STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Guy Gorman Sr Care Home	Highway 191 & Hospital Road Chinle, AZ 86503

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35588 Based on interview and record review, the facility failed to make residents personal trust fund money available on the weekends. In addition to not having access to their personal fund account on the weekend, residents could also only access up to $49 in cash from their personal fund account, otherwise a check was issued. These failures represented a systemic failure affecting all residents who had a personal fund account and did not honor the resident's right to manage their financial affairs including right to reasonable access to their funds which had the potential to diminish the residents' quality of life. Findings include: Review of facility census document provided upon entrance on 09/20/21 at 7:44 AM documented census of 58 residents. Review of Resident 46's (R46) record documented the resident was admitted to the facility on [DATE] with diagnosis including diabetes. R46's Minimum Data Set (MDS-assessment tool) dated 07/27/21 documented resident's brief interview of mental status score was 9, indicating moderate cognitive impairment. During an interview on 09/20/21 at 11:59 AM Licensed Nurse (LN)7 stated R46 was reliable and interviewable but primarily spoke Navajo. During an interview on 09/20/21 at 10:24 AM with Social Services Coordinator (SSC)2 providing Navajo interpretation and with assistance of pocket talker (Amplifier device for hearing impairment), when asked if resident had a personal funds account, R46 nodded his head and said yes. When asked if resident could access monies in his personal funds account over the weekend, SSC2 stated no. SSC2 further stated that residents can't get money from their personal funds on the weekends. They have to get money on Fridays, if they want money on the weekends. SSC2 stated that social services does not work on the weekends. When asked if SSC2 could ask this question to R46 to get R46's response, SSC2 asked question in Navajo and R46 confirmed that personal funds account monies could not be accessed on the weekends. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/21 at 2:28 PM Payroll Specialist (PS) stated that almost all residents in the facility have a personal funds account. PS stated that residents can access up to $49 in cash. PS describe process for residents to access personal funds in which Social Services (SS) brings a list of residents with their withdrawal request and she puts the money (up to $49 cash or check if amount is over $50) in an envelope and gives envelope to SS who distributes to residents. PS also stated that residents can come directly to her office to make withdrawal requests. When asked how residents access personal funds accounts on the weekends, PS stated that staff call her and she comes into the facility. PS stated that she lives next door to the facility in the apartments and she is always readily available and doesn't go anywhere. When asked how residents are informed of this process, PS stated that it is discussed in resident group/council meeting and SS informs residents. During a confidential interview (CI) on 09/23/21 at 4:41 PM CI stated that residents are not able to access their personal funds monies on the weekend, hours to access personal funds account is not posted in the building, staff is not always available when resident wants money, and $49 is maximum cash that residents can withdraw, otherwise a check is issued. During an interview on 09/24/21 about 9:30 AM PS stated that she doesn't go to [NAME] for shopping and instead has stayed in Chinle area for the past 2 years and staff and residents know they can call her on the weekends. PS confirmed banking hours or hours when residents can access their personal funds account is not posted anywhere but stated that it's general knowledge and everyone knows she's available and residents are informed in group meetings. PS stated that she relies on SS to help with resident requests for withdrawals and distribution of monies. Review of Resident 43's (R43) record documented the resident was admitted to the facility on [DATE] with diagnosis including stroke. R43's Minimum Data Set (MDS-assessment tool) dated 08/05/21 documented resident's brief interview of mental status score was 14, indicating intact cognition. During an interview on 09/24/21 at about 10:55 AM R43 was sitting outside main dining room. R43 was alert and oriented and stated that when he wants to get money from his personal funds account, he asks SSC2. R43 stated that SSC2 doesn't work on the weekends so he can't get his money on the weekends. When asked if he can go to anyone else to access his personal funds account, R43 stated PS and then stated that he can't go see PS's office because they were all told not to go there. R43 pointed to Administrative Offices. When asked if R43 was referring to PS's office in the Administrative area, R43 nodded his head. During an interview on 09/24/21 at about 10:50 AM LN2 stated that R11 is very alert and reliable and has a personal funds account with the facility. Review of Resident 11's (R11) record documented the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including chronic kidney disease. R11's Minimum Data Set (MDS-assessment tool) dated 06/20/21 documented resident's brief interview of mental status score was 15, indicating intact cognition. During an interview on 09/24/21 at 11:03 AM with Certified Nursing Assistant (CNA)34 providing Navajo interpretation R11 stated that she had a personal funds account and was unable to access personal fund monies on the weekends. Resident stated that she has to let SSC1 know by Friday as SSC1 is not here on weekends and PS is busy. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/21 at 12:13 PM PS stated that the facility does not have a written policy on personal funds including that $49 is the maximum cash allowed but it has been this way for a long time. PS confirmed that R43, R11 and R46 all had personal funds account. When informed of R43's statement that he was not allowed in Administrative area where PS office is located so he could access his money, PS stated that was true only during covid lockdown. PS stated that if residents requested funds greater than $50, she cuts a check and generally the resident's family assists with cashing the check. PS stated that typically residents personal funds account withdrawals are for clothing, shoes, or shopping outing purchases. When informed that some of these purchases would likely exceed $49, PS stated that since most residents in the facility have personal funds account, if all the residents ask for cash, she would not have enough cash in the till and have to go to the bank often.

