 mg by mouth two times a day for deep vein thrombosis prophylaxis (formation of blood clots); (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bupropion HCl extended release tablet 150 mg; give one tablet by mouth in the morning for major depression; -Famotidine tablet 10 mg; give 10 mg by mouth one time a day for gastric GERD (gastroesophageal reflux); -Furosemide tablet 40 mg, give 40 mg by mouth two times a day for edema; -Lisinopril tablet 10 mg, give 10 mg by mouth in the morning every Tuesday, Thursday, Saturday, Sunday for hypertension; -Midodrine HCl tablet 2.5 mg, give one tablet by mouth in the morning every Monday, Wednesday, Friday for hypotension; -Mucinex tablet extended release, 12 hour 600 mg, give one tablet by mouth two times a day for congestion; -Nephro vitamin tablet 0.8 mg (B complex-C-folic acid), give one tablet by mouth at bedtime for supplementation; -Paxil tablet 30 mg, give 30 mg by mouth one time a day for depression; -Sevelamer HCl tablet 800 mg, give 1600 mg by mouth with meals for dialysis; -Prednisolone acetate suspension 1%; instill one drop in left eye in the morning for prophylactic until 11/4/22; -Diclofenac sodium solution 0.1%, instill one drop in right eye four times a day for eye pain, space drops three minutes apart, until surgery 11/8/22; -Budesonide-formoterol fumarate aerosol inhaler 80-4.5 microgram/activated clotting time (MCG/ACT), inhale two puffs orally (by mouth), two times a day, for chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues. Medications prescribed to be taken on an as needed medications: -Acetaminophen tablet 500 mg, give two tablet by mouth every eight hours, as needed for pain -Albuterol sulfate HFA aerosol solution inhaler 108 (90 Base) MCG/ACT, give one puff inhale orally every six hours, as needed for shortness of breath; -Ondansetron HCl tablet 4 mg, give 4 mg by mouth every eight hours, as needed for nausea or vomiting; -Oxycodone HCl tablet 5 mg, give 5 mg by mouth, every 12 hours, as needed for moderate pain; -Sevelamer HCl tablet 800 mg, give 1600 mg by mouth every six hours, as needed for end stage renal disease with snacks. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes revealed the following: Social services notes dated 9/16/22 at 3:47 p.m. read: Resident was given a 30 day discharge notice due to nonpayment after BOM (business office manager) made multiple attempts to collect payment. The Ombudsman notified and CDPHE (Colorado Department of Public Health and Environment) was mailed a copy. Social services to follow up as needed. Social services notes dated 9/29/22 at 12:19 p.m., read: Spoke with resident about 30 day discharge notice with BOM, resident states that no one has talked to him about his non-payments, BOM confirmed that herself, administrator, and AIT (administrator in training) have spoken to him. Resident states that he is unable to pay the balance due to the difference in what he actually receives from Social Security. Resident was agreeable to paying facility, but would need to make arrangements with BOM. The SSD (social services director) encouraged resident to call Social Security for an award letter. SSD also informed the resident's daughter and medical power of attorney (MDPOA) about non-payment and has not heard back from MDPOA. SSD and BOM to follow up with res as needed. -Review of the medical record revealed there was no discharge notice provided to the resident for either date listed above. There was a facility initiated discharge notice dated 9/15/21 in the resident record that documented an effective date of the discharge as 10/15/21. There was no discharge location documented and the discharge notice was missing several required pieces of information giving details on how to appeal the notice and all parties to contact within the resident's rights. Facility progress notes revealed the resident was observed by facility staff smoking marijuana on facility grounds on 10/4/22, 10/7/22, and 10/12/22. Each time the resident was reminded that smoking marijuana on the grounds of the facility was not allowed by federal law and reminded the facility was a non-smoking facility and all types of smoking on the premises were not permissible. Social services notes dated 10/14/22 at 3:48 p.m., read: SSD and AIT delivered 30 day discharge notice due to resident not following smoking policy after multiple educations, although res denies smoking on property. Resident was asked if he needed assistance being placed elsewhere, resident states not at this time; that he will figure it out. Ombudsman notified. MDPOA was called, no answer, VM (voice message) was left with a callback number. The discharge notice dated 10/14/22 read in part: RE (regarding): Letter of discharge: Dear (Resident #106), I regret to inform you of our intent to discharge (Resident #106) from (facility name) in the next 30 days. Under Colorado Department of Public Health and Environment Health Facilities and Emergency Medical Services Division 6 CCR 1011-1 Standards for Hospital and Healthcare Facilities, 12.6, we are able to give you 30 days of notice of discharge if: Resident has failed to follow smoking policy in facility. Please be advised that the facility has educated res numerous times on smoking policy. The effective date of the discharge will be 11/13/22. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	You have the right to appeal the nursing care facility's decision to transfer or discharge you. If you think you should not be transferred or discharged , you may appeal to (Name of person), Administrator. I am enclosing a copy of the facility grievance policy for your review. If you do not wish to handle the appeal yourself, you may use an attorney, relative, or friend. If your appeal is not resolved to your satisfaction by the staff designee, you can continue your appeal to the nursing care facility's grievance committee, and if necessary, the Colorado Department of Public Health and Environment (CDPHE). You may direct questions regarding this notice to the Department of Public Health and Environment at . -The contact information provided next was for the County Human Services Adult Protection Division, not CDPHE. In addition, the notice failed to provide the resident with a discharge location and all pertinent information on the appeals process and resources available to the resident in an easily understood language and format for the resident to read and understand. The notice also did not provide information and instructions on how to obtain the appeal documents or how to file an appeal to the 30-day notice decision. -Review of the resident's medical record revealed no documentation to show that the facility spoke to the resident's MDPOA about discharge planning; there was no record that the facility worked to set up after care services or provide a safe discharge location. The record instead revealed documentation that the facility only provided the resident with the name of a homeless shelter and a medical clinic that the resident was instructed to contact post discharge. Nurse Practitioner-medical visit notes dated 10/14/22 documented that the resident was engaging in risky behavior, smoking marijuana and refusing recommended treatment, putting himself and possibly others at safety risk. The note read in pertinent part: previously discussed this with his daughter as well in whom has asked for psychiatry evaluation to possibly revoke his (Resident #106's) rights. However, his BIMS is recorded at 13 (out of 15) in which indicates that he is neurologically intact enough to make conscious and capable decisions for himself, and he simply chooses to neglect himself. Yes, this is his right, but we expressed that it is our responsibility to keep both him and others out of any domain for risk of harm. The patient gets progressively agitated with this and continues to try and justify these types of behaviors and his self-neglect and he simply does not see it this way. Therefore, we recommend that the patient be discharged from our care and this facility due to safety/harm risk and despite multiple discussions to provide him with what is needed to thrive and possibly return to the community. In the interim, we will go ahead and ask for a psychiatric evaluation, and see if there are more underlying issues that may need to be addressed prior to making this type of recommendation. I have discussed this with the social services director, director of nursing and IDT staff here at [NAME] in whom all agree with the plan of care at this time. Physical exam performed and we will continue to manage and monitor accordingly and as indicated. -There was no record that the NP's recommendation for a psychiatric exam was pursued. Nurse Practitioner-medical visit notes dated 10/21/22 read in pertinent part: Assessment and plan: Resident diagnosis included adjustment disorder, phobic anxiety, medical noncompliance, as of now, the plan of care is to discharge to respite facility with all ancillary services including transportation facilitation so that he can continue hemodialysis. It will be up to him to take his own health into his own responsibility. I have discussed this with the social services director, director of nursing and IDT (interdisciplinary) staff here at (facility name) in whom all agree with the plan of care. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse's notes dated 10/28/22 at 6:18 p.m., read in part: Resident left for dialysis at 10:00 a.m. Vital signs taken by the nurse, and were within normal limits, resident denies pain or acute distress. All personal belongings were packed by a CNA (certified nursing aide) at 2:00 p.m. All medications except narcotics were given to social service and administrators. Administrator stated 'we will pick the resident up at dialysis and take him to the homeless shelter.' Nurse completed her side of the discharged summary. Social services notes dated 10/28/22 at 4:09 p.m., read: AIT and SSA arrived at (name of dialysis provider) dialysis to pick up the resident and assist him with his discharge. AIT called to inform the dialysis staff we had arrived and provide details of the vehicle and its location, the staff confirmed that the resident was heading out to us. The resident along with a dialysis staff member approached the AIT and SSA walking. The AIT asked the resident where his wheelchair was, and the resident stated, 'You will get the wheelchair once I get my weed.' Both AIT and SSA reminded resident that his paraphernalia was discarded the same day he surrendered it to his daughter per his daughter's requests. Resident became upset and stated he did not believe it and refused to get on the transportation bus and preferred to remain at the dialysis provider. The SSA provided resident with a notice of transfer or discharge forms to sign, and resident signed with no concerns and or refusal. Resident demanded for his belongings and AIT gave the resident his suitcase, duffle bag, cane and medications. SSA and AIT attempted to educate resident on his medications but refused. AIT and SSA called the resident's POA informed her of the resident's discharge location and along with the conversation between the resident, AIT and SSA. The POA was extremely apologetic due to the situation. The POA expressed gratitude for all the assistance for the resident. A Notice of Transfer or Discharge document dated 10/28/22, signed by the social services director (SSD), documented the resident was discharged on [DATE] to the dialysis provider. The reason given for discharge was for non-payment. -The resident was discharged 14 days after receiving the 10/14/22 discharge notice. The resident was not provided the full 30 days prior to discharge as stated on the 10/14/22 discharge notice letter provided to the resident. Additionally, although there was a discharge notice dated 9/14/21 for nonpayment, there was no discharge notice dated for 9/14/22. -Review of facility progress note revealed the facility did not follow the physician's recommendations to discharge the resident to a respite facility with all ancillary services including transportation assistance so resident could continue hemodialysis. -Review of the resident's medical record revealed the resident needed assistance with activities of daily living, medication administration and getting to and from dialysis. The resident had care needs as well as medical/health, physical and mental health deficits that, based on the facility's own nursing assessment, indicated the resident required skilled nursing care. The facility failed to take these needs into account or provide discharge planning around all of the resident's care needs. D. Additional documents A Medical Durable Power of Attorney for Healthcare Decisions form signed by Resident #106 on 8/23/22 documented the resident appointed his two daughters to be his MDPOA effective the date of signature (8/23/22). (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A review of the resident's medical record revealed there was no documentation that the facility tried to involve both of the resident's legally appointed MDPOAs in a formal care conference process for the planning of the resident's facility initiated discharge. E. Staff interviews The nursing home administrator (NHA) and social services director (SSD) were interviewed on 11/16/22 at 2:35 p.m. The NHA said the resident failure to make payment for services started in August 2022. The resident was doing fairly well but started to decline after his roommate passed away. This was a hard time for the resident. The resident was not taking care of himself and was refusing to bathe and change clothing. It took a lot of staff coaxing to get him to comply with and accept assistance to complete hygiene tasks. The resident wanted to move out into an apartment in the community, but was not always compliant with completing the tasks needed to make the move successfully. The SSD said the resident was issued two 30 day notices, one on 9/14/22 for non-payment and then issued a second 30 day notice on 10/14/22 for failure to follow the facility smoking policy; however the facility did not change the anticipated discharge notice with the newly issued facility initiated discharge notice. The SSD said the notices were not provided to the resident representative/MDPOA. The SSD said they kept trying to work with the resident to reach his original discharge goals for independent living, but he was not completing the steps he needed to accomplish to make the move. The NHA said the resident was his own responsible person and they were not required to provide the resident representative (MDPOA) with a copy of the 30-day discharge notice. The NHA said they did not conduct discharge planning with the resident because when they presented the initial 30-day discharge letter to the resident and tried to discuss discharge plans with the resident, the resident told them (the NHA and SSD) to leave the room. The NHA said the resident was capable of setting up his own services, so they provided the resident with a list of resources including the name and address of the homeless shelter and the name of a local medical clinic where the resident would be able to see physician services and medical oversight. The SSD said she provided the resident with contact information for a local food bank, clothing resource, bus passes, and the energy assistance program. Both acknowledged the discharge plan was to take the resident to a homeless shelter and let him contact the provided resources for his ongoing care needs. (See the resident's care plan for care needs that were identified by facility assessment, documented above). The SSD said the homeless shelter permitted individuals to reserve bed space for a small fee. The shelter had showers and a space for individuals to hang out in during daytime hours. The NHA said when they (the NHA and SSD) went to pick up the resident on 10/28/22 after the resident's dialysis treatment to take the resident to the homeless shelter, the resident became upset and refused to be taken to the homeless shelter. Instead, the resident went to the local hospital. The hospital social workers and discharge coordinators took over the resident's discharge from that point. The director of nursing (DON) was interviewed on 11/16/22 at 3:30 p.m. The DON said she was not involved in the resident's discharge. The DON was not sure what medications were provided to the resident and did not know about the potential services set up for the resident.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and staff reviews, the facility failed to provide notice of discharge to the resident representative and Office of the State Long-term Care Ombudsman at least 30 days before the resident's discharge for one (#106) of two reviewed for discharge out of 49 sample residents. Specifically, the facility failed to: -Ensure the resident was provided an appropriate discharge notice at least 30 days prior to actual discharge date ; -Ensure Resident #106 and the resident representative/medical power of attorney (MDPOA) was provided written notice of transfer/discharge in a language/format the resident could understand; -Ensure the resident and resident representative were fully informed of their appeal rights and how to request and file an appeal to the resident's discharge from the facility; -Provide the resident and resident representative with information about the specific location where the resident would be discharged ; -Provide the resident and resident representative with the mailing and email address and the telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder; -Forward a copy of the notice to the Office of the State Long-term Care Ombudsman; -Maintain evidence that a copy of the notice was sent to the Ombudsman; and, -Provide a discharge notice with a discharge location and all other required information. Cross reference to F624, failure to ensure a safe and orderly discharge. Findings include: I. Facility policy The Discharging the Resident policy, undated, was provided by the nursing home administrator (NHA) on 11/16/22 at 3:15 p.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for the discharge process. -The resident should be consulted about the discharge. -Discharges can be frightening to the resident. Approach the discharge in a positive manner. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The policy failed to include the facility's responsibility to provide written notice of a transfer or discharge notice to the resident, the resident's representative, and the Office of the State Long-term Care ombudsman to include language that the resident could understand, and all required information to ensure the resident and resident representative were fully informed of the details of the discharge and legal right for appeal. II. Resident #106 A. Resident status Resident #106, under the age of 65, was admitted on [DATE] and discharged on [DATE]. According to the November 2022 computerized physician order (CPO), diagnoses included acute respiratory failure, diabetes, end stage renal failure, and anxiety. The 10/27/22 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. B. Record review The resident's medical record revealed the following: Social services notes dated 9/16/22 at 3:47 p.m. read: Resident was given 30 day discharge notice due to nonpayment after BOM (business office manager) made multiple attempts to collect payment. The Ombudsman notified and CDPHE (Colorado Department of Public Health and Environment) was mailed a copy. Social services to follow up as needed. The resident record contained two 30-day discharge notices, one dated 9/15/21 and a second dated 10/14/22. The resident progress notes documented that the resident was issued a 30 day facility initiated discharge letter on 9/15/22; however the resident record failed to contain a 30 day discharge letter with a date of 9/15/22. The 30-day discharge notice that was dated 9/15/21 was documented as an effective date of 9/15/22 and was documented as being uploaded to the resident medical record on 11/7/22. The resident record contained a second 30-day facility initiated discharge letter dated 10/14/22 (see for more detail of the content of the discharge letter below). The 9/15/21 discharge notice revealed the resident was being discharged for nonpayment. There were no corresponding progress notes in the resident record to show the business office manager (BOM) and social services workers spoke to the resident in September 2022 about the resident's failure to make required payments for care. The 9/15/22, 30-day discharge notice document read in pertinent part: Resident has failed to make patient portion payment. 1. Please be advised that the facility has made numerous attempts to collect your payment portion. 2. The effective date of the discharge will be October 15, 2021. -It is unclear if this document was provided in 2021 and uploaded to the resident record a year later or if the document was dated incorrectly. Based on progress notes the resident had issues with no payment in September 2022 not September 2021. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social services notes dated 9/29/22 at 12:19 p.m. read: Spoke with resident about 30 day discharge notice with BOM, resident states that no one has talked to him about his non-payments, BOM confirmed that herself, administrator, and AIT (administrator in training) have spoken to him. Resident states that he is unable to pay the balance due to the difference in what he actually receives from Social Security. Resident was agreeable to paying the facility, but would need to make arrangements with BOM. The SSD (social services director) encouraged resident to call Social Security for an award letter. SSD also informed the resident's daughter and medical power of attorney (MDPOA) about non-payment and has not heard back from MDPOA. SSD and BOM to follow up with res(ident) as needed. Facility progress notes revealed the resident was observed by facility staff smoking marijuana on facility grounds on 10/4/22, 10/7/22, and 10/12/22. Each time the resident was reminded that smoking marijuana on the grounds of the facility was not allowed by federal law and reminded the facility was a non-smoking facility and all types of smoking on the premises were not permissible. Social services notes dated 10/14/22 at 3:48 p.m., read: SSD and AIT delivered 30 day discharge notice due to resident not following smoking policy after multiple educations, although resident denies smoking on property. Resident was asked if he needed assistance being placed elsewhere, resident states not at this time; he will figure it out. Ombudsman notified. MDPOA was called, no answer, a voice message was left with a callback number. The resident record contained a 30-day discharge notice dated 10/14/22. The discharge notice revealed the resident was being discharged for failure to comply with the facility's non smoking policy. The document read in pertinent part: Resident has failed to follow smoking policy in the facility. 1. Please be advised that the facility has educated res numerous times on smoking policy. 2. The effective date of the discharge will be 11/13/22. -Although there was a change in the resident's 30-day discharge notice reason for discharge and date of discharge, the facility did not make a change in the resident's discharge timeline to permit the resident time to appeal the newly issued discharge notice. Additionally, the discharge notice failed to provide a discharge location and a full explanation of the right to appeal the transfer or discharge to the State, including the timeline and appeal process; and the name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; information on how to obtain an appeal form; and information for the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorders. Nurse's notes dated 10/28/2022 at 6:18 p.m., read: Resident left for dialysis at 10:00 a.m.Vital signs taken by the nurse, and were within normal limits, the resident denies pain or acute distress. All personal belongings were packed by a CNA (certified nurse aide) at 2:00 p.m. All medications except narcotics were given to social service and administrators. Administrator stated 'we will pick the resident up at dialysis and take him to the homeless shelter.' Nurse completed her side of the discharged summary. A Medical Durable Power of Attorney for Healthcare Decisions form signed by Resident #106 on 8/23/22 documented the resident appointed his two daughters to be his MDPOAs effective the date of signature. C. Non-staff interviews (continued on next page)

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident family MDPOA was interviewed on 11/9/22 at 10:35 a.m. The MDPOA said she was never notified of any care-planning meeting to discuss Resident #106's potential discharge and was not provided the facility initiated discharge notice until one week before the resident was discharged from the facility. The MDPOA acknowledged the resident had mental health issues and was using marijuana, and said as the MDPOA she asked the facility to provide additional mental health services, which she felt were not provided. The MDPOA said the resident was not able to read the discharge notice well enough to understand his rights for the appeal process because the resident had cataracts and his vision was impaired at the time of the facility-initiated discharge. The MDPOA said the resident was discharged without any community support services being set up in advance of the discharge and the resident was left without the needed care assistance to complete hygiene tasks and oversight to take medications and seek medical care when needed. These were the very things that led to Resident #106's admission to a nursing facility in the first place. Prior to admission, the resident was admitted to a local hospital due to self-neglect, not being able to take care of himself, and going out for the day covered in his own feces. A frequent visitor (FV) to the facility was interviewed on 11/15/22 at 1:50 p.m. The FV said the facility had made notification they were going to issue a 30-day discharge letter to the resident but did not provide the official discharge notice. Resident #106 got in contact with the FV two days prior to the scheduled discharge. That was when the FV reached out to the facility social worker for more details about the discharge and was provided a copy of the resident's discharge notice. The FV was unaware that the resident was provided two separate 30 day discharge notices. The FV said she spoke with the resident, who told the FV he did not go through the appeals process because he was not provided the 30-day discharge notice until two weeks prior to the stated discharge date , and that he could not read the notice due to impaired eyesight resulting from cataracts in his eyes. D. Staff interviews The nursing home administrator (NHA) and social services director (SSD) were interviewed on 11/16/22 at 2:35 p.m. The SSD said the resident was issued two 30 day notices, one on 9/14/22 for non-payment and then issued a second 30 day notice on 10/14/22 for failure to follow the facility smoking policy; however the facility did not change the anticipated discharge notice with the newly issued facility initial discharge notice. The SSD said she sent an email to the ombudsman on 9/14/22 to inform the ombudsman the facility would be issuing a 30-day discharge notice to Resident #106, but did not send an updated notice for the 10/14/22 discharge notice. The SSD provided a copy of the email notice sent to the ombudsman. The email from the SSD to the ombudsman dated 9/14/22, read in pertinent part: Hello, just wanted to let you know that we will be issuing 30-day discharge notices for the residents: (Resident #106). We have currently written off from (sum of money and dates of nonpayment). Currently on the books unpaid is (total amount unpaid and dates). -No other details of the resident's discharge were provided in the body of the email and there was no indication of any attachments included with the email. The email did not indicate the actual or anticipated date when the discharge notice would be provided to the resident and did not provide an anticipated discharge location. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said this email was proof of the facility notifying the ombudsman of the resident being provided a 30-day facility initiated discharge. The facility did not send notification by registered or certified mail. The NHA said the facility did not provide a copy of the 30-day discharge notice to either of the resident's representatives who were also the resident's legally appointed MDPOAs. The director of nursing (DON) was interviewed on 11/16/22 at 3:30 p.m. The DON said she was not involved in the resident's discharge. It was the responsibility of the SSD to provide discharge notices to the appropriate persons.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review and staff interviews, the facility failed to incorporate the recommendations from the PASARR (preadmission screening and resident review) level II determination and evaluation report into the assessment, care planning and transition of care for two (#62 and #21) or four residents reviewed for PASARR out of 49 sample residents. Specifically, the facility failed to: -Take steps to ensure services were provided as recommended in Resident #62 and Resident #21's PASARR level II report; -Ensure the PASSAR recommendations were included in Resident #62 and Resident #21's medical record; and, -Ensure the PASSAR recommendations were included in Resident #62 and Resident #21's care plans. Findings include: I. Resident #62 A. Resident status Resident #62, age 77, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO) diagnoses included respiratory failure, paranoid schizophrenia (mental disorder that causes impaired perception of reality) and dementia. The 8/4/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The 9/8/22 MDS documented the resident did not have hallucinations or delusions. The 10/1/22 MDS documented the resident needed supervision for all activities of daily living (ADLs). B. Record review The 5/4/22 MDS assessment revealed the resident had not been evaluated for level II PASARR. Upon request Resident #62's PASARR was provided by the SSD on 11/16/22 at 9:42 a.m. -The resident's PASARR was not in the resident's medical record. The 10/21/22 PASARR level II report was submitted approximately six months after the resident was admitted to the facility (see social services director interview below). (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/21/22 documented Resident #62 met criteria for serious mental illness of paranoid schizophrenia. The report read the resident had behaviors of causing herself to vomit related to delusion and had a history of suicidal ideations. The PASARR level II recommendations included Resident #62 was to participate in a psychiatric consultation quarterly to address the resident's delusions and paranoia. It was also recommended to help coordinate a discharge plan to a lower level of care such as an assisted living community. -The resident's comprehensive care plan was reviewed on 11/16/22; the individualized comprehensive care plan failed to identify a care focus for Resident #62's PASARR in their entirety. C. Staff interviews The social services director (SSD) and the nursing home administrator (NHA) were interviewed on 11/16/22 at 10:46 a.m. The SSD said Resident #62 was admitted in April 2022 and her PASSRR was not submitted until October 2022. She said the PASSRR should have been submitted within 30 days of the residents' admission. The SSD said she was not aware of the recommendations Resident #62's PASSRR documented. She said Resident #62 was receiving psychiatric care. The SSD said she had not helped the resident discharge to a lower level of care because the resident was unable to recall the address of her home. The SSD said she had not considered helping the resident discharge to an assisted living. The SSD said the PASSRR should have been a part of the resident's medical record and the recommendations should have been included on the plan of care. 31821 II. Resident #21 A. Resident status Resident #21, age 65, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included diabetes mellitus, end stage renal failure, dependence on renal dialysis, congestive heart failure, schizophrenia, and bipolar. According to the 10/20/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had no behavioral symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. B. Record review The PASARR level II, provided to the facility on [DATE] at 11:37 a.m., revealed: -Specialized service recommended for mental health illness: psychiatric case consultations; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Individual has an intellectual developmental delay (I/DD) or related condition PASARR condition contingent on referral. -Transition plan to community warranted for I/DD or related condition; -Individual require specialized services for I/DD or related conditions; and -Specialized services recommended for I/DD or related conditions: case management, day habilitation, specialized habilitation, day habilitation, and supported community connections and transportation. -A review of social services notes failed to reveal the facility was made aware of the PASARR level II recommendations (see interview below). The PASARR level II was not located in the resident ' s chart. The care plan, initiated 6/27/22 and revised 10/20/22, identified the resident was at risk for increased behaviors, directed at self/others r/t (related to) Schizophrenia. Interventions included encourage the resident to be patient with other residents. Maintain a safe environment with minimal stimulation The care plan, initiated 6/27/22 and revised 10/20/22, identified the resident exhibits and reports signs and symptoms of depression related to life circumstances, and medical conditions. Interventions include utilizing antidepressant for depression. Monitor for increase in depression/anxiety and address accordingly. Reassure the resident about the progress he was making towards goals. C. Staff interviews The SSD was interviewed on 11/16/22 at 10:46 a.m. She said she should have followed the recommendations indicated on the PASRR level II for Resident #21. She said she would make the referrals to have Resident #21 assessed for potential I/DD evaluation and psychiatric evaluation as per recommendations. The SSD stated the PASARR should have been in the resident ' s chart.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 31821 Based on observations, record review and interviews, the facility failed to ensure proper activities of daily living care (ADLs) for two (#21 and #25) of two residents reviewed for ADL care out of 49 sample residents. Specifically, the facility failed to: -Address Resident #21's request for incontinent care in a timely manner; and, -Implement an effective communication system for Resident #25. Findings include: I. Facility policy and procedure The Activities of Daily Living (ADLs): Supporting policy, revised March 2018, provided by the nursing home administrator (NHA) on 11/21/22 at 11:47 a.m., read in pertinent part, residents would be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADLs. Residents who were unable to carry out activities of daily living independently would receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. II. Resident #21 A. Resident status Resident #21, age 65, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included diabetes mellitus, end stage renal failure, dependence on renal dialysis, congestive heart failure, schizophrenia, and bipolar. According to the 10/20/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had no behavioral symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. The residents were a two person assist for all ADLs. B. Observations On 11/15/22 at 9:03 a.m., Resident #21 was observed sitting in his wheelchair next to the nursing station on 400 hall. Resident #21 verbally told the license practical nurse (LPN) #2, he was wet. LPN #2 stated go to your room and I would send a certified nurse aide (CNA) to help you. Resident #21 self-propelled himself to his room and placed himself next to his bed and waited from 9:09 a.m.