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F 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. 35588 Based on interview and record review, the facility failed to ensure the facility's surety bond was set at an amount to cover the amount of money in the resident personal trust account. These failures represented a systemic failure affecting all residents who had a personal fund account and placed residents at risk to be unable to recover their money in the event of loss from their account funds. Findings include: Review of facility census document provided upon entrance on 09/20/21 at 7:44 AM documented census of 58 residents. Review of Chinle Nursing Home Bank Activity Report, dated 9/1/2021 - 9/30/2021, with print date of 09/23/21 at 3:34 PM, showed current residents had personal funds entrusted to the facility that totaled over $253,000. 00. Review of Continuation Certificate from insurance company, dated 7/1/2020, documented the facility's surety bond was for $110,000.00 and was effective for the time period of September 29, 2020 to September 29, 2021. During an interview on 09/23/21 at 2:28 PM Payroll Specialist (PS) stated that almost all residents in the facility have a personal funds account. When asked about the surety bond not covering the resident trust account, PS stated that the personal funds account total had really increased with stimulus and tribal monies received by residents and she should have increased the surety bond coverage and will do that immediately today. PS acknowledged the surety bond amount was insufficient to cover the higher balances of resident funds. During an interview on 09/24/21 at 12:13 PM PS stated that the facility does not have a written policy on personal funds but know that the surety bond should cover the resident trust account.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 35588 Based on interview and record review, the facility failed to ensure residents' have the right to formulate an advance directive (AD) when it did not periodically review AD with the resident/resident representative, for 8 of 16 sampled residents (R) (R49, R1, R46, R27, R36, R31, R7, and R47) reviewed for AD. AD preferences may change over time and systemic processes for periodical review of Advance Directives was not in place. These failures increased the risk of residents not being able to have their choices, needs, and preferences documented, honored, and respected when they were unable to make or communicate health care preferences. Findings include: Review of facility's policy, Advance Directive, review date 2/8/2017, documented 3. Upon admission by Social Services, all information related to Advance Directive will be available along with the form, to be signed by the resident, family member or legal guardian, making a decision or opting to refuse to make a decision regarding Advance Directive at this time. The policy did not delineate the various steps necessary to promote and implement these Advance Directive rights including identifying, clarifying, and periodically reviewing, as part of the comprehensive care planning process, the existing care instructions and whether the resident wished to formulate, change or continue these Advance Directive instructions. Review of Code of Federal Regulations S 489.100, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-489/subpart-I/section-489.100, last amended 9/15/21, defines an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Resident 49 Review of R49's Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions, signed and dated 2/24/20 by resident, showed a box labeled I do not choose to formulate or issue any Advance Directives at this time was checked. Review of resident's records on 9/21/21 did not show any documented evidence that the facility periodically reviewed or discussed Advance Directives with the resident/representative. Resident 1 Review of R1's Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions, signed and dated 2/2/11, showed a box labeled I do not choose to formulate or issue any Advance Directives at this time was checked. Review of resident's records on 9/14/21 did not show any documented evidence that the facility periodically reviewed or discussed Advance Directives with the resident/representative. Resident 46 (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R46's Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions, signed and dated 10/11/19, showed a box labeled I do not choose to formulate or issue any Advance Directives at this time was checked. Review of resident's records on 9/21/21 did not show any documented evidence that the facility periodically reviewed or discussed Advance Directives with the resident/representative. Resident 27 Review of R27's Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions, signed and dated 11/13/02, showed a box labeled I do not choose to formulate or issue any Advance Directives at this time was checked. Review of resident's records on 9/21/21 did not show any documented evidence that the facility periodically reviewed or discussed Advance Directives with the resident/representative. Resident 36 Review of R36's Acknowledgement of Receipt Advance Directives/Medical Treatment Decisions, signed and dated 2/23/21, showed a box labeled I have chosen to formulate and issue the following Advance Directives was checked. Below this section, boxes with blank spaces to enter date issued were shown for Living Will, Do Not Resuscitate, Do Not Hospitalize, Organ Donation, Autopsy Request, Feeding Restrictions, Medication Restrictions, Other Treatment Restrictions, Other Advance Directives. The box for Do Not Resuscitate was checked. Review of resident's records on 9/21/21 did not show any documented evidence that the facility periodically reviewed or discussed Advance Directives with the resident/representative. Resident 7 R7's Acknowledgement of Receipt-Advance Directives/Medical Treatment Decisions form indicated that This is to acknowledge that I have been informed in writing that I understand of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate and to issue Advance Directives to be followed should I become incapacitated. The form then had two boxes to choose from: 1. I have chosen to formulate and issue the following Advance directives. I understand it is my responsibility to provide the facility copies of all pertinent documentation which verify those advance directives specified below for placement in my medical record. In this section, the resident then would selection his choices (Living Will, Do Not Resuscitate, Do Not Hospitalize, Organ Donation, Autopsy Request, Feeding Restrictions, Medication Restrictions, Other Treatment Restrictions, and Other Advance directives). 2) I do not choose to formulate or issue any Advance Directives at this time. I want efforts made to prolong my life and I want life-sustaining treatment to be provided. Neither box had been checked to indicate the resident's wishes. However, under box #1 (chose to formulate the following Advance Directives) the Do Not Resuscitate box had been marked and dated 8/31/2018. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R7's clinical record did not reveal any other documented evidence that the facility had reviewed or discussed Advance Directives with the R7 and/or his representatives since his initial admission on 8/31/2018. Resident 31 R31's Acknowledgement of Receipt-Advance Directives/Medical Treatment Decisions form dated 6/27/2018 indicated that This is to acknowledge that I have been informed in writing that I understand of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate and to issue Advance Directives to be followed should I become incapacitated. The form indicated that the resident did not want to formulate an Advance Directive. There was no other documentation in R31's clinical record to indicate that Advance Directives had been discussed with the resident and/or his representative since 6/27/2018. Resident 47: R47's Acknowledgement of Receipt-Advance Directives/Medical Treatment Decisions form dated 5/7/2019 indicated that This is to acknowledge that I have been informed in writing that I understand of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate and to issue Advance Directives to be followed should I become incapacitated. Under the section indicating the resident and/or his representative chose to formulate an Advance directive, there was a check mark in the box indicating Do Not Resuscitate. There was no other documentation in the resident's clinical record to indicate that Advance Directives had been discussed with the R47 and/or his representative since 5/7/2019. *Interviews During an interview on 09/23/21 at 2:49 PM with another surveyor and Social Services Coordinator (SSC)2, SSC2 stated that Advance Directives (AD) are two things, if you want to be resuscitated if worse comes to worse or we will let you go. If they want tube feeding or no code. When asked further to describe and define AD, SSC2 stated that many residents don't want a Living Will because they have to go to court and settle that with the family. Regarding Power of Attorney (POA), SSC2 stated that family already have that and they provide that, if doctor says they need POA at the hospital, families provide that. Some of the residents can't make their own decisions so we tell the family they need to make a POA. SSC2 stated that AD is discussed with residents/representatives upon admission and when requested by doctor or family. When asked if AD is discussed periodically throughout the year or on routine basis such as quarterly care plan meetings, SSC2 stated that the facility has not had family involved in care plan meetings because we closed our doors to everyone because covid was so severe and care plan meetings were stopped in April or May 2020. SSC2 further stated that it their culture to not talk about death/dying so AD is not discussed. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/21 at 11:19 AM Director of Nursing (DON) stated that SSCs should be talking with residents/families about AD periodically. DON further stated that she spoke with SSC2 and asked about educational materials provided to residents on AD, including the frequency of when AD information is reviewed with residents and if AD is initiated by SSC after admission. Some of the residents have been in the facilities for a long time and have not had their AD reviewed since admission years ago. DON stated this was her expectations but this has not been done by SSC2. DON stated that AD change over time and are not set in stone from time of admission and need to be reinitiate over time; maybe one year after admission, AD need to be revisited. We don't just stop at the time of admission. 29642

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview and record review the facility failed to ensure one of 16 sampled residents, Resident (R) 2's privacy when they installed a camera in their bed room without evident resident/resident representative involvement and/or consent, and expressly prohibited in facility policy. Furthermore, the camera monitor was placed in the hallway near the communal area visible to any resident, visitor or staff in the area. This practice violated R2's right to personal privacy. Additionally, the facility failed to maintain confidentialty of resident's medical records when charting monitors were easily visable to other residents or visitors in the corridors. Findings: Review of the Electronic Health Record (E-HR) revealed the facility readmitted R2 on 05/07/21 following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection (C-diff is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 05 which indicates severe impairment of cognitive (intellectual activity such as thinking, reasoning, or remembering) abilities. Observed R2 sitting in a wheel chair beside the bed on 09/20/21 at 09:41 AM. A sign on the door read Contact Precautions (a type of isolation precautions) and personal protective equipment (PPE) was stationed outside the door. R2's room was on the Household 1 unit. During an observation and concurrent interview on 09/21/21 at 11:30 AM, R2 was sitting in a wheel chair beside the bed. Unit Aide (UA) 3 stated she used a lift to transfer R2 from the bed to the wheel chair, and confirmed R2 was on isolation for C-diff. On 09/22/21 at 08:24 AM observed R2 was sitting in a wheel chair beside the bed. On this day, R2 had a white cloth device wrapped around their torso encompassing the wheel chair. Certified Nursing Assistant (CNA) 18 was preparing to enter the room and stated, I'm gonna put [R2] in bed. CNA18 described the white cloth device as a positioner which keeps the resident upright. After donning (putting on) required PPE surveyor requested CNA18 ask R2 to remove the device. After looking at the device, CNA18 stated It is secured in the back, [R2] can not take if off. Observed the device was positioned high on 2's chest, approximately 1 inch below the neck. CNA18 confirmed the device had shifted during use and was not applied correctly. [Cross reference F604 and F689] During the same observation, CNA18 stated the camera was not set to face the resident. Observed a small white device with a lens on the movable overbed table pushed against the wall at the foot of the bed. After transferring R2 to the bed and completing her care, CNA18 positioned the camera to face the resident in bed. Upon exiting the room CNA18 showed the surveyor the camera monitor which was stationed at her charting desk in the hallway near the common area. On 09/22/21 at 09:37 AM observed the camera monitor for R2 faced into the hallway. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviewed Licensed Nurse (LN) 2 on 09/22/21 at 09:39 AM. LN2 confirmed she was the charge nurse for R2 and was familiar with their care. When asked about the camera in the room LN stated, That is a way we keep an eye on her sometimes. When asked how/why the camera was initiated, LN2 stated It all came from the top. We were informed it was going to be in there. It is part of monitoring. She further stated that when new things are implemented staff have to notify the family. During a concurrent review of the resident's paper chart, no consents were found. Interviewed Social Services Coordinator (SSC) 1 on 09/22/21 at approximately 10:00 AM regarding the camera in R2's room. SSC1 said the camera was for safety. When asked if she was involved in the decision to place the camera in the room she stated, No because it was just there. I'm not sure who made the initial decision to put it in there. When asked if the responsible party was aware of the use of a camera she stated, I believe so and indicated it would have been discussed at a care plan meeting. When asked what was discussed at the meeting she was unable to find any notes relating to that and stated, I have to get back with you on that. Documentation of the meeting was not provided during the survey. Additionally, SSC1 described in the beginning of the pandemic (the Public Health Emergency for SARS-CoV-2 was declared in March of 2020) families where included in The very first ones we had them on the phone. It worked good. [Now] it is only if the family request it. Further review of the of Annual MDS assessment dated [DATE] and the comprehensive significant change MDS assessment dated [DATE] both revealed R2's family did not participate in the assessments. During the same interview SSC1 described privacy concerns, First [R2's] privacy, notifying the family . she further explained it was a right to make a decision to have a camera or not. When asked if was a concern that other residents and visitors could see the monitor scree she stated, Absolutely. On 09/22/21 at 10:25 AM surveyor observed a small monitor on the charting desk near the communal area on Household 1 (R2's unit). A resident was fully visible lying in bed. The monitor was facing the corridor. CNA2 was asked what the monitor was for and she said it was to monitor R2. Someone was observed on the monitor to enter the room. CNA2 explained that it was UA33. UA33 was clearly observed on the monitor to don PPE and approach the resident in the bed. UA33 pulled the covers back to mid chest and leaned over the resident. Surveyor could see UA33 place something on the resident's hand. CNA2 explained UA33 was taking the resident's vital signs. UA33 went out of view for a few seconds then returned to the resident's bedside where she was could be seen providing care to R2. The monitor was not redirected away from the resident and was not turned off while the staff (UA33) provided care. UA33 was then observed to doff (remove) PPE and leave the room. After UA33 left the room, the resident was in full view on the monitor which sat on the charting desk facing the corridor. On 09/22/21 at 11:10 AM requested policy on the use of cameras in resident's room. During an interview on 09/22/21 at 12:06 PM the Director of Nursing (DON) and the Quality Assurance/Quality Improvement nurse (QAQI) was asked if there was a policy for use of cameras in resident room. The DON stated No, not for that. She further explained that the camera was utilized when a satellite building was being used as a COVID-19 unit and they continued the use of the camera because R2 had falls. QAQI nurse stated [R2] was crawling out bed. When asked if there were any consents obtained regarding the camera the DON stated, I gonna say yes because it has been a topic of discussion. Requested any documentation to support the use of the camera. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/22/21 at 02:00 PM, observed R2's image on the monitor lying in bed. The monitor was visible while walking past the CNA desk in the Household 1 corridor. There were approximately 6 other residents around the common area. On 09/22/21 at 04:10 PM, observed the monitor screen at the CNA desk in Household 1 faced the corridor. R2 could be seen lying in bed. room [ROOM NUMBER] was directly across from the CNA desk and a resident was in the door way with a clear un-obstructive view of the monitor. On 09/23/21 at 11:33 AM observed the camera monitor for R2 was no longer at the CNA desk. On 09/23/21 a search of scanned Consents in the E-HR revealed a lack of consent for use of the camera. The facility provided a care plan detail of an intervention under the high risk for fall focus. It read, Audio/Visual two-way monitoring device placed in [R2's] room (below TV stand) to monitor attempt to self transfer and prevent fall and injury. Nursing staff will monitor video during day and night shift and the monitoring device will NOT be utilized during personal ADL care. Please inform R2 and family. Date Initiated: 05/20/2021 The facility provided an Information Note from SSC1 dated 05/20/21. It read, Writer made attempt to call [Family Member] . for consent to place a monitor camera at [R2's] bedside for fall precautions, and safety measures. awaiting (sic) call back from representative. No other information was provided by the facility. An undated facility policy (found in the Disaster Manual provided to the survey team) titled Video Surveillance Policies & Procedures was reviewed. It read, 1. Video Surveillance Cameras are installed in CNH (Chinle Nursing Home) building entrances, rooftop and/or parking areas, hallways, dining room, and various departments with a date and time stamp. 2. Video Surveillance will not occur in bathrooms & resident rooms, nor in areas where there is an expectation of privacy, e.g. washrooms, change rooms, etc. 29087 2. On 9/22/21 at 10:25 AM CNA2 was observed seated at the charting area on Household One. The charting area consisted of a long work surface attached to the wall in an alcove open to the main corridor. A computer monitor/screen and keyboard sat on the work surface. CNA2 said she was documenting care she provided to the residents such as bowel and incontinence care, feeding, and other personal care. The monitor screen and entries on the screen were in full view of the corridor and visible to anyone in the area or passing by. During the entrance conference at 8:30 AM the DON stated the facility utilized a web-based electronic health record system. Observation of Household One and Household Two revealed two charting desk areas in each of the households as described above. Various staff were observed seated at the charting areas with data visible on the computer screens during random observations conducted 9/22/21 to 9/24/21.