-10:38 a.m., and the following staff members were observed to walk past the resident's room while he was requesting incontinent care: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Resident #21 pressed his call light. CNA #2 walked into residents room with Resident #21 stating he was wet and required changing. CNA #2 turned off his call light exited his room and returned with a glass of water and exited Resident #21's room. CNA #2 walked by the residents room several times without providing care. -LPN #2 walked into the resident's room. Resident #21 stated he may need a stool softener as he was constipated. LPN #2 stated he would check Resident #21's medical record to see what he had for constipation and exited Resident #21's room. -Resident #21 stated to his roommate, Oh I guess I don't need that laxative anymore. -LPN #2 entered Resident #21's room and was heard telling Resident #21, Oh you pooped and exited the room. -Physical therapy (PT) entered the resident's room. PT asked Resident #21 if he was ready to go to the gym. Resident #21 said he was required to be changed as he was soiled. PT said when you get changed come over to the gym and we would start exercising. PT asked CNA #2 if she could change Resident #21. She said okay and exited hall 400. -Resident #21 was asked if he had been provided incontinent care, which Resident #21 replied No. Resident #21 was instructed to turn on his call light again. -CNA #2 and CNA #4 entered Resident #21's room with mechanical lift. On 11/15/22 at 2:56 p.m., Resident #21 pressed his call light as he wanted to be put into bed. -At 2:59 p.m., CNA #4 entered the resident's room. He turned off the call light and exited the resident's room. -At 3:13 p.m., Resident #21 again pressed his call light. CNA #2 walked past the resident's room. -At 3:43 p.m., CNA #4 returned to Resident #21's room with the mechanical lift and was assisted with Resident #21 transfer. C. Record review The care plan, initiated 6/27/22 and revised 10/20/22, identified the resident had limited physical mobility related to weakness due to right below knee amputation (RBKA). The resident wears a prosthesis to the right leg below the knee. Interventions include applying prosthetic shrinker only on notification of compliance status (NOCS). Encourage full weight bearing, provide supportive care, and assistance with mobility as needed. Document assistance as needed. -The resident care plan was reviewed and did not reveal any information about two person mechanical lift for transfers. D. Staff interviews (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #4 was interviewed on 11/16/22 at 3:48 p.m. He said Resident #21 required total assistance for all ADLS and he required a two person transfer with mechanical lift. He said the resident was able to make his needs known and was able to tell staff when he needed to care. CNA #4 said the problem was when a resident who requires a mechanical transfer the CNAs have to go and find one since they were limited on how many mechanical lifts we have in the facility. CNA #4 said, I think we have two. LPN #2 was interviewed on 11/15/22 at 11:33 a.m. He said Resident #21 was extensive assistance with care and was a two person mechanical lift for transfers. He said the resident utilized his call light. He said staff should be responding to him when he requires assistance in a timely manner. The director of nursing (DON) was interviewed on 11/17/22 at 10:52 a.m. The DON was told of the observations above. She said staff needed to answer the call light as fast as they could. She said, there are some instances when a resident may have to wait if there was an accident or other resident care was being provided. She said she said the facility had hired another CNA who will be providing daily showers but I had several call offs today so I had to put the shower CNA on the floor. She said the facility had two mechanical lifts in the facility which were causing problems with resident response times. She said the facility might have three mechanical lifts but she would clarify how many the facility actually had. She said staff should respond to residents' call lights immediately and they should not turn off the call light and as something may come up and they forget to provide care. She said all staff can answer a call light. III. Resident #25 A. Resident status Resident #25, age 94, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included pulmonary fibrosis, atrial fibrillation, anxiety, adult failure to thrive, dysphagia (swallowing difficulty), dementia and cognitive communication. According to the 9/24/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had difficulty staying on track and disorganized thinking. She required extensive assistance for bed mobility, transfers, grooming and toilet use. The MDS assessment revealed a request for a translator. B. Observations On 11/15/22 at 10:22 a.m. certified nurse aide (CNA) #2 was observed going into the resident's room. She tried to communicate with the resident but neither could understand each other. CNA #2 gave her a cracker and left. -At 2:01 p.m. Resident #25 was trying to get the staff's attention. She called out. An unknown CNA entered the resident's room and tried to use the cards on the bulletin board but there was no clear communication of what Resident #25 needed. On 11/16/22 at 9:34 a.m. CNA #2 entered the resident's room to see what she needed. CNA #2 utilized the picture cards but resident did not respond to anything CNA #2 tried. CNA #2 walked out. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:30 p.m. CNA #6 entered the resident's room. She asked the resident are you cold? She attempted to use the picture cards and asked the resident do you want some water? CNA #6 exited the room. On 11/17/22 at 1:00 p.m., CNA #4 entered the resident room. She said, Oh, I hope I can help you today. B. Record review The care plan, initiated 9/1/22 and revised 9/24/22, identified the resident had impaired communication due to: non English speaking/language barrier. Resident speaks [NAME]. Interventions include staff to engage family to assist in communicating needs when family is available. The care plan, initiated 9/1/22 and revised 9/24/22, identified the resident experiences behaviors of screaming. Interventions include if a resident cannot be redirected or calmed, and if safe to do so, staff to attempt to perform care at a later time after the resident is calmer. Staff to explain care to residents prior to and during the process of care. Staff to involve family as necessary to assist with behavioral management. Staff to redirect residents to other activities. The November 2022 CPO included unspecified dementia with behavioral disturbance. Start date 9/9/22. Physician note dated 9/30/22 documented in part: The patient was awake and globally confused and not able to respond to questions appropriately given her dementia plus language barrier. She is currently on 1.5 liters per minute (LPM) via nose cannula and she does not indicate any pain when I point to her chest, lungs, and legs. She was mildly improved from her increased agitation and aggressive behaviors compounded by both language barrier plus severe dementia to which we started trial of Seroquel 12.5 MG two times daily (BID) to assess her tolerance in addition to Xanax 0.25 mg as rescue dosing every 12 hours as needed (Q12/PRN). The patient has since tolerated low dose Seroquel and we will increase that same dose TID (three times per day) and see how she does. Physical exam performed, chart reviewed and we will continue to manage and monitor accordingly and as indicated. Certified nurse aide (CNA) behavior monitoring and interventions documented in part: From 10/19/22-11/17/22 no behaviors were observed. Nursing log note date 11/14/22 at 4:09 p.m., revealed in part: Resident was very anxious and agitated this shift. Unable to communicate with her due to language barrier and she refuses to even look at the communication cards tonight. D. Staff interviews Certified nurse aides (CNA) #2 was interviewed on 11/15/22 at 9:05 a.m. She said Resident #25 was very difficult to work with because she did not speak English and she could not understand the staff. She said Resident #25 did not have any behaviors and if there were any behaviors by any residents she would document it in the CNA notes and also report the behavior to the nurse on duty and the nurse would make the progress note. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 11/15/22 at 9:46 a.m. He said it was pretty much hit or miss when it came to communicating with Resident #25 because of the language barrier. He said the staff had a translator program but he never used it. He said, I think it was in the social service office. LPN #3 was interviewed on 11/15/22 at 11:50 a.m. She said she was familiar with Resident #25. She said Resident #25 did not understand English as she spoke a specific Indian dialect which no staff understands, which made working with her difficult. She said it was trial and error when it comes to communicating with Resident #25. CNA #3 was interviewed on 11/16/22 at 8:46 a.m. She said it was very difficult to provide care for Resident #25 because of the language barrier. She said the resident had picture cards on a stick but they did not help with what care Resident #25 was wanting. She said the staff just monitored the resident to see if she was wet or soiled because they could not understand her. She said there was a number at every nursing station for a translating service used by the facility to translate for residents. She said, I used it several times. She said the resident did not have behaviors but she would call out because she needs something. The SSD was interviewed on 11/16/22 at 10:46 a.m. She said she used a company translator to communicate with the resident. She said she had not used the translator in a couple of weeks. She said she had not received any concerns or need for the translator services this week. She said if staff required it they would request her assistance. She said she did not use the translator information that was provided by CNA #3. The SSD was told the number and she said the facility did not have an account to use it. She said, I do not use that translator number. s. CNA #5 was interviewed on 11/16/22 at 3:17 p.m. She said it was very hard to communicate with Resident #25 because of the language barrier. She said, I use hand signals but I never understand what she wants and she doesn't understand what I am trying to tell her. It gets very frustrating for me but I can only imagine what she was going through. She said she did not have any behaviors and if she did, I would document in the computer and tell the nurses. CNA #4 was interviewed on 11/17/22 at 2:17 p.m. He said it was very difficult to work with Resident #25 because of the language barrier. He said he would use his translator on his phone but he really could not pronounce any of the words correctly so that added to the problem. He said she did not have any behaviors. He said she would call out but that was to get the staff's attention because she could not use the call light. The director of nursing was interviewed on 11/17/22 at 10:52 a.m. The DON was told about the observations and interviews above. She said the language barrier was a problem. She said it did cause frustration with staff and with the resident. She said the facility had a translator program which was used to communicate with Resident #25. She said the translator was in the social services office and the staff utilized it to communicate with the resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure three (#15, #95 and #53) of six residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, hygiene, dressing and grooming out of 49 sample residents. Specifically, the facility failed to provide each resident a dignified dining experience with timely feeding assistance, proper positioning, and adaptive equipment as recommended for Resident #15, #95 and #53. Findings include: I. Facility policy and procedure The Meal Assistance policy, dated 2018, was provided by the director of nursing (DON) on 11/17/22 at 6:30 p.m. It read in pertinent part: Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. -Facility Staff will serve resident trays and will help residents who require assistance with eating. -Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: Not standing over residents while assisting them with meals; Keeping interactions with other staff to a minimum while assisting residents with meals; Avoiding the use of labels when referring to residents (' feeders '); and Avoiding the use of bibs or clothing protectors instead of napkins, unless requested by the resident. -Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. -Assistance will be provided to ensure that residents can use and benefit from special eating equipment and utensils. II. Meal observations The lunch meal was observed over several days in the assisted feeding dining room. All residents present needed either physical feeding assistance; monitoring during the meal; cuing to continue eating; and or adaptive equipment. No adaptive equipment was provided to any resident and only some residents were provided consistent and timely assistance throughout the meal. On 11/14/22 from 11:00 a.m. to 12:45 p.m., the lunch meal was observed in the assisted feeding dining room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #15 entered the dining room with staff assistance, at 11:00 a.m. and sat at the table waiting for the lunch meal to be served. Drinks were served to the resident at 11:22 a.m. The resident started to yell out at 11:25 a.m. saying shut up; I ' ll kill you and other similar statements in a repetitive fashion. No staff approached or redirected Resident #15. The resident was served her meal at 11:50 a.m. Staff set up the meal for the resident and the resident became quiet and began to eat the meal. The resident had chopped steak with gravy, potatoes and green bean casserole. The meal was served on a flat foam style disposable plate and the resident was provided regular style plastic utensils to eat the meal with; the plate was not divided. The resident had a hard time getting food on to the spoon and into her mouth and she began eating with her fingers. The meal was messy to eat in this manner. After a few minutes of eating, the resident clothing protector fell into the resident plate and the resident was unable to get to the food. The resident stopped eating and started to yell out again. At 12:07 p.m., one of the certified nurse aides stopped by the table to ask Resident #15 if she needed help. The resident stopped yelling but did not answer the staff. The staff left the table and did not remove the clothing protector from the resident ' s plate or provide cuing assistance to help the resident resume eating the meal. The resident resumed yelling until another staff came by and removed the resident from the dining room. The resident ate approximately 25% of the meal. Resident #95 entered the dining room at 11:08 a.m. with staff assistance. Resident #95 sat at a table alone waiting for the lunch meal to be served. Staff delivered drinks to the resident, which the resident drank, some of the beverage. The resident was served lunch at 12:12 p.m. The meal was served on a flat foam style disposable plate and the resident was provided regular style plastic utensils to eat the meal with; the plate was not divided. The resident was provided a mechanically altered meal of chopped steak with gravy, potatoes and green bean casserole. The resident tried to scoop up food with the plastic spoon but could not get anything on the spoon. The resident put several empty spoons of food in her mouth. After approximately two minutes of trying to spoon food unsuccessfully, the resident put her head down and closed her eyes. After a few minutes, the resident put her hand on her plate but did not try to eat the food. A staff person walked by the resident ' s table. The resident sat up to look at the staff, but put her head back down when the staff person kept walking by. A second staff member approached and handed the resident her spoon and put the plastic fork on the resident ' s dish. The resident again tried to spoon food onto the plastic spoon but was unsuccessful. The resident put the spoon down on the plate and then tried to pick up the spoon again, getting it tangled with the fork. The resident eventually ended up holding the fork and was able to prong several bites of food and eat them off the plastic fork. Resident #95 was able to eat approximately 50% of her food before staff approached and escorted her from the table out of the dining room. No staff sat with or monitored the resident as she ate and no staff asked the resident if she was done eating before removing her from the dining room. On 11/15/22 from 11:30 a.m. to 12:38 p.m., the lunch meal was observed in the assisted feeding dining room. At 11:40 a.m., Resident #53 was observed in the dining room waiting for lunch to be delivered. Resident #53 was chewing aggressively on his blanket. The chewed tip was extremely wet and stained with a bright red substance (the resident had not yet started to eat any part of the meal). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:51 a.m., a certified nurse aide (CNA) delivered Resident #53 ' s plate and walked away. The resident meal was served on a flat foam plate with regular plastic silverware. The plate was close enough to the resident that the resident reached out and quickly grabbed a chicken thigh bone in for the plate and was aggressively trying to bite the meat off the bone. (Resident #53 needed supervision during the meal for safe eating-see below). The resident continued to attempt to bite off pieces of chicken but dropped in on his lap and when he picked up the chicken he kept getting the blanket and chicken thigh in his mouth at the same time; trying to bite off pieces. At 11:56 p.m. staff approached Resident #53 to assist him with the meal. The CNA asked the resident how he got the piece of chicken and moved it to the plate so it could be cut into pieces and bones removed. The CNA proceeded to assist Resident #53 his meal. The resident continued to chew on his blanket throughout the meal. The staff occasionally removed the blanket for the resident mouth but did not remove it from his reach. The CNA did not talk with the resident as she assisted him with his meal. At 11:41 a.m., Resident #95 was served a pureed meal (Resident #95 was prescribed a regular textured diet no pureed-see below). She was trying to scoop food onto her fork and the food kept falling off the fork. At 12:01 p.m., staff approached to ask how the meal was Resident #95 said so so and complained that the food was too runny. Staff told the resident her meal was pureed so she would not choke. The CNA left Resident #95 to struggle to eat the meal. A few minutes later, Resident #95 started to complain that she was hungry. At 12:28 p.m., a different staff approached the resident and offered the resident a peanut butter and jelly sandwich and a regular textured meal of the daily menu entree item. The resident ate the sandwich. On 11/17/22 from 11:30 a.m. to 12:55 p.m., the lunch meal was observed in the assisted feeding dining room. Resident #15 was observed at 11:46 a.m., eating her lunch; regular consistency diet, on a flat foam style disposable plate and the resident was provided regular style plastic utensils to eat the meal with; the plate was not divided. Resident #15 was struggling to eat her meal with the plastic utensils. Staff was alerted and removed the napkin in the resident ' s mouth. A replacement napkin option was not provided. After 15 minutes of struggling with the silverware, the resident started to eat her mashed potatoes, zucchini, and fish with her hands. The resident also ate her chocolate pie with her hands. The resident had food all over her hands at the end of the meal but ate 100% of the meal. The resident was not assisted or monitored with the meal by staff. Resident #53 was observed at 11:47 a.m. sitting in a reclined broad type wheelchair waiting for lunch. The resident meal was sitting on the table in front of him but no staff was present to assist the resident with the meal. The resident was chewing on his towel-clothing protector very aggressively. Staff set the resident lunch on the table at 11:49 a.m., but did not remove the cloth towel from the resident ' s mouth (the resident care plan documented the resident had been known to eat non-floor items-see care plan below). The resident was not able to reach or eat the meal without staff assistance and based on facility assessment the resident needed monitoring and feeding assistance for safe ingestion of the meal (see below). At 11:54 a.m., certified nursing assistant (CNA) #11 approached the resident to provide feeding assistance. CNA #11 stood in front of the resident the entire time while providing feeding assistance and did not talk with the resident or tell the resident what he was about to eat. III. Resident #15 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #15, age 82, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included Alzheimer ' s disease, dementia with agitation, need for assistance with personal care, abnormality of gait. The 10/10/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment and was unable to participate in the brief interview for mental status (BIMS) exam. The staff was unable to make further assessment of the resident ' s cognitive ability. The resident had clear speech, was able to make self-understood and was sometimes able to respond adequately to simple direct communication but not able to respond appropriately to conversations. The resident needed extensive assistance from staff to complete activities of daily living (ADL) and limited assistance with eating where staff provided partial assistance with eating. The resident did not reject care. B. Record review Resident #15 ' s comprehensive care plan revealed the resident was at risk for weight loss. A care focus revised on 1/12/22 documented the resident ' s goal for the care need was for the resident to accept the prescribed diet and eat 75-100% of meals provided. Interventions included: provide adaptive equipment per occupational therapy recommendation for ease of self-feeding, as needed; and provide adequate set-up, cue, encouragement and assistance with dining, as needed. Occupational therapy assessment dated [DATE], read in pertinent part: Resident #15 will improve the ability to safely and efficiently perform eating tasks with partial/moderate assistance with use of a divided plate to facilitate the ability to live in an environment with least amount of supervision and assistance and to ensure adequate nutrition and hydration. Resident #15's November 2022 CPO revealed a diet order: Regular diet regular easy to chew texture with thin (regular) consistency liquids. Nurse practitioner note dated 9/26/22 revealed the resident was assessed for weight loss. The assessment and plan revealed Resident #15 experienced a progressive decline with dementia and a steady weight loss decline from 135.5 pounds (lbs) in March 2022 to 128.5 lbs in July 2022. The resident was consuming 25-50% of meals. As of the September 2022 visit and exam the resident weight was back up to 131.5 lb. The NP recommended staff continue to provide the resident enriched cereal, med pass drink (nutrition) supplement, and a regular diet. Occupational therapy session note dated 11/14/22 at 5:31 p.m., read in part: Therapist facilitated feeding this date, providing maximum assistance to load spoon and bring to mouth after forward training (training for the sequencing the steps of the task) attempted. S/u (set up) with finger foods, s/u and verbal cues to take drinks in between dry bites of food. Moderate spillage with self-feeding. Response to treatment: Response to session interventions: Resident demonstrated good attention and tolerance to therapy. IV. Resident #53 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #53, under the age of 65, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance, restlessness and agitation, and need for assistance with personal care. The 9/10/22 minimum data set (MDS) assessment revealed the resident had severely impairment cognitive ability and was not assessed by the BIMS exam. The resident presented with consistent inattention and was easily distractible. The resident who did not talk was rarely to never able to make self understood in conversations; the resident was sometimes able to understand others in conversation. The staff assessment of the resident revealed the resident had short and long-term memory impairment and was not able to recall the current season, location of room, staff names or faces, or that she was in a nursing home. The resident did not present with behaviors or reject care. The resident was totally dependent on staff to complete activities of daily living (ADL) including eating meals and snacks. B. Record review Resident #53 ' s comprehensive care plan revealed the resident was at risk for malnutrition and weight loss. A care focus revised on 9/29/22 documented the resident ' s goal for the care need was to receive nutritious foods. Interventions included providing assistance with eating; provide adequate set-up, cue, encouragement, and assistance with meals as accepted. Related precautions included: -The resident was observed trying to eat non-food items (paper); encourage safe eating practices. -The resident was at risk for aspiration. Encourage resident to attend meals in the dining room. Encourage proper positioning for meals in upright position -Instruct resident to eat slowly and to chew each bite thoroughly -Monitor, document and report if the resident experienced difficulty swallowing; holding food in mouth; prolonged swallowing time; repeated swallows per bite; coughing; throat clearing, drooling; and pocketing food in mouth. Occupational therapy assessment dated [DATE], read in pertinent part: Resident #53 will improve the ability to safely and efficiently perform eating tasks with supervision or touching assistance with the use of a built up spoon to facilitate the ability to live in an environment with least amount of supervision and assistance and to ensure adequate nutrition and hydration. Resident #53's November 2022 CPO revealed a diet order: Regular diet regular texture with thin (regular) consistency liquids. Facility dietitian note dated 9/14/22 at 4:23 p.m. read in part: Weight warning: positive 10.0% change. Nutrition at risk review. Reason for review: significant weight gain. Current weight: 282 lbs. Diet: Regular consistency with thin liquids. Intakes: 75-100%. Supplements: none (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Meal Assistance: full assist often. -Summary/Recommendations: Resident triggers for significant weight gain after weight loss six months ago. Current weight back to previous weight range this past quarter. Alert and oriented times one. Unable to answer questions appropriately. Receives regular portions. Will monitor weights monthly. V. Resident #95 A. Resident status Resident #95 age 75 was admitted on [DATE]. According to the November 2022 CPO, diagnoses included dementia with behavioral disturbance, anxiety, diabetes mellitus with insulin dependence, need for assistance with personal care, and depression. The 9/17/22 minimum data set (MDS) assessment revealed the resident had severely impairment cognition and was not assessed by the BIMS exam. The staff assessment of the resident revealed the resident had short and long-term memory impairment and was not able to recall the current season, location of room, staff names or faces, or that she was in a nursing home. The resident did not present with behaviors or reject care. The resident needed extensive assistance from staff to complete activities of daily living (ADL) including eating meals and snacks where staff provided significant/maximal assistance where staff performed more than half the effort for the resident to be successful with eating meals. B. Record review Resident #95 ' s comprehensive care plan revealed the resident was at risk for nutritional problems. A care focus revised on 9/27/22 documented the resident ' s goal for the care need was that the resident will not develop complications related to weight status. Interventions included: Provide, serve diet as ordered and monitor intake. Resident #95's November 2022 CPO revealed a diet order: Regular diet regular regular texture with thin (regular) consistency liquids. Facility dietitian note dated 11/5/22 at 1:04 p.m., read in part: Nutrition at risk review. Reason for review: weight loss. Current weight: 129.5 lbs. Weight change: 8 lbs loss since admission Diet: regular/regular/thin. Intakes: 0-50%. Supplements: house made shake twice a day. Meal assistance: set up and encouragement. -Summary/Recommendations: Resident with weight loss since admission. Intakes are erratic and poor. Slight improvement in intakes since Monday. House made shakes twice a day. Resident accepted 69%; providing 1000 calories (cal) per 7gram (g) of protein. Will not accept feeding assistance with meals. Fluids are encouraged but not always accepted. Current intakes may not consistently meet estimated needs. Will continue regimen for this week for continued improvement. Monitor weekly. Review of progress notes, from September 2022 to November 2022, revealed the resident had fluctuations in eating. Sometimes eating on her own and sometimes accepting staff assistance to eat meals. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	VI. Staff interviews CNA #12 was interviewed on 11/17/22 at 12:32 p.m. CNA #12 said each CNA could only provide feeding assistance to one resident at a time. The CNAs were not supposed to go between residents to provide simultaneous feeding assistance. Despite this, CNA #12 felt the facility provided sufficient staff to fully assist, in a timely manner, all the residents who needed feeding assistance and monitoring in the assisted dining room. CNA #12 said as far as she knew none of the residents who use the assisted dining room needed any type of adaptive equipment for eating. The CNA confirmed all residents were currently using plastic utensils and foam plates; and as far as she was aware none of the residents were supposed to be provided any specialized adaptive equipment for the meal. Speech therapist (ST) #1 was interviewed on 11/17/22 at 12:40 p.m. ST #1 said she had been assisting residents in the assisted dining room for a month now for therapeutic swallowing therapies and as far as she was aware none of the residents were provided adaptive eating equipment. ST #1 said she was aware the interdisciplinary team (IDT) had recently met and ordered specialized cups for resident tremors so they would not spill liquids on themselves; but that was the extent of adaptive equipment being used at this time. The registered dietitian (RD) was interviewed on 11/17/22 at 1:30 p.m. The RD said she had not observed the assisted dining room lately. The RD said recommendations for resident feeding assistance and need for adaptive equipment came mainly from occupational and speech therapy assessments of the resident ' s eating. The number of residents in the facility with complex eating needs was high and the staff did the best they could to meet those needs. The director of nursing was interviewed on 11/17/22 at 5:17 p.m. The DON said Resident #53 needed total feeding assistance due to a neurological condition. Staff should sit when providing feeding assistance and talk with the resident during the meal and begin feeding assistance as soon as the food was delivered to the resident. The DON acknowledged the resident was impulsive and needed prompts to chew food fully and not choke. The staff should never deliver a resident food and walk away if they cannot get right back to assist the resident with their meal; the meal could get cold. The DON was not aware of Resident #15 or #95 ' s adaptive eating device needs. The DON acknowledged that Resident #95 needed cuing and occasional feeding assistance during the meal service. The dietary manager (DM) was interviewed on 11/17/22 at 5:30 p.m. The DM said the kitchen did not give direction on the resident eating needs but the kitchen could meet with the IDT to make sure the resident received appropriate food textures and had available adaptive equipment as needed. The DM said he would meet with the DON and RD to make sure the resident needs were being met.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on observations, record review and interviews, the facility failed to prevent development of pressure ulcers for two (#14 and #101) of four residents reviewed for pressure ulcers of 49 sample residents. Specifically, the facility failed to prevent avoidable pressure ulcers and to provide necessary services to promote healing and prevent new ulcers from developing. The facility failed to obtain physician orders for pressure ulcer prevention, to update the resident's care plan, to implement interventions, and to monitor the effectiveness of interventions for Residents #14 and #101. Due to the facility's failures, Residents #14 developed an unstageable pressure ulcer to her right ischium (the area of skin covering the lower hip bone) that worsened to a Stage 4. Resident #101 developed a deep tissue injury pressure ulcer to his right heel and unstageable pressure ulcer to his coccyx. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf on 11/21/22, pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf (retrieved 11/22/22): (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Skin assessment is crucial in pressure ulcer prevention because skin status is identified as a significant risk factor for pressure ulcer development. The skin can serve as an indicator of early pressure damage. Skin and tissue assessment underpins the selection and evaluation of appropriate preventive interventions. Repositioning involves a change of position in the lying or seated individual, with the purpose of relieving or redistributing pressure and enhancing comfort. Repositioning and its frequency should be considered in all at risk individuals and must take into consideration the condition of the individual and the support surface in use. Repositioning should maintain the individual's comfort, dignity and functional ability. Support surfaces are specialized devices for pressure redistribution and management of tissue load and microclimate. The importance of using a high specification pressure redistribution support surface in all individuals at risk of pressure ulcers or with existing pressure ulcers is highlighted. Individuals with a medical device are at a high risk of pressure ulcers related to the device. These pressure ulcers often conform to the pattern or shape of the device and develop due to prolonged, unrelieved pressure on the skin, often contributed to by associated moisture around the device, impaired sensation or perfusion and/or local edema, as well as systemic factors. Assessment of skin that is placed at risk due to a medical device is highlighted. II. Facility policy and procedure The facility policy and procedure regarding prevention and care of pressure ulcers was requested on 11/17/22 and was not received. III. Resident #14 A. Resident status Resident #14, age 70, was admitted on [DATE], discharged to the hospital on 10/14/22 and readmitted on [DATE]. According to the November 2022 computerized physician orders (CPO) diagnoses included dementia, major depression, lack of coordination, need for assistance with personal care, and muscle wasting. The 10/21/22 minimum data set (MDS) assessment revealed that the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) of 11 out of 15. The resident was totally dependent on staff to complete activities of daily living including assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was at risk for developing pressure injuries; had one unstageable pressure ulcer; and used a pressure reducing device in her wheelchair and was on a turning/repositioning program. B. Observations On 11/14/22 at 10:45 a.m. Resident #14 was asleep in a semi-reclining position in her bed and her legs were folded slightly to her left side. The resident was lying on an alternating air mattress, had a pillow beneath her head, and was covered with bed linens. Resident #14 was interviewed on 11/16/22 at 9:55 a.m. The resident said repositioning was difficult for her because her pressure ulcer was painful. The resident described the ulcer pain as constant and burning and not having relief. The resident said she expected to have some pain because she had a pressure wound. The resident reported she received narcotic pain medication prior to dressing changes which helps reduce her pain during wound care to a tolerable level. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 11/16/22 a continuous observation was made from 9:55 a.m. through 12:20 p.m. During the observation period the resident was awake in her bed and was served her lunch. At 12:20 p.m. the resident was observed in the same position as she was observed at 9:55 a.m., lying in her bed in a semi-reclining position, on her left side. The resident was not offered any repositioning over the two hour period. On 11/17/22 at 9:30 a.m., Resident #14 was observed during a wound care procedure performed by the resident's wound physician. The resident's right ischium pressure wound was covered by whitish yellow slough and necrotic (both dead tissue). The skin surrounding the wound was a purplish color. The wound physician performed surgical debridement to remove some of the dead tissue from the wound. The wound physician said the wound was starting to spread underneath the top layer and edge of the wound and said the skin surrounding the wound appeared to have a fungal rash. The wound physician recommended changes to the resident's wound care, suggesting the skin surrounding the wound be treated with an antifungal barrier cream. The wound care physician said the wound was improved because there was less slough and the size of the wound was decreasing. Resident #14 was interviewed just after wound care and the dressing change Resident #14 said the staff had talked with her in the past and told her how important repositioning was to help heal her wound; the resident said she understood why the staff encouraged her to accept regular repositioning assistance. The resident said she depended on staff for repositioning due to her paralysis, contractures, and multiple sclerosis; and accepted the assistance whether or not she was in pain. C. Record review Resident #14's comprehensive care plan, revised 9/15/22, revealed the resident had a potential for altered skin integrity related to her decreased mobility, multiple sclerosis, paraplegia, dementia and chronic pain. Interventions included: alternating air mattress on bed; assisting the resident to reposition frequently; document any beginning stages of breakdown; notify wound consultant/nurse and MD (medical doctor); follow skin breakdown protocol and take above measures to prevent further breakdown and promote healing. Perform labs and administer medications,as ordered. Observe and report any changes to skin integrity such as discoloration, blisters, open areas, injuries, provide diet as ordered, provide treatments as ordered, and reinforce the importance of mobility, turning, repositioning of pressure ulcers. The Weekly Head to Toe Skin Check Assessments dated 7/20/22, 8/17/22, and 8/25/22 revealed the resident's skin was clean, dry, and intact. A skin check assessment dated [DATE] revealed the resident had a new skin tear to the right buttock that measured 0.3 cm x 0.2 cm. The assessment gave no other details. A skin check assessment document dated 9/13/22 revealed the resident had a small post surgical wound on the right iliac crest (the upper bone of the pelvic region). -There were no skin assessment notes in the resident's chart until 10/6/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound physician assessment dated [DATE], revealed the resident had developed an unstageable pressure wound on her right ischium (the area of skin covering the lower hip bone) due to necrosis (dead tissue). The pressure injury was facility acquired and had been present for at one day. The wound measured 3.2 centimeters (cm) by 4.0 cm by a non measurable depth. The wound was unstable or due to being covered with 100% slough (whitish yellow stringy dead tissue). The wound was cleansed with normal saline and cleaned by surgical technique. The physician removed a depth of 0.2 cm of dead tissue to reveal healthy bleeding tissue was observed. A weekly skin assessment dated [DATE], documented that the resident had developed a wound on the right bottock; there was no description or measurement of the wound. Wound physician note dated 10/13/22, revealed the resident's right ischium pressure wound remained unstageable due to necrotic dead tissue. The wound present seven days measured 3.2 cm by 4.0 cm and was covered with 80% slough and 20 % granulated tissue inflamed tissue with new capillaries. The skin surrounding the wound was macerated (wrinkly, soft and soggy). The resident was admitted to the hospital 10/14/22-10/17/22 for an medical reason unrelated to the resident pressure wounds. A readmission skin assessment completed on 10/17/22 indicated the resident had a right ischium wound that was unstageable and measured 3.2 by 4.0 cm. A description of the wound was not documented. The resident had a surgical incision present on her back where a nephrostomy tube was placed while she was at the hospital. Wound physician note dated 10/20/22, revealed the resident's right ischium pressure wound had deteriorated. The wound remained unstageable and now measured 5.5 cm by 4.5 cm with an unmeasurable depth due to thick adherent necrotic tissue. The wound was present for more than 13 days. The resident had a new unstageable deep tissue injury to the right sacral area (the coccyx - the skin covering the area between the end of the lumbar spine and the tailbone) measuring 3.2 cm by 2.0 cm. The injury was present for one day. Wound physician note dated 10/27/22, revealed the resident's right ischium pressure wound was improving and measured 5.0 cm by 4.0 cm the depth was unmeasurable. The wound remained unstageable with 80% slough and 20 % dermis viable skin. The wound was present for 19 days. The resident's unstageable deep tissue injury to the right sacral area measured 2.0 cm by 1.0 cm. The injury was present for seven days. A weekly skin assessment, dated 11/2/22 documented the resident's right buttock wound had slough and purulent (foul smelling) drainage. The assessment did not document measurements. Wound physician note dated 11/3/22, revealed the resident's right ischium pressure wound stage 4 pressure wound measured 4.0 cm by 3.5 cm the depth was unmeasurable with 80% slough and 20% dermis viable skin. The resident's unstageable deep tissue pressure injury to the right sacral area measured 1.9 cm by 0.8 cm. The injury was present for 13 days. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound physician note dated 11/10/22, revealed the resident's right ischium pressure wound stage 4 pressure wound measured 3.5 cm by 3.0 cm the depth was unmeasurable with 70% necrotic tissue, 10% granulation and 20% dermis viable skin. The wound was present for 31 days. The resident's unstageable deep tissue pressure injury to the right sacral area measured 1.0 cm by 1.0 cm. The injury was present for 19 days. Wound physician note dated 11/17/22, revealed the resident's right ischium pressure wound stage 4 pressure wound measured 3.2 cm by 2.8 cm the depth was unmeasurable with 60% necrotic, 10% slough, 10% granulation and 20% dermis viable skin. The wound was present for 37 days. The resident's unstageable deep tissue pressure injury to the right sacral area measured 0.5 cm by 0.5 cm. The injury was present for 25 days. The November 2022 CPO revealed the following orders related to wound care: -Cleanse wound on right buttock with wound cleanser apply skin prep to periwound, cover the wound with medi-honey, apply a silver alginate wound dressing (used to prevent or reduce infection), cover with foam dressing one time a day every other day. -Limit the resident's time in her wheelchair to one hour as the resident will allow, start date 10/7/22. -Turn resident frequently throughout the shifts, when in bed, start date 10/7/22. Review of the resident October and November 2022 treatment administration record (TAR) revealed the staff repositioned the resident 21 of 22 opportunities until 10/6/22. On 10/7/22 the order was changed to reposition the resident frequently during each shift. From 10/7/22 to 10/31/22 the TAR indicated the resident was repositioned each shift 42 of 43 opportunities and 11/1/22 to 11/17/22 the TAR indicated the resident was repositioned 27 of 29 opportunities. D. Staff interview Licensed practical nurse (LPN) #2 was interviewed 11/17/22 at 2:55 p.m. LPN #2 said the resident was dependent on staff for repositioning and preferred to be on her left side due to her contractures. The resident was alert and oriented and would sometimes refuse repositioning. The LPN said the resident had not been repositioned that afternoon because she was sleeping and appeared comfortable. The LPN did not want to disturb the residents. The LPN said when caring for a resident with pressure ulcers staff was expected to provide care assistance to provide repositioning and help the resident offload to relieve pressure on vulnerable areas of the body. III. Resident #101 A. Resident status Resident #101, age 89, admitted on [DATE]; discharged to the hospital on 11/6/22; readmitted on [DATE]; discharged to the hospital on 11/14/22; and readmitted on [DATE]. According to the November 2022 CPO diagnoses included type 2 diabetes mellitus, atrial fibrillation, neuropathy, need for assistance with personal care, and dislocation of lumbar vertebra. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 9/28/22 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. The resident required limited assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was at low risk for pressure ulcers. B. Observations On 11/14/22, the resident was observed from 9:00 a.m to 11:30 a.m. The resident was laying in bed with the head of the bed up at 30 degrees propped up with a pillow to the left side. The resident had not been repositioned during the observation. On 11/16/22 a continuous observation was made from 10:00 a.m. to 12:20 p.m. The resident was sleeping, lying on his back. His head was on a pillow and he had one heel protector in place on his right foot. The resident had not been repositioned during this continuous observation. C. Record review The Braden Scale assessment dated [DATE], (a tool used to determine a resident's risk for pressure ulcer development), documented Resident #101 was a low risk for developing pressure ulcers. The Weekly Head to Toe skin check on 10/15/22, 10/29/22 and documented the resident had no skin issues. -There were no weekly skin checks for the other weeks since admission on 9/22/22 that were present in the resident chart. The 11/11/22 hospital discharge note revealed the resident had a facility acquired pressure injury related to tissue damage on his right heel and sacrum that were present when the resident was admitted to the hospital on 11/6/22. On 11/11/22 the readmission nurse documented a pressure wound on the residents coccyx and a deep tissue injury on the residents right heel. There were no descriptions or measurements of either wound. Review of resident #101's November 2022 CPO revealed the following physician order: -Coccyx wound care cleanse with wound cleanser, pat dry, apply medi honey and alginate and cover with foam dressing, one time a day, every other day for wound care. The order started on 11/12/22. The comprehensive care plan updated on 11/15/22 identified the resident had a pressure injury. Interventions included to complete the Braden Scale, preform weekly skin inspection, do not massage over bony prominence, float heels, heel boots, nutritional and hydration support, preventative foot care shoes, inserts, pads, provide pressure reducing wheelchair cushion, provide pressure reduction/relieving mattress, provide thorough skin care after incontinent episodes and apply barrier cream, administer treatments as ordered. Wound physician note dated 11/17/22, revealed the resident was seen for an initial consultation by a wound specialist. The note documented the resident had: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-An unstageable deep tissue pressure injury to the right heel. The wound was present for less than two days. The wound measured 4.2 cm by 4.2 cm, the depth was not measurable. -An unstageable pressure injury to the sacrum/coccyx, present for less than two days. The wound measured 11.5 cm by 3.0 cm the depth was not measurable due to the presence of necrotic dead tissue. The skin surrounding the wound was purplish maroon in color. -Recommendations included: wound care and offloading and repositioning for pressure relief. D. Staff interviews The director of nursing (DON) was interviewed on 11/17/22 at 5:30 p.m. The DON said staff were expected to follow facility protocol and physician orders and offload pressure points and assist dependent residents with repositioning in order to promote healing and prevent pressure wounds. The DON stated when a resident refused positioning the nurse should make notes in the record and the physician needs to be notified.

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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** 47536 Based on observations, record review and interviews, the facility failed to ensure supervision and assistive devices to prevent accidents for three (#34, #62 and #4) four residents reviewed for accidents/hazards out of 49 sample residents. Specifically, the facility failed to prevent residents at risk for falls from having repeated falls, falls with injury, and major injury. Resident #34 experienced multiple falls while a resident of the facility. Resident #34 was assessed to have had poor balance, unsteady gait and poor safety awareness. The resident was blind and had severely impaired cognitive impairments, however, the resident's fall prevention care plan lacked any specific person centered interventions which would be appropriate for the blindness and the cognitive impairments. The facility failed to implement effective fall precautions. As a result, the resident had multiple falls causing pain and injuries. On 2/12/22 the resident fell and hit her head on the floor. The fall caused the resident pain and required pain relief medication. On 5/28/22 the resident fell and hit her head on the floor. The physician determined x-rays of her skull were necessary. On 6/14/22 the resident fell to the floor and had hip pain. The resident had pain and x-rays were ordered for evaluation. On 9/6/22 the resident fell to the floor and had severe hip pain. She was transferred to the hospital for evaluation and it was determined she had a fractured right hip that required hip replacement surgery and hospitalization . On 9/21/22 the resident fell and had pain in her wrist and required narcotic pain relief medication. She was transferred and evaluated at the hospital where it was determined she had a non operable wrist fracture that required use of a soft cast for healing. On 9/28/22 the resident fell and hit her head. She required x-rays of her previously fractured wrist and pain relief medication. On 10/22/22 the resident fell to the floor and had pain in her hip. She was transferred to the hospital emergency department for evaluation and it was determined she had a chronic non operable thoracic spine fracture and returned to the facility. In addition, the facility failed to: -To assess risk and maintain safety for Resident #62, who verbalized a desire to go home and then left the facility; and, -To assess Resident #4 for community awareness and ensure adequate supervision to prevent an accident/hazard. Findings include: I. Resident #34 A. Professional reference (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to [NAME], P.A., [NAME], A.G. , et.al. Fundamentals of Nursing, ninth ed., 2017, pp. 375: Falls are a major public health problem. Among adults [AGE] years and older, falls are the leading cause of both fatal and nonfatal injuries. Numerous factors increase the risk of falls, including a history of falling being age 65 or over, reduced vision, orthostatic hypotension, lower-extremity weakness, gait and balance problems, urinary incontinence, improper use of walking aids, and the effects of various medications (e.g., anticonvulsants, diuretics, hypnotics, sedatives, certain analgesics). Common physical hazards that lead to falls in the home include inadequate lighting, barriers along normal walking paths and stairways, loose rugs and carpeting, and a lack of safety devices in the home. Falls are also a common problem in health care settings. Hospitals throughout the country carefully monitor the incidence of falls and fall-related injuries as part of their ongoing performance improvement work. Falls are often a combination of individual and transient risk factors, the physical environment (e.g., poor lighting, high bed position, improper equipment), and the riskiness of a person's behavior (unwilling to call for assistance when getting up). Falls often lead to serious injuries such as fractures or internal bleeding. Patients most at risk for injury are those with bleeding tendencies resulting from disease or medical treatments and osteoporosis. B. Facility policy and procedure On 11/17/22, a request was made to the nursing home administrator (NHA) for the facility's fall prevention policy; the policy was not provided during the survey. C. Resident status Resident #34, age 87, was admitted on [DATE], discharged to the hospital on 9/5/22 and readmitted on [DATE]. According to the September 2020 computerized physician orders (CPO) diagnoses included fracture of the right femur (hip), dementia, cognitive communication deficit, abnormalities of gait and mobility. On 10/1/22 she was admitted to hospice care. The 10/7/22 minimum data set (MDS) assessment showed the resident had severely impaired cognitive status with a score of four out of 15 on the brief interview for mental status (BIMS). The resident required one person extensive assistance from staff for bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and limited assistance for walking in her room and in the corridor. D. Observations On 11/14/22 at approximately 10:30 a.m., the resident was observed in her wheelchair near the nurses' station. Facility staff walked in the hallways, entered and exited other resident rooms. The resident was frequently without line of sight supervision. On 11/16/22 at 9:30 a.m., the resident sat in her wheelchair next to the nurses' station. There were no staff members present at the nurses' desk or in the hallways. The staff were observed as they entered and exited other resident rooms. The resident was frequently without line of sight supervision. At 9:50 a.m., the resident was observed sitting in her wheelchair in the middle of her room. The resident's room was near the nurses' station; however, she was not in the line of sight of staff members. The resident did not have her call light pull cord within her reach. C. Record review (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The progress notes indicated the resident had suffered eleven or more falls since admission on 9/17/20, and seven of those falls occurred in 2022. The falls were as follows: Fall #1 Nursing progress note dated 2/12/22 at 11:30 a.m., documented the resident stated she was standing and talking to her roommate for a long time, then slipped in her socks, tripped and fell . The nurse assessment revealed the resident hit her head and hip and she had pain requiring pain medication. It was determined that no injury occurred. The resident was educated she should sit in her chair while talking for long periods or use her walker for support. The note stated the resident was legally blind and the trip hazard was moved to the corner of the room. Interdisciplinary team (IDT) post fall review note