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview and record review the facility failed to ensure Resident 2 (R2), one of three residents reviewed for vest positioning devices, was not physically restrained when they failed to apply it correctly. R2 was not assessed for appropriateness or safety prior to implementing the device, and did not receive ongoing re-evaluation when the staff secured the vest behind the resident. This placed the resident at risk for injury (Cross reference F689) as well as violating the resident's right to be free from physical restraints. Findings: Review of the Electronic Health Record (E-HR) revealed the facility readmitted R2 on 05/07/21 following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection ('C-diff' is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 05 which indicates severe impairment of cognitive (intellectual activity such as thinking, reasoning, or remembering) abilities. Observed R2 sitting in a wheel chair beside the bed on 09/20/21 at 09:41 AM. A sign on the door read Contact Precautions (a type of isolation precautions) and personal protective equipment (PPE) was stationed outside the door. R2's room was on the Household 1 unit. During an observation and concurrent interview on 09/21/21 at 11:30 AM, R2 was sitting in a wheel chair beside the bed. Unit Aide (UA) 3 stated she used a lift to transfer R2 from the bed to the wheel chair, and confirmed R2 was on isolation for C-diff. On 09/22/21 at 08:24 AM observed R2 was sitting in a wheel chair beside the bed. On this day, R2 had a white cloth device wrapped around their torso encompassing the wheel chair. Certified Nursing Assistant (CNA) 18 was preparing to enter the room and stated, I'm gonna put [R2] in bed. CNA18 described the white cloth device as a positioner which kept the resident upright. After donning (putting on) required PPE surveyor requested CNA18 ask R2 in their native language to remove the device. After looking at the device, CNA18 stated It is secured in the back, [R2] can not take if off. Observed the device was positioned high on R2's upper chest, approximately 1 inch below the neck. CNA18 confirmed the device had shifted during use and was not applied correctly. She further described R2 as 'sometimes combative' gesturing with her arms like she is struggling or hitting out. During an interview on 09/22/21 at 09:39 AM the Charge Nurse, Licensed Nurse (LN) 2 was asked about the positioning device. She stated, It is something to hold [R2] in place. [R2] used to be one of those that climb out of the chair . It is almost like a restraint. [R2] wiggles and squirms. that is why it should be here (gestured to upper abdomen) . [R2] is actually capable of taking it off. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/22/21 at 01:10 PM, Unit Aid (UA) 33 confirmed she provided care to R2. She stated that in the past she had been assigned to provide one to one care around June of this year. R2 was on isolation at that time, and when R2 was moved back to Household 1 they was not on the one to one supervision anymore. Review of active orders in the E-HR on 09/22/21 revealed an order for the positioner dated 03/30/21. It read, May use TORSOSUPPORT, to maintain body posture & positioning - attach & secure daily to ensure above. A review of assessment under the Assessments tab of the E-HR and progress notes revealed a lack of assessment prior to implementing the positioning device. Reviewed R2's care plan on 09/22/21. It revealed a focus area for the torso support positioning device. An intervention read, Apply [R2's] Self release torso support's Velcro strap in the front while seated in wheelchair so she can self release as needed. Date Initiated: 07/21/2021 [Cross reference F656] Manufacture's instructions for the Posey Torso Support was reviewed on 09/22/21. Under Indications for Use it read, Patients requiring upper torso postural support to help reduce tilting, leaning and falling from chairs . Product applications considered self-release or assisted -release must be specified by the ordering physician. A caution read, This product is designed for self-release. If the patient is not able to easily self-release, it is considered a restraint and must be prescribed by a physician. Contraindications included, DO NOT use on a patient who is or becomes . combative, agitated . STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device . Adverse Reactions read, Severe emotional, psychological, or physical problems may occur if the applied device is uncomfortable; or if it severely limits movement. The application instructions described to apply the device with the patient seated, around the torso and then apply the shoulder straps. It read The hook and loop may be secured in front of the patient for 'self- release'. The next sentence was crossed out and not legible with per policy hand written next to it. The text continued, The proper medical authority should determine which way the patient is to be utilized. A warning read, If the patient has poor upper trunk control or has a tendency to slide or fall off the chair it should not be used over the torso in a chair without a belt or pelvic piece over the lower pelvis/lap area. Additional warning on the instructions read, Straps must ALWAYS be snug but not interfere with breathing or circulation. Under the heading Staff Training it read, Staff must have on going training and be able to demonstrate competency to use this device in accord with Posey instructions, facility policies and state and federal regulations. It further read Before Applying Any Restraint: Make a complete assessment of the patient to ensure restraint use appropriate. Identify the patient's symptoms and if possible, remove the cause. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	You may need to cater to individual needs and routines, increase rehabilitation and restorative nursing, modify the environment or increase supervision. Use a restrain only when all other options have failed. Use the least restrictive device for the shortest time until you find a less restrictive alternative. Patients have the right to be free from restraint. Obtain informed consent from the patient or guardian prior to use. Explain the reason for restraint use to the patient and./or guardian to help ensure cooperation . Reviewed undated facility policy titled Torso Trunk Support on 09/22/21. Under Procedures it read, 1. Asses the resident to determine he/she is cognitively intact to remove posey trunk support. 2. Physical Therapy will assess resident to determine if Posey trunk support will be beneficial and safe for resident to use. 3. Physician order will be obtained. instructions will include 1. On/Off application 2. Check for skin integrity and circulation. 4. Inform family and obtain consent from family and resident. Review of facility policy tilted Use of Restraints dated 8/2012 revealed, It is the policy of Chinle Nursing Home to prohibit the use of any type of restraint. Each resident has the right to be free from physical or chemical restraint imposed for purposes of discipline or convenience and not required to treat the resident's medical condition. During an interview on 09/22/21 at 04:57 PM when asked if there were any assessments for the safety or if the device was appropriate for R2, the DON stated that there was not. The DON confirmed the device should be applied as a self-releasing. [Cross reference F689] An interview was conducted with the Quality Assurance/Quality Improvement (QAQI) nurse on 09/24/21 at 12:20 PM. When asked about how the facility ensure competencies of nurse aides and nurses for specific tasks and responsibilities, QAQI said the facility has talked about it for a long time and plans to start conducting competency testing with the annual performance evaluations, but there has been no time to get to this. QAQI confirmed competencies are not being performed/conducted.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 29642 Based on interview and record review, the facility failed to ensure comprehensive assessments including annual assessments, were timely for 1 of 16 sampled residents reviewed comprehensive assessments reviewed. This placed the resident at risk for delayed or unidentified care needs. Findings include: Review of a paper facility policy titled Comprehensive Assessment and Care Planning, dated 02/08/17 indicated .Initially and periodically .will conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity . Per the MDS (Minimum Data Set) 3.0 RAI (Resident Assessment Instrument) Manual: MDS- Minimum Data Set-A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies . The RAI required Assessment Summary indicates that the Annual (Comprehensive) assessment completion date is the Assessment Reference Date (ARD-refers to the last day of the observation period that the assessment covers for the resident) plus 14 calendar days. Resident 31 According to the MDS the type of assessment due was an Annual. R31's Annual Comprehensive MDS had an ARD date of 7/12/2021, thus making the completion date 7/27/2021. Per the MDS (MDS 3,0) Summary Review, the submission date was 8/9/2021 for the MDS assessment, Care Areas, and the Care Plan Decisions which were 13 days late. During an interview on 09/22/21 at 8:40 AM, the Minimum Data Set (MDS) Coordinator stated the MDS assessment was based on the assessment review date (ARD) schedule and in the electronic medical records (EMR) the schedule was already set for the 92 days for the review for an annual/quarterly MDS assessments. The MDS Coordinator stated the facility has a Registered Nurse (RN) Coordinator who is also known as the Nurse Consultant. The MDS Coordinator stated she keeps tract of the MDS schedules and alerts the nurses and Social Services about the dates for completion. The MDS Coordinator stated the Nurse Consultant will contact charge nurses by phone to gather data on the resident. The MDS Coordinator stated the Nurse Consultant will also use an interpreter to speak with the residents during the assessment period. During an interview on 09/22/21 at 10:35 AM, Registered Nurse (RN)2 stated the only time she did a complete assessment on a resident was during the admission process or a readmission of a resident from the hospital. RN2 stated nursing provides lots of updates in the EMR and the Nurse Consultant has off-site access to the EMR for all the residents. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/22/21 at 2:01 PM, the Director of Nursing (DON) stated the MDS Coordinator does not come to the floor to assess the residents during the assessment period. During an interview on 09/22/21 at 2:56 PM, RN2 stated again she did not perform a complete assessment such as reviewing bowel/bladder, cognition, vision, skin, and other physical areas. RN5 stated she did get information on when the MDS assessments were to be completed by from the MDS Coordinator. During an interview on 09/22/21 at 3:01 PM Lead Certified Nursing Assistant (NA) 31 confirmed she has communication with the Consultant Nurse and would do the translation from the resident to the Consultant Nurse during the assessment period for areas such as pain and eating. NA31 stated there were times in which the Consultant Nurse would ask her to ask the residents to move their arms and legs and she will pass the information to the Nurse Consultant. During an interview on 09/22/21 at 3:23 PM, the Nurse Consultant confirmed she did not come onsite to perform resident assessments and worked remotely. When asked how she determined functional status, the Nurse Consultant stated she participates in the care planning process and staff will report on the functional status of a resident. The Nurse Consultant stated she will speak with the NAs and the charge nurse, and they help with the translation from the residents to her. The Nurse Consultant stated the MDS Coordinator will sign off on the MDS assessment when it has been completed. During an interview on 09/24/21 at 8:43 AM, the Director of Nursing (DON) stated her expectation was for the MDS assessment to be submitted timely.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, staff interview, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to complete a quarterly assessment in a timely manner for five (Resident (R) 19, R47, R2, R18, and R20) out of 16 sampled residents reviewed. Findings include: Per the MDS 3.0 RAI (Resident Assessment Instrument) Manual dated 10/01/19: MDS- Minimum Data Set - A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies . The RAI required Assessment Summary indicates that the Quarterly (Non-Comprehensive) assessment completion date is the Assessment Reference Date (ARD-refers to the last day of the observation period that the assessment covers for the resident) plus 14 calendar days. Resident 19 Review of the Electronic Medical Record (EMR) Admission Record under the MDS tab revealed R19 was admitted to the facility on [DATE]. A review of R19's EMR Minimum Data Set (MDS) 3.0 Assessment section revealed the quarterly assessment dated [DATE] indicated it was Still in Progress and had not been completed and submitted. During an interview on 09/22/21 at 9:27 AM the MDS Coordinator confirmed R19's quarterly MDS assessment was not submitted timely since sections of the resident's cognition and mental health were not yet completed. During an interview on 09/24/21 at 8:43 AM, the Director of Nursing (DON) stated her expectation was for the MDS assessment to be submitted timely. 