dated 2/14/22 at 9:41 a.m., read: (Resident) was diagnoses dementia with behavioral disturbance, malnutrition, homicidal ideations. The resident's medications were reviewed, the care plan reviewed and updated. The IDT determined the root cause was the resident tripped over roommate's possessions. Intervention: Therapy to evaluate and treat. Therapy progress note dated 2/14/22 revealed the resident fell in her room, tripping over roommate's possessions. Resident #34 was to be evaluated by physical therapy to facilitate safety and functional mobility. The comprehensive care plan dated 1/18/22 documented the resident was at risk for falls. Pertinent interventions included, offer non-skid footwear, encourage resident to call for assistance with items not immediately in reach, encourage resident to use a wheelchair and monitor for resident impulsivity to decrease fall. -The care plan was updated on 2/25/22 to include therapy evaluation. The physician's assistant (PA) note dated 3/15/22 documented, the resident was observed standing in her room without an assistive device. She had good balance and gait (manner of walking). The PA recommended continue to monitor closely with frequent check-ins by staff for fall prevention. Fall #2 A nurse's progress note dated 5/28/22 at 7:53 a.m., documented the resident was observed as she fell backward and hit her head on the floor. The nurse assessment was completed and skull series x-rays were ordered. The 5/31/22 IDT post fall review note documented, the root cause was she slipped and fell backward. The care plan was updated to ensure she was wearing proper footwear at all times. Fall #3 A nurses's progress note dated 6/15/22 at 10:53 a.m., documented the resident was observed on 6/14/22 lying on the floor on her right side in her room. The resident complained of pain when the nurse touched her right hip. An x-ray film of the right hip was ordered and had no evidence of fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	TheIDT post fall review note dated 6/16/22, revealed the root cause of the resident's fall was the resident slipped and fell to the floor, she was not wearing socks. The care plan was updated to include, frequent checks by staff to meet resident's needs. Therapy progress note dated 6/16/22 documented the resident fell ambulating in the room while completing her morning routine. Resident #34 was currently receiving therapy services and would continue safety awareness education and training. A physician note dated 6/19/22 at 23:00 p.m., documented the resident requested to be evaluated but the staff had not been responding to her needs and wished to be transferred to the hospital. The physician documented he evaluated the resident in follow up to residents complaints and follow up for dementia, hypertension, and depression. It was noted by the physician the resident had confusion, was angry, agitated, and had a decreased mood. Fall #4 A nurse's progress note dated 9/6/22 at 4:46 p.m., documented the resident was found lying supine between her bed and bedside table. The resident screamed during the nurse assessment when her right hip was touched. The physician was contacted and ordered the resident be transferred to the hospital for evaluation. The resident sustained a right hip fracture and required hip replacement surgery. An IDT post fall review note dated 9/7/22 at 9:53 a.m., indicated: medications were reviewed. Root cause: resident tripped and fell in her room. The care plan was updated. Intervention: educate staff to ensure all articles are off floor room free of clutter. A therapy note 9/9/22 at 3:23 p.m., documented the resident's fall incident was discussed with the IDT. Resident fell in her room, was sent to ED (emergency department) for evaluation, will complete therapy evaluation upon return. The PA note dated 9/13/22 documented the resident had a mechanical fall with injury and the resident should continue with physical and occupational therapy. The PA noted the resident had a history of falling, had diagnoses of dementia and poor vision, and the facility should continue fall precautions per facility protocol. The care plan updated 9/17/22 indicated fall prevention interventions included: encourage resident to call for assistance with items not immediately in reach, frequent checks by staff to meet resident's needs, re-educate staff on use of non skid shoes and socks, resident to be in wheelchair near nurses station within sight while awake, staff to provide textured tennis ball attached to call light so resident can find it due to her low vision, staff to rearrange room for safety, therapy to evaluate and treat as indicated, therapy to evaluate for safety with transfers. Fall #5 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's progress note dated 9/21/22 at 6:53 p.m., documented the resident was heard yelling for help. The resident was found sitting on her buttocks in front of her bed holding her right hand and stated she thought she hurt her right wrist. The nurse assessment indicated the resident required narcotic pain medication after the fall. The resident was transferred to the hospital for evaluation of her painful and swollen wrist. The resident sustained a right wrist fracture from the fall that required wrapping with a soft cast. The IDT post fall review note dated 9/23/22 documented the root cause was self-transferring. Pertinent interventions were to: place a tennis ball on her call light so the resident can find easily secondary to poor eyesight. A nurse practitioner (NP) note dated # 9/22/22 documented the resident had a history of falling, had diagnoses of dementia and poor vision, and the facility should continue fall precautions per facility protocol for fall prevention. Fall #6 A nurse progress note dated 9/28/22 at 8:56 p.m., documented the resident was found lying on her right side on the floor in the hallway. Resident reported that she hit her head. The nurse determined that no injury was sustained. Resident complained of pain that required pain medication. An order was obtained to x-ray the previously fractured wrist. A NP note dated 9/28/22 documented the NP evaluated the resident for a recent fall with wrist fracture and did not indicate a plan for fall prevention. A PA note dated 9/29/22 documented the PA evaluated the resident for a recent fall and recommended the facility continue to follow facility protocol for fall prevention. A social services note dated 9/30/22 at 12:00 p.m., revealed the resident was referred to hospice services. An IDT post fall review note dated 10/3/22 9:20 a.m., indicated: the team reviewed and discussed resident's usual self-care and functional mobility performance as reflected in above evaluation. The note indicated the score was derived from an IDT review and discussion of activities of daily living (ADL) documentation, nursing progress notes, staff observations, nursing assessment/evaluation, and skilled therapy evaluation/notes. The following goals have been identified by the IDT: Resident did not reach her goals. discharged to Hospice services. The Hospice diagnosis: senile degeneration of brain. An IDT post fall review note dated 10/3/22 documented the root cause of the fall was ambulating without assistance and fell . Interventions put into place were to keep the resident in line of sight to prevent falls. Although the IDT note documented the care plan would be updated, it was not. Fall #7 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse progress note dated 10/22/22 at 6:30 p.m., documented the nurse responded to a loud noise and resident screaming for help. The resident was found sitting on her floor. Resident complained of excruciating pain to her right hip and tailbone area. The physician ordered to the transfer the resident to the hospital for evaluation. On 10/25/22 at 4:34 p.m., the PA evaluated the resident for a post-fall follow up. It was determined at the emergency department the resident sustained a thoracic spine fracture at the T12 level and it was thought to be chronic because the examination at the emergency department was benign. The IDT post fall review note dated 10/24/22 documented, the resident had a diagnosis of dementia, and was blind. The root cause was self- transferring. -The care plan was not updated after fall #7. A physician noted dated 10/24/22 documented the resident had a fall with injury and the plan was to continue to follow facility protocol. The physician noted the resident was unlikely to rebound from her injuries in sequence and discussed the plan to pursue hospice services. Fall risk assessment A falls assessment was completed following each of the resident's fall's. The assessment evaluated the resident status pertaining to falls within the last six months, medications used, memory and recall ability, vision, continence in the last 14 days, agitation in the last seven days, confinement to a chair, blood pressure, and gait analysis. The post fall assessments revealed the resident was: -On 2/12/22 at moderate risk for falls; -On 5/28/22 at moderate risk for falls; -On 6/15/22 at moderate risk for falls; -On 9/6/22 at moderate risk for falls; -On 9/21/22 at high risk for falls; -On 9/28/22 at high risk for falls; and, -On 10/22/22 at moderate risk for falls. E. Interviews Certified nurse aide (CNA) #13 was interviewed 11/17/22 at 10:50 a.m. The CNA stated the resident had several falls and because of staffing it was not always possible to keep the resident in line of sight due to staffing assignment. The CNA stated the resident would sometimes sit in her wheelchair next to the nurses' desk where the staff could watch the resident. The CNA was not aware of specific interventions for fall prevention except to keep a close watch on the resident so that she did try to stand up without assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed 11/17/22 at 12:45 p.m. LPN #2 said that the resident was identified as a fall risk based on her fall history. The LPN said a fall assessment was completed after a fall. When the doctor was notified after a fall the doctor would indicate what action was necessary for the resident. The LPN stated the staff could add what was needed like a fall mat and make sure the call light is in place within residents' reach. The LPN stated that Resident #34 was independent and mobilized throughout the facility when she was admitted to the facility and now she was wheelchair bound. The director of nursing (DON) was interviewed 11/17/22 at 5:30 p.m. The DON said Resident #34 was blind and impulsive, that she was not compliant and had gone downhill in her health. She stated Resident#34 had a right to fall. The facility staff recognized that she was impulsive and relocated the resident to a new room to be close to the nurses' desk where staff could watch her closely by keeping the resident in sight. The DON stated the resident received physical and occupational therapy and the facility staff tried the best they could to prevent the resident falls. 44949 II. Resident #62 A. Facility policy and procedure The Elopements policy and procedure, initiated 2018, was provided by the director of nursing (DON) on 11/17/22 at 6:05 p.m. It read in pertinent part, Staff shall investigate and report all cases of missing residents. When the resident returns to the facility, the director of nursing services or charge nurse shall: complete and file an incident report and document relevant information in the resident's medical record. B. Resident status Resident #62, age 77, was admitted on [DATE]. According to the November 2022 computerized physician orders, diagnoses included paranoid schizophrenia, dementia, and symptoms and signs of cognitive functions and awareness. The 8/4/22 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. It indicated the resident was independent with activities of daily living. It indicated the resident did not have signs of psychosis, no physical or verbal behaviors, and did not wander. C. Record review The 9/8/22 progress note indicated a nurse found the resident attempting to leave the facility through the front entrance. It indicated the resident said I'm going home and was reluctant to come back inside. The 10/31/22 progress note indicated staff found the resident sitting in the parking lot. It indicated the resident asked for a ride home. The resident was agreeable to come into the facility and the nurse was notified to check on the resident frequently. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing home administrator (NHA) provided psychiatrist notes for Resident #62 on 11/17/22 at 1:30 p.m. On 11/8/22 the resident was seen by the psychiatrist and the notes indicated the resident was having delusions that she was going home and people were outside waiting for her. The behavior care plan, revised 5/17/22, indicated Resident #62 experienced delusions where they made her vomit and a history of suicidal ideations. Interventions included performing care when resident was calm, explaining care prior to and during the process of care, involving family as necessary in behavior management, redirection, and reorientation. -There was not a care plan related to wandering or elopement behaviors. -There was no wandering or elopement assessment. The treatment administration record indicated behavior tracking for antipsychotic use as evidenced by distressing delusions. No delusions were indicated for September, October and November 2022. D. Interviews Registered nurse (RN) #2 was interviewed on 11/16/22 at 4:02 p.m. She said Resident #62 did not have behaviors and had no history of elopement. Certified nurse assistant (CNA) #6 was interviewed on 11/17/22 at 10:05 a.m. She said she was not sure if Resident #62 had a history of elopement. RN #3 was interviewed on 11/17/22 at 11:49 a.m. She said Resident #62 stayed in her room a lot and was not an elopement risk. The director of nursing (DON) was interviewed on 11/17/22 at 1:38 p.m. She said Resident #62 had a diagnosis of paranoid schizophrenia and had frequent paranoia. She said the resident preferred to stay in her room but would work with physical therapy. She said the resident had been found outside of the facility a few times and she was confused. She said the events appeared to be isolated and the resident had not attempted to elope again. She said any attempt to leave the facility would require an assessment related to wandering. She said she was unsure if the resident had an assessment completed for wandering or elopement and she was unsure if a WanderGuard was an option for the resident. The social services director (SSD) was interviewed on 11/17/22 at 2:56 p.m. She said Resident #62 experienced distressing delusions. She said there were a few times the resident had left the facility but was easily redirected inside by staff. She said the resident was experiencing a delusion when she left the facility and said she wanted to go home. She said the care plan should be updated to include wandering or elopement behaviors. She said the resident enjoyed sitting outside and was allowed to sit outside if she wanted but should notify the nurse first. 31821 III. Resident #4 A. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #4, age 61, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, diabetes Mellitus, and cerebral palsy. According to the 9/9/22 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had verbal and physical behaviors directed toward other symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. B. Record review The care plan, initiated 4/11/22 and revised 9/15/22, identified the resident exhibits and reports mood problems related to life circumstances, verbal outbursts towards staff. The resident makes false allegations against staff members. Residents would delay times of shower times and get out of bed. Interventions include offering grievance forms as needed. Monitor for increase in depression, anxiety, and address accordingly. Encourage residents to participate in activities outside of the room, including meals and other social activities. Validate residents' feelings and concerns, as needed. The care plan, initiated 4/11/22 and revised 9/15/22, identified the resident has a physical functioning deficit related to multiple sclerosis (MS). Resident has a left hand splint that is managed by therapy. Interventions include assistive devices for motorized wheelchairs. Inform the resident of risk of refusal of care. Resident required two person assistance for all ADL and transfers. Log note dated 11/7/22 at 3:02 p.m., revealed in pertinent part: Report received that the resident left the building at 9:30 a.m. this morning and did not give a description of where he was going. Resident is currently still not in the building and his cell phone is not going through. Director of nursing (DON), assistant director of nursing (ADON), and nursing home administrator (NHA) notified. Resident was self-responsible. Lakewood police department notified. Log note dated 11/2/22 at 7:03 p.m., revealed in pertinent part: Resident left the building this morning at 9:30 a.m. Medications were administered per physician's order. Resident stated I would be back by 3:00 p.m., it is currently 7:05 p.m., and he is not back yet. DON, and NHA were notified. NHA stated to tell the night nurse to call him if the resident is not back by 8:00 p.m. Written request for missing person investigation for Resident #4 was given to the nursing home administrator on 11/16/22 at 2:07 p.m., and again on 11/16/22 at 4:26 p.m. In addition, a request for Resident #4 sign out sheet, facility off ground assessment, and education for Resident #4's safety of campus. C. Interviews The social services director (SSD) and nursing home administrator (NHA) were interviewed on 11/16/22 at 10:46 a.m. The NHA said Resident #4 was his own person and he could leave the facility as long as he signed out and gave a description of where he was going and when he would return. The SSD said there was no assessment completed for Resident #4, which identified if Resident #4 was safe to go out into the community. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA said there was an assessment which assessed the resident's ability to use his power chair indoors but there was not an assessment for residents community use. The SSD said the facility had not received a report on condition of Resident #4 or if Resident #4 would return to the facility. At time of facility exit facility on 11/17/22, documentation was not provided including the resident's sign out sheet, facility off ground assessment and safety education for Resident #4.