29642 Resident 47 Resident (R) 47 Quarterly (Non-Comprehensive) MDS had an ARD date of 7/29/2021, thus making the completion date 8/12/2021. Per the MDS (MDS 3,0) Summary review, the submission date was 8/17/2021, which was 5 days late. During an interview on 09/24/21 at 8:43 AM, the Director of Nursing (DON) stated her expectation was for the MDS assessment to be submitted timely. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40844 Resident 2 R2 Quarterly (Non-Comprehensive) MDS had an ARD date of 08/18/21, thus making the completion date 09/01/2021. Per the MDS (MDS 3,0) Summary review, reviewed on 09/22/21, the Quarterly MDS was In Progress and red alert text read it was 21 days overdue. Resident 18: R18 Quarterly (Non-Comprehensive) MDS had an ARD date of 08/27/21, thus making the completion date 09/10/2021. Per the MDS (MDS 3,0) Summary review, reviewed on 09/23/21, the Quarterly MDS was In Progress and red alert text read it was 13 days overdue. Resident 20: R20 Quarterly (Non-Comprehensive) MDS had an ARD date of 08/31/21, thus making the completion date 09/14/2021. Per the MDS (MDS 3,0) Summary review, reviewed on 09/24/21, the Quarterly MDS was In Progress and red alert text read it was 10 days overdue. During an interview on 09/24/21 at 08:56 AM the MDS Coordinator confirmed she was a licensed nurse and familiar with the MDS process. Concurrently review of Quarterly MDS assessments for R2, R18, and R20 revealed they were overdue and not submitted yet since sections of the resident's cognition and mental health were not yet completed. She stated the staff who complete those sections had been out. When asked what the back up plan for such a situation she first stated another social services coordinator will do what she can. When asked if there were other staff beyond the other social services staff, she confirmed a licensed nurse could and added, They don't have time. During an interview on 09/24/21 at 8:43 AM, the Director of Nursing (DON) stated her expectation was for the MDS assessment to be submitted timely.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, interview, and record review including Resident Assessment Instrument (RAI) Manual, the facility failed to ensure two residents (Resident (R) 19, R36) out of 16 sampled residents had an accurate Minimum Data Set (MDS) assessment. These failures to address the individualized care needs of the residents placed the residents at increased risk for inconsistent care. Findings include: Review of the RAI Manual, dated 10/01/19, indicated, . It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment . Review of the Electronic Medical Record (EMR) Admission Record under the MDS tab revealed R19 was admitted to the facility on [DATE]. Review of the EMR annual MDS, with an Assessment Reference Date (ARD) of 05/31/21, indicated R19 used an invasive mechanical ventilator. During an interview on 09/22/21 at 9:27 AM, the MDS Coordinator stated R19 did not use an invasive mechanical ventilator and she would get that corrected. During an interview on 09/22/21 at 2:01 PM, the Director of Nursing (DON) stated her expectation was the MDS was to be accurate. 35588 Resident 36 Review of Resident 36's (R36) record documented the resident was admitted to the facility on [DATE] and most recent readmission was on 6/26/21 with diagnosis including heart failure, urinary tract infection, COVID-19 infection, pressure ulcer of right buttock stage 4, and dementia. R36's Minimum Data Set (MDS-assessment tool) dated 07/29/21 documented resident's brief interview of mental status score was 3, indicating severe cognitive impairment and was total dependent with activities of daily living, including bed mobility, transfers and personal hygiene. Review of the Electronic Medical Record (EMR) Admission Record under the MDS tab revealed R36 was admitted to the facility on [DATE] and most recent readmission was on 6/26/21 Review of the EMR annual MDS, with an Assessment Reference Date (ARD) of 07/29/21, documented R36 ate with supervision (staff provided oversight, encouragement, or cuing). The previous MDS with ARD date of 04/28/21 documented R36 was totally dependent for eating and required full staff assistance for eating. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/20/21 at 11:00 am Medical Assistant (MA)5 was sitting next to resident who was in his bed. CMA5 spooned pureed food into resident's mouth. CMA5 stated that staff provides feeding assistance to resident. Resident was not observed to eat with supervision. During an interview on 09/24/21 at 9:46 AM Lead Certified Nursing Assistant (LCNA)31 stated R36 required staff to provide total feeding assistance to resident and resident should not have been coded as supervision. LCNA31 further stated that total dependence is if you are feeding resident and supervision is if you are just watching resident and the resident is feeding self and staff is making sure resident doesn't aspirate and you are cueing resident such as your drink is here. LCNA31 stated that resident is total dependence, you have to 100% feed him, he doesn't reach for the spoon, motions forward with head when he wants more food or drink. LCNA31 stated that she provided feeding assistance to resident last Friday where resident was totally dependent. LCNA31 stated that resident has been totally dependent for eating for at least the last six months. During an interview on 09/24/21 at 11:19 AM the Director of Nursing (DON) stated her expectation was the MDS was to be accurate. DON stated that R36 was dependent on eating and not safe for supervision and coding resident as supervision is incorrect.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29642 Based on observation, interview, and record review, the facility failed to ensure care plans were completed to address all aspects of care, or were followed for 4 of 16 sampled residents (Residents (R) R7, R2, R20 and R40) whose care plans were reviewed. This failure placed residents at risk for inconsistent or inadequate care. Cross reference F604, F688 Findings include: The facility's policy entitled Care Plan Policy dated 2/8/2017 indicated Our facility will develop a comprehensive care plan for each resident, including measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs as identified in the Comprehensive Assessment 10. The care plan committee will review as often as changes occur in the resident's condition and will be revised to maintain accuracy .12. Licensed nurses will initiate a care plan in PCC (Point Click Care) for new medications and change of condition as they occur' The facility's policy, Torso Trunk Support (undated) indicated the device maintains proper body alignment and is used for upper