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F 0690 Level of Harm - Minimal harm or potential for 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** 47536 Based on resident observations, record reviews, and interviews, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections for one (#82) of two residents reviewed for urinary tract infections of 49 sample residents. Specifically, the facility failed to for Resident #82: -Provide timely nursing assessment of urinary status/condition when the resident experienced a change in condition consistent with a urinary tract infection; and, -Ensure the consistent nursing assessment and catheter care for a placed indwelling urinary catheter to ensure urinary health. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G. , et.al. Fundamentals of Nursing, tenthed., 2021, pp. 1155,-1160: Urinary tract infections are the most common hospital acquired infection, accounting for up to 40% of infections reported by acute care hospitals. The major risk factors for catheter-associated urinary tract infection (CAUTI) are the presence of an indwelling urinary catheter and the length of its use. Effective prevention strategies that must be implemented to reduce the risk of CAUTIs include training and education of health care providers and increasing their awareness regarding basic infection control knowledge of optimal hand hygiene practices and methods for handling indwelling catheter and urine collecting systems appropriately, securing catheters properly, and maintaining unobstructed urine flow and closed sterile drainage system using sterile technique properly. Characteristics of Urine. Inspect the patient's urine for color, clarity, and odor. Monitor and document any changes. Color: Normal urine ranges in color from a pale straw to amber, depending on its concentration. Urine is usually more concentrated in the morning or with fluid volume deficits. As the patient drinks more fluids, urine becomes less concentrated, and the color lightens. Blood in the urine (hematuria) is never a normal finding. II. Facility policy The Urinary Tract Infections?Bacteriuria Clinical protocol policy, dated 2018, was provided on 11/17/22 at 6:30 p.m. It read in pertinent part: The staff and practitioner may identify individuals with possible signs and symptoms of a UTI (urinary tract infection). (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Signs and symptoms of a UTI may be specific to the urinary tract and/or generalized. The presentation of symptomatic UTis varies. -Nurses should observe, document, and report signs and symptoms (for example, fever or hematuria blood in the urine) in detail and avoid premature diagnostic conclusions. -The physician may help nursing staff interpret any signs, symptoms, and lab test results. Diagnosis must be based on the entire picture and not just on one or several findings in isolation. -The physician may order appropriate treatment for verified or suspected UTIs and/or urosepsis based on a pertinent assessment. III, Resident #62 A. Resident status Resident #82, under the age of 65, was admitted on [DATE]. According to the computerized physician orders (CPO), diagnoses included intracerebral hemorrhage (brain bleed), fibula (ankle) fracture, bilateral tibia (shin) fractures, acute kidney failure, benign prostate hypertrophy (prostate gland enlargement), retention of urine, communication deficit, and history of traumatic brain injury. According to the 9/9/22 minimum data set assessment (MDS) the resident had moderate cognitive impairment as evidenced by a score of 13 out of 15 on the brief interview for mental status (BIMS). The resident required extensive assistance from one or two staff members for transfers, bed mobility, toilet use, personal hygiene, dressing, and limited assistance from one staff member for eating, walking in the room, and locomotion on and off the unit. The resident was always incontinent of bladder and sometimes incontinent of bowel. B. Observation On 11/15/22 at 10:18 a.m., resident #62 was observed in his bed. The resident's urinary collection bag was observed attached to his bed frame. The collection bag was full and contained dark orange-brown colored urine. -The facility nurse did not assess this change in the resident's health or notify the resident physician in a timely manner for a request for the physician's assessment and treatment orders until two days after the potential symptoms of a urinary tract infection first appeared (see below). C. Record review The admission nurse assessment dated [DATE] at 6:42 p.m., revealed the Resident #62 had a 16 fr. (French) newly placed indwelling urinary catheter. The assessment failed to include information regarding the appearance of the draining urine; the pertinent diagnosis for the indwelling catheter; whether or not catheter hygiene care was completed; and how the resident tolerated the device. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The November 2022 CPO failed to document a physician's order to the reason for the resident's catheter placement, orders for routine catheter care; assessment; maintenance to ensure proper function; placement of tubing; use privacy bag covers for the urine collection bag; and use of a leg bag for urine collection during waking hours. The physician's assistant evaluated the resident on 11/15/22, and the physician evaluated the resident on 11/16/22. Each evaluation documented the resident urinated well and did not differentiate if that pertained to before or after the catheter was placed. The evaluations did not include documentation regarding the diagnosis and rationale for the placement of the indwelling urinary catheter. Nurses progress note dated 11/17/22 at 10:46 a.m., documented the resident developed a body temperature of 102.5 and was transferred to the emergency department for evaluation. D. Interviews Licensed practical nurse (LPN) #2 was interviewed on 11/17/22 at 12:45 p.m. LPN #2 said when the nurse is caring for 26 residents the nurse does not have a whole lot of time to catch when the resident has a change in condition. The LPN stated when a resident had an indwelling urinary catheter, the nursing assistant was responsible for emptying the urine collection bag and completing catheter hygiene care. Therefore, the nurse depended on the certified nursing aide (CNA) to report and changes of condition discovered during routine care. When the CNA observed any changes outside of the resident's baseline condition or signs or symptoms consistent with illness while caring for the resident the CNA should have obtained a set of vital signs with a temperature, blood pressure and pulse and reported the symptoms to the nurse for further assessment. The LPN said the nurse was responsible to monitor and assess the status of the urine produced and collected. LPN #2 was interviewed on 11/17/22 at 3:30 p.m. LPN #2 said the resident was assessed at the hospital and was diagnosed with a urinary tract infection. The DON was interviewed on 11/17/22 at 6:45 p.m. The DON said nurses should check and monitor the position and fullness of the drainage tube and collection bag every shift. The DON stated dark colored urine in the collection bag was not normal and should have been evaluated when discovered. The DON stated the nurse was responsible to notice when the resident has a change in condition and should call the physician to report what was going on with the resident; not the CNA. The DON stated when a resident was admitted with a urinary catheter the admitting nurse should follow through to obtain physicians orders for the catheter, in order to maintain healthy bladder function. 41032

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure each resident received necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the residents choice for three (#96, #90 and #67) of four residents reviewed for oxygen therapy out of 49 sample residents. Specifically, the facility failed to: -Ensure Resident #96, and Resident #90 had complete oxygen orders to include a prescribed liter flow rate; -Ensure Resident #96, and Resident #90 had a person-centered care plan focus for oxygen therapy based upon the resident's assessed needs; and, -Ensure Resident #67's continuous positive airway pressure (CPAP) was cleaned per manufacturer's recommendations. Findings include: I. Facility policy The Oxygen Administration policy, dated 2020, was provided by the nursing home administrator (NHA) on 11/16/22 at 3:15 p.m. It revealed, in pertinent part, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. II. Resident #96 A. Resident status Resident #96, age 67, was admitted on [DATE]. According to the November 2022 computerized physicians orders (CPO), diagnoses included neurocognitive disorder with Lewy bodies (dementia), Parkinson's disease (brain disorder that causes uncontrolled movements), adult failure to thrive, need for assistance with personal care and anxiety disorder. The 10/31/22 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. She needed extensive assistance from two people for bed mobility, transfers and toilet use. She needed extensive assistance from one person for dressing. The assessment documented that the resident was not on oxygen therapy. B. Observation Resident #96 was observed on 11/15/22 at 11:32 a.m. She was sitting in her wheelchair in her room receiving oxygen therapy at 2 liters per minute (LPM) by nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #96 was observed on 11/16/22 at 9:20 a.m. She was lying in bed receiving oxygen therapy at 2 LPM by nasal cannula. C. Record review The resident had a physician order reading: -Apply O2 (oxygen) to keep pt (patient) above 90%, ordered 11/16/22 (during the survey process). -The resident did not have an order for oxygen therapy prior to the survey process. -The resident's comprehensive care plan was reviewed on 11/16/22; the individualized comprehensive care plan failed to identify a care focus for oxygen therapy in their entirety. D. Staff interviews Registered nurse (RN) #2 was interviewed on 11/16/22 at 9:20 a.m. She said Resident #96 did not have a physician's order for oxygen therapy. She confirmed Resident #96 was receiving 2 LPM of oxygen through a nasal cannula. RN #2 said Resident #96 should have a physician order for oxygen therapy if she was receiving it. RN #2 said she would call the physician to confirm if Resident #96 should receive oxygen therapy and an order. RN #2 was interviewed again on 11/16/22 at 11:09 a.m. She said she contacted the resident's physician. The physician ordered for the resident to have oxygen therapy through a nasal cannula at 2 LPM until she was able to visit the resident. RN #2 said in reviewing the resident's medical record another licensed nurse had documented that the resident's oxygen level was low on 10/31/22. The licensed nurse that day initially administered the oxygen to help with the resident's low oxygen levels. The director of nursing (DON) was interviewed on 11/16/22 at 11:12 a.m. She said residents who received oxygen therapy should have a physician order with the liter flow included. She said residents should also have a care plan that indicated they were on oxygen therapy. The DON confirmed RN #2 had obtained an oxygen order from the physician on 11/16/22 (during the survey process). She said the resident should have had a physician's order for oxygen before it was originally administered. 31821 III. Resident #90 A. Resident status (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #90, age 87, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included Heart failure, dysphagia (swallowing difficulty), and lack of expected normal physiological development in childhood. According to the 9/21/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had disorganized and incoherent rambling. He required extensive assistance for bed mobility, transfers, grooming and toilet use. The MDS assessment revealed the resident was not receiving oxygen therapy. B. Record review Resident #90 did not have a care plan in place for oxygen. -The November 2022 CPO did not include a physician's order for oxygen. C Observation On 11/14/22 at 2:24 p.m., the resident was sleeping in bed. The resident was wearing his oxygen cannula while sleeping. The resident's oxygen concentrator was set on two liters per minute (LPM). On 11/15/22 at 8:45 a.m., the resident was sleeping in bed. His oxygen concentrator was turned off. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 11/15/22 at 8:45 a.m. CNA #4 said Resident #60 was always taking his oxygen cannula off. CNA #5 said he would tell the nurse when he saw a resident not wearing their oxygen. The director of nursing was interviewed on 11/17/22 at 10:52 a.m. She said oxygen was a medication. She said the oxygen should be administered as the provider ordered it. The DON said Resident #90 should have had the physician order in place for his continuous oxygen and he should have had a care plan identifying his oxygen use. The DON said a negative outcome from not being administered oxygen when ordered could be altered mental status, dizziness, falls, and hypoxic events and could have put the residents in respiratory distress. IV Resident #67 A. Resident status Resident #67, age 60, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included heart failure, chronic respiratory failure with hypoxia, diabetes mellitus, chronic kidney disease, and chronic obstructive pulmonary disease. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 10/31/22 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no behavioral symptoms. She limited assistance for bed mobility, transfers, grooming and toilet use. The resident was receiving oxygen therapy. B. Observation resident interview The resident was observed in her room on 11/17/22 at 3:14 p.m., sitting in her recliner watching television. Resident #67 said she used her continuous airway pressure (CPAP) every evening. She said no staff had cleaned her CPAP machine since she had been in this facility. She said she even has to fill her water on her CPAP machine herself. C. Record review The care plan, initiated 6/7/19 and revised 10/30/22, identified the resident was at risk for impaired gas exchange related to chronic obstructive pulmonary disease (COPD). Resident #67 wears oxygen and has a continuous positive airway pressure (CPAP) at night for obstructive sleep apnea (OSA). Interventions include clean CPAP weekly. Verify that CNA has cleaned CPAP (mask & Tube) with warm water & mild soap (agitated for 5 minutes) , rinse, then hang to air dry. The November 2022 CPO included an oxygen order dated 9/8/22 for O2 at 4 liters per minute (LPM) continuously via nasal cannula every shift due to diagnosis of pneumonia. -No records were found indicating when the CPAP was cleaned and by whom. D. Staff interview CNA #4 was interviewed on 11/17/22 at 3:58 p.m. CNA #4 said Resident #67 did wear oxygen and it was supposed to be continuous. CNA #4 said Resident #67 used a CPAP at night. CNA #4 said, I think the evening shift cleans the CPAP machine. CNA#3 was interviewed on 11/17/22 at 4:05 p.m. CNA #3 said Resident #67's CPAP machine was cleaned by evening shift. CNA #3 said if any record of cleaning the CPAP would be located in the miscellaneous tab on the computer. The director of nursing was interviewed on 11/17/22 at 4:35 p.m. The DON said any resident who had a CPAP in the facility should have it cleaned on a daily basis. She said it should be documented in the medication administration record (MAR) and in the treatment administration record (TAR). The DON reviewed the resident's medical chart and could not find any documentation of if or when the CPAP was cleaned. The DON said a negative outcome of not cleaning the CPAP could be the CPAP machine harboring germs. If the machine was not cleaned overtime bacteria could grow and get the resident sick.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observation, record review and interviews, the facility failed to ensure behavior monitoring was conducted for target behaviors related to the use of a stimulant for one (#62) of five residents reviewed for unnecessary medications of 49 sample residents. Specifically, the facility failed to track and document binge and purge behaviors prior to and after starting a stimulant medication for Resident #62. Findings include: I. Facility policy The Behavioral Assessment, Intervention, and Monitoring policy and procedure, initiated 2018, was provided by the director of nursing (DON) on 11/17/22 at 6:05 p.m. It read, in pertinent part, Behavioral symptoms will be identified using facility-approved behavioral screening tools and the comprehensive assessment. The facility will comply with regulatory requirements related to the use of medications to manage behavior changes. The interdisciplinary team (IDT) will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly. If the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood, and function. II. Resident #62 A. Resident status Resident #62, age 77, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included paranoid schizophrenia, dementia, and symptoms and signs of cognitive functions and awareness. The 8/4/22 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. It indicated the resident was independent with activities of daily living. It indicated the resident did not have signs of psychosis, and did not have physical or verbal behaviors. B. Observation Resident #62 was observed in her room on 11/15/22 at 2:02 p.m. The resident was in bed and had several jars of jam and other snack foods on her bedside table. The resident had a bin with a plastic liner sitting next to her bed. Upon exiting the room, the resident was heard making gagging noises and spitting. C. Record review The November 2022 CPO revealed the following: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Vyvanse capsule 10 milligrams one capsule by mouth in the morning for binge eating disorder ordered 11/11/22; -Behavior tracking for antidepressant use as evidenced by loss of interest ordered 6/22/22; -Behavior tracking for antipsychotic use as evidenced by distressing delusions ordered 6/23/22. The treatment administration record indicated behavior tracking for antipsychotic use as evidenced by distressing delusions. No delusions were indicated for September, October and November 2022. The behavior care plan, revised 5/17/22, indicated Resident #62 experienced delusions where they made her vomit and a history of suicidal ideations. Interventions included performing care when resident was calm, explaining care prior to and during the process of care, involving family as necessary in behavior management, redirection, and reorientation. The nursing home administrator (NHA) provided psychiatrist notes for Resident #62 on 11/17/22 at 1:30 p.m. On 11/8/22 the resident was seen by the psychiatrist and reported she threw up every day. The note indicated the resident was in her room and there was an emesis bowl beside her that was full of vomit. It indicated she denied making herself throw up but her throat was highly inflamed and her fingers were reddened. On 11/10/22 a physician note was completed and indicated Resident #62 was seen by the psychiatrists on the previous day. The note indicated staff had observed the resident inducing vomiting by sticking her fingers down her throat. The note mentioned possibly starting vyvanse (medication). On 11/13/22 a progress note was completed and indicated Resident #62 was on monitoring for a new order of vyvanse. It indicated no adverse reactions and the resident was pleasant and cooperative with care. On 11/14/22 a progress note was completed that indicated Resident #62 was continued on monitoring for a new order of vyvanse. It indicated no adverse reactions and the resident was tolerating it well. D. Staff interviews Registered nurse (RN) #2 was interviewed on 11/16/22 at 4:02 p.m. She said Resident #62 did not have behaviors. She said the resident was on medications related to schizophrenia and anxiety and the nurses tracked if the resident experienced hallucinations. She said the resident started taking vyvanse recently but there was no charting for it. She said she would expect charting and tracking binge eating in order to provide feedback to the physician. She said the certified nurse aides (CNA) would not document these behaviors but could notify the nurse if they observed behaviors. CNA #6 was interviewed on 11/17/22 at 10:05 a.m. She said Resident #62 did not have behaviors. She said if a resident had behaviors the staff was monitoring she could document in the resident's electronic health record. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 was interviewed on 11/17/22 at 11:49 a.m. She said a few staff members and the physician observed the resident attempting to purge after eating and vyvanse was started. She said she did not know if the resident's binge eating was being monitored. She said the resident did not have behaviors. The DON was interviewed on 11/17/22 at 1:38 p.m. She said the resident was experiencing episodes of vomiting and had recently started on vyvanse. She said for the vyvanse medication the facility should monitor binges and vomiting. She said the resident was monitored for 72 hours following the start of the medication but there should be more documentation in order to know if it was influencing binges and vomiting. The social services director (SSD) was interviewed on 11/17/22 at 2:56 p.m. She said Resident #62 had behaviors that involved delusions. She said the resident had said they make her vomit according to her care plan. She said the behavior tracking the nurses completed was related to distressing behaviors. She said she did not know if vyvanse medication was initiated for binge eating or vomiting since the psychiatrist ordered it. She said she would expect binge eating or vomiting to be tracked under delusions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on record review, observations and interviews, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards, for two of four medication rooms. Specifically, the facility failed to discard expired medical supplies and laboratory testing items. Findings include: I. Observations A. Medication room [ROOM NUMBER] On [DATE] at 9:05 a.m., medication room [ROOM NUMBER] was observed with licensed practical nurse (LPN) #1. The following was observed in the clean supply area: -17 vials which were labeled BD Universal Transport for viruses, chlamydia, mycoplasma, ureaplasma, expired on [DATE], which was 139 days prior. B. Medication room [ROOM NUMBER] On [DATE] at 1:30 p.m., medication room [ROOM NUMBER] was observed with registered nurse (RN) #3. The following was observed in the clean supply area: -Seven packaged kits labeled: Wolf Pak dressing change kit with cholera prep on step application, labeled with an hour-glass symbol and expired [DATE], 506 days prior; -One packaged kit labeled: Wolf Pak medical catheter insertion kit, labeled with an hour-glass symbol expired [DATE], 113 days prior; -One packaged item labeled: BD suf-T-intima safety y adapter, expired [DATE], 19 days prior; and, -One packaged item labeled: BD vacutainer eclipse blood collection needle, expired [DATE], 202 days prior. III. Staff interviews LPN #1 was interviewed on [DATE] at 9:20 a.m. She verified the BD packaged vials in medication room [ROOM NUMBER] was expired and said the items should be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #3 and LPN# 2 were interviewed on [DATE] at 1:40 p.m. regarding medication room [ROOM NUMBER]. RN#3 verified the BD packaged items were expired. She said the hourglass timer symbol on packaged supplies indicated the symbol was a use by date and the expired items should be discarded. LPN #2 said that it is the responsibility of the night shift nurse to review supplies on hand and review expired items for disposal. The director of nursing (DON) was interviewed [DATE] at 5:30 p.m. She acknowledged supplies should be removed and disposed of once the item had expired. She said if the expired items were used that expired item could increase a risk of infection or contribute to inaccurate laboratory test results.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821 Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the resident's cultural needs for one (#25) of one resident reviewed for nutrition out of 49 sample residents. Specifically, the facility failed to ensure reasonable efforts to meet the ethnic and cultural food needs of Resident #25. Findings include: I. Facility policy and procedure The Resident Food Preferences policy and procedure, dated September 2017, was provided by the director of nursing (DON) on 11/17/22 at 6:00 p.m. It revealed in pertinent part: Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative consent. II. Resident #25 A. Resident status Resident #25, age 94, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included pulmonary fibrosis, atrial fibrillation, anxiety, adult failure to thrive, dysphagia (swallowing difficulty), dementia and cognitive communication. According to the 9/24/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had difficulty staying on track and disorganized thinking. She required extensive assistance for bed mobility, transfers, grooming and toilet use. B. Record review The care plan, initiated 9/1/22 and revised 9/24/22, identified the resident had impaired communication due to: Non English speaking/Language barrier. Resident speaks Punjabe. Interventions include staff to engage family to assist in communicating needs when family is available. Nutritional assessment dated [DATE] at 5:15 p.m. documented in part: Cultural/religious food preference or considerations to include no meat or fish. Food and beverage preference dated 9/3/22 at 5:15 p.m., documented in part: Vegetarian, resident does not eat meat; (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vegetarian, resident does not eat fish; No animal broths; and The resident did not eat eggs. Lunch menu meal for 11/14/22 listed the following: Chopped steak with gravy; Oven baked potatoes; Green bean casserole; and, Bread/roll butter or margarine Lunch menu meal for 11/15/22 listed the following: Honey roasted chicken; Wild rice; [NAME] carrot; and, Bread/roll, butter or margarine. Lunch menu meal for 11/16/22 listed the following: Moroccan pork cutlet; Orzo Pilaf; Spinach and garlic; and, Bread/roll, butter or margarine C. Observations During the lunch meal on 11/14/22 at approximately 11:22 a.m. Resident #25 received her meal. The meal consisted of chopped steak with gravy, oven baked potatoes, and bread. Resident #25 did not eat her meal and picked at the potatoes. An unknown certified nurse aide (CNA) attempted to assist the resident with her meal but was unsuccessful. The CNA did not offer the resident an alternative. During the lunch meal on 11/15/22 at approximately 11:45 a.m. Resident #25 received her meal. The meal consisted of honey roasted chicken, wild rice, julienne carrots, and bread Resident #25 did not receive any cueing or encouragement to eat her meal. Licensed practical nurse (LPN) #3 asked Resident #25 if she was done and if she wanted to go back to her room. LPN #3 did not offer the resident an alternative meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the lunch meal on 11/16/22 at approximately 11:23 a.m. Resident #25 received her meal. The meal consisted of Moroccan pork cutlet, orzo pilaf, spinach and garlic, and bread. Resident #25 did not receive any cueing or encouragement to eat her meal. Licensed practical nurse (LPN) #3 asked Resident #25 if she was done and if she wanted to go back to her room. D. Staff interviews LPN #3 was interviewed on 11/15/22 at 11:50 a.m. She said she was familiar with Resident #25.She said Resident #25 did not understand English and she speaks a specific Indian dialect which no staff understands, which made communicating with her difficult. She said it was a hit or miss when it comes to communicating with Resident #25 and what she needs. The dietary manager (DM) was interviewed on 11/17/22 at 3:19 p.m. He said he was not too familiar with Resident #25 cultural food preferences. He requested Resident #25's meal ticket and he reviewed it. He said, Yep it identifies her as a vegetarian and no meat. He said the menus populate and apparently kitchen staff missed the resident's for preferences. He said a negative outcome would be the resident would stop eating and weight loss. He said, I would get the meal ticket addressed immediately. The registered dietitian (RD) was interviewed on 11/17/22 at 3:35 p.m. She said she had started providing oversight for this facility due to regional issues. She said she was not too familiar with Resident #25 but quickly reviewed her chart. She said she did see the resident cultural food preferences and stated that there had to be better communication between her and the DM to ensure resident's food choices were being met. She said bringing in the resident's family to assist with food choices and even bringing in food could help. She said a negative outcome would be a risk of weight loss.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41032 Based on observations, record review, and staff interviews, the facility failed to ensure food was prepared, stored, and served under safe and sanitary conditions to prevent the potential contamination of food and the spread of food-borne illness in one of one kitchens and one of two dining rooms. Specifically, the facility failed to: -Ensure food was served in a sanitary manner where staff did not handle resident ready to eat foods with bare unwashed hands; and, -Ensure staff performed proper hand hygiene prior to assisting a resident with their meal. Findings include: I. Professional standards According to the Colorado Retail Food Establishment Rules and Regulations (effective 1/1/19), retrieved online https://drive.google.com/file/d/18-uo0wlxj9xvOoT6Ai4x6ZMYliuu2v1G/view, 11/28/22; read: Employees are preventing cross-contamination of ready to eat foods with bare hands by properly using suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. II. Facility policy and procedure The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policies, dated 2018, was provided by the director of nursing (DON) on 11/17/22 at 6:30 p.m. It read in pertinent part: All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. -Contact between food and bare (ungloved) hands is prohibited. -Food service employees will be trained in the proper use of utensils such as tongs, gloves, and deli paper and spatulas as tools to prevent foodborne illness. III. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/22 at 11:45 a.m., certified nurse aide (CNA) #4 was observed serving lunch to a male resident in the assisted dining room. CNA #4 brought the resident a hamburger and set the meal up for the resident. CNA #4 open the resident's plastic silverware package and touched each utensil at the eating end with bare unwashed hands. Then the CNA handled the hamburger bun with bare hands; topped the hamburger with ketchup, lettuce and tomato and set the bun on top of the hamburger patty and cut the sandwich in half touching the bun with bare unwashed hands. The CNA handed the resident the half of the sandwich, handling it with bare unwashed hands. Next, the CNA brought the resident drinks handling the drinking cups over the top with bare unwashed fingers gripping the drinking edge of both cups. The resident proceeded to eat the sandwich and drink for the cups where the CNA had placed bare unwashed hands. CNA #4 left the dining room and returned at 12:02 p.m. with another food tray for a different male resident. CNA #4 set up the meal for the resident by removing the plastic wrap. The CNA opened the resident plastic utensils from a sealed plastic package, touching the eating end of each utensil with bare unwashed hands. CNA #4 then proceeded to dress the resident's hamburger and in the same manner as above; the CNA touched the sandwich roll with bare unwashed hands and cut the sandwich in half. Then the CNA picked up the half sandwich with bare unwashed hands and handed the roll to the resident. The resident then ate the sandwich. On 11/14/22 at 12:12 p.m. CNA #2 was observed picking up a used napkin and plastic spoon from the floor in the dining room. The CNA threw the item into the trash. The CNA then went to the paper towel dispenser without performing any type of hand hygiene the CNA removed the paper towel and wet it and approached a male resident to wipe his face and sat to assist the resident to finish his meal. On 11/15/22 at 11:39 p.m., CNA #2 was observed assisting a resident with their meal. The CNA mixed the resident's pureed food and spooned it onto a fork. Just before the CNA gave the resident a bite of food from the spoon, the CNA touched food on the spoon to her own bare skin on her wrist, and then spooned the food into the resident's mouth. IV. Staff interviews CNA #2 was interviewed on 11/15/22 at 12:42 p.m. CNA #2 said staff were not supposed to hand resident food with their bare hands. They could wash their hands and use a glove or use silverware to move food and assist the resident with food. CNA #2 said the staff should always wash their hands prior to assisting a resident with eating or any care task and in between helping other residents in the dining room. The director of nursing was interviewed on 11/17/22 at 5:17 p.m. The DON said staff should not hand resident food with their bare hands. The DON acknowledged the staff should use a napkin to hand a resident food or use utensils when they need to cut or assist the resident with eating.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821 Based on observations, record review and interviews, the facility failed to ensure that the hospice services provided meet professional standards and principles that applied to individuals providing services in the facility for one (#90) of two residents reviewed for hospice services out of 49 sample residents. Specifically, the facility failed to: -Have a written agreement to ensure for Residents #90, a written plan of care included both the most recent hospice plan of care and a description of the services furnished by the long term care (LTC) facility; and, -Ensure that the LTC facility staff provide orientation regarding the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff. Findings include: I. Resident #90 A. Resident status Resident #90, age 87, was admitted on [DATE]. According to the November 2022 computerized physician orders (CPO), diagnoses included heart failure, dysphagia (swallowing difficulty), and lack of expected normal physiology development in childhood. According to the 9/21/22 minimum data set (MDS) assessment, the resident was not administered the brief interview for mental status (BIMS). The resident had disorganized and incoherent rambling. He required extensive assistance for bed mobility, transfers, grooming and toilet use. The MDS assessment revealed the resident was receiving chospice care. B. Record review The care plan, initiated 4/28/22 and revised 9/21/22, identified the resident was receiving hospice care due to cerebral palsy. Interventions include encouraging socialization and activity daily as tolerated. Encourage visitors. Hospice services as ordered. Monitor for complaints or signs and symptoms of pain/discomfort and apply interventions as ordered. -The care plan failed to delineate the responsibilities of the facility versus what the hospice would provide in terms of services. -The facility failed to have the hospice aide/nurse notes available in the resident's medical chart at the facility. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The facility failed to have a designated staff member with a clinical background, coordinating care for the resident between the hospice agency and the facility. C. Interviews Hospice certified nurse aide (HCNA) #1 was interviewed on 11/15/22 at 10:58 a.m. HCNA #1 said he was in facility twice a week and provided bed baths and other activities of daily living (ADL) care for Resident #90. He said he had not received an orientation to the facility's policy and procedures. He said his documentation went to the hospice company and he gave facility staff a short verbal report if there were any issues. CNA #4 was interviewed on 11/15/22 at 8:54 a.m. He said Resident #90 did receive hospice services but he did not know when they came in. He said the hospice CNA gave the resident showers but he did not know if the resident refused any care. He said he never talked to the hospice CNA. Hospice registered nurse (HRN) #1 was interviewed on 11/15/22 at 9:16 a.m. She said she was in the facility once a week or as needed (PRN). She said she had been in the facility every day this week because the resident was having issues. She said Resident #90 was having aspiration issues and he had decreased oxygen saturation. She said she was familiar with the facility and with the residents' she provided care. She said she had not received any type of orientation from the facility. She said her documentation went to the hospice company and she gave facility staff a short verbal report if there were any issues. Licensed practical nurse (LPN) #2 was interviewed on 11/15/22 at 9:46 a.m. LPN #2 said Resident #90 received hospice care. He said, I don't want to speak to their services but I think nursing comes once a week and CNA comes twice a week. He said we would discuss the resident if there were any concerns such as medication showers or any other issues. He said the hospice book was at the nursing station. -At 10:01 a.m., LPN #2 stated, I was wrong, we do not have a hospice book at the nursing station. The director of nursing was interviewed on 11/17/22 at 10:52 a.m. She said she was not familiar with the regulation specific toward hospice care. She said she thought social services was the coordinator between all hospice providers but she was not for sure. She said she would check. She said the facility had no formal orientation for hospice aides. The director of nursing (DON) was interviewed on 11/17/22 at 10:52 a.m. She said she was not familiar with the regulation specific toward hospice care. She said she used to be the assistant director of nursing (ADON) and now was the DON so she was trying to get staff into place. She said the facility medical records department would get the notes from the hospice workers but the facility's medical records staff had been out on maternity leave and did not get any of the notes transferred into the resident's charts. She said the facility had no formal orientation for hospice aides. The DON was interviewed again on 11/17/22 at 1:20 p.m. She said the human resource staff would now be the coordinator of care between all of the hospice providers. She said the goal was to get the facility and hospice together to ensure all the required documentation was in the resident's chart and to ensure all care plans were addressing each provider's responsibilities.