torso postural support to prevent tilting and leaning. Under the procedure section of the policy, the following is indicated, .5. Initiate individualize care plan specific to trunk support use . Resident 7 R7 had diagnoses that included dementia (memory problems), congestive heart failure (heart does not pump effectively), high blood pressure, and chronic kidney disease (gradual loss of kidney function). A Physician's Order dated 7/14/2021 was received for a Self-Release Torso Support to be applied while seated in a wheelchair. Resident requiring upper support to help reduce tilting, leaning, and falling from chair. On 9/20/20201 at 11:19 AM, R7 was observed in a wheelchair. R7 had on a posture device that had a seatbelt-like strap over his lap, which velcroed closed. There were also two straps that crossed on the back of the wheelchair back and came over the resident's shoulders and velcroed to the seatbelt-like device. R7 also had a motion sensor pad (placed on the seat) on his wheelchair. Review of R7's plans of care revealed the following: *High risk for falls related to weakness, unsteady gait, poor vision, and disease process (Dementia) with an initiated date of 9/1/2018. *R7 had an unwitnessed fall on 7/13/2021 fell from wheelchair related to sliding, poor balance, poor communication/comprehension, and unsteady gait revision date of 7/14/2021. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	None of the above care plans addressed the use of the posture support devise the resident was observed wearing. On 9/22/2021 at approximately 2:15 PM, Licensed Nurse (LN)7 was asked about care planning. LN7 stated that if something was changed or added to a residents' care those changes should be reflected on the care plan. 40844 R2 - staff failed to follow the care plan: Review of the Electronic Health Record (E-HR) revealed the facility readmitted R2 on 05/07/21 following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection ('C-diff' is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 05 which indicates severe impairment of cognitive (intellectual activity such as thinking, reasoning, or remembering) abilities. During an observation and concurrent interview on 09/21/21 at 11:30 AM, R2 was sitting in a wheel chair beside the bed. Unit Aide (UA) 3 stated she used a lift to transfer R2 from the bed to the wheel chair, and confirmed R2 was on isolation for C-diff. On 09/22/21 at 08:24 AM observed R2 was sitting in a wheel chair beside the bed. On this day, R2 had a white cloth device wrapped around their torso encompassing the wheel chair. Certified Nursing Assistant (CNA) 18 was preparing to enter the room and stated, I'm gonna put [R2] in bed. CNA18 described the white cloth device as a positioner which kept the resident upright. After donning (putting on) required PPE surveyor requested CNA18 ask R2 in their native language to remove the device. After looking at the device, CNA18 stated It is secured in the back, [R2] can not take if off. Observed the device was positioned high on R2's upper chest, approximately 1 inch below the neck. CNA18 confirmed the device had shifted during use and was not applied correctly. She further described R2 as 'sometimes combative' gesturing with her arms like she is struggling or hitting out During an interview on 09/22/21 at 09:39 AM the Charge Nurse, Licensed Nurse (LN) 2 was asked about the positioning device. She stated, It is something to hold [R2] in place. [R2] used to be one of those that climb out of the chair . It is almost like a restraint. [R2] wiggles and squirms. that is why it should be here (gestured to upper abdomen) . [R2] is actually capable of taking it off. LN2 confirmed it should be secured in the front. Review of active orders in the E-HR on 09/22/21 revealed an order for the positioner dated 03/30/21. It read, May use TORSOSUPPORT, to maintain body posture & positioning - attach & secure daily to ensure above. Reviewed R2's care plan on 09/22/21. It revealed a focus area for the torso support positioning device. An intervention read, Apply [R2's] Self release torso support's Velcro strap in the front while seated in wheelchair so she can self release as needed. Date Initiated: 07/21/2021 Facility staff failed to apply the device correctly. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/22/21 at 04:57 PM the DON confirmed the facility policy was to secure the straps in the front so they were self-releasing, and it was her expectation for staff to follow that practice. [Cross reference F604 and F689] Resident 20 - Review of the E-HR revealed the facility admitted R20 on 05/15/2012. Current diagnoses included generalized muscle weakness, osteoarthritis of both knees, diabetes, dementia with behavioral disturbance, and chronic obstructive pulmonary disease (lung disease). Active orders in the E-HR revealed an order dated 09/24/2019 and read, PT [Physical Therapy] for ROM [range of motion] per Neurology consults: start range-of-motion as they deem appropriate given contractures on exam. If there is progressive worsening despite maximal PT care, may need ortho eval if consideration for interventional care. Observed R20 on 09/21/21 at 01:57 PM lying in bed on her right side. The bed was in a low position and there was a grab bar installed on the side. Residents knees were bent. Nursing Assistant (NA) 85 came into R20's room during the observation. When asked if R20 received any ROM exercises, she stated that staff would attempt ROM however R20 refused the attempts. During an interview with the charge nurse, LN2 on 09/24/21 at 11:33 AM, LN 2 confirmed R20 had contractures. She is not able to fully extend her legs. When asked about staff facilitating ROM, she stated 'not on a daily basis. When asked where such documentation would be, she stated, I don't think that's being done. She explained that PT had not coming to the facility since the early 2020 when the pandemic started. When asked how nursing assessed the limitations in a resident's range of motion, she stated there was not a formal assessment that was done. Review of R20's care plan revealed three focus areas which touched on the resident's limited range of motion, however there was not a focus area which addressed the limitation or provided staff with a plan to assess the limitation and prevent further decline. Under the focus area for self-care performance deficit revised on 9/14/21, it read that limited ROM was a relating factor. The resident's goal was to maintain the current level of function in with staff assistance. Interventions addressed bathing, bed mobility, dressing, eating, hygiene, toileting and transfers. Interventions addressing the plan for maintaining the current level of ROM was lacking. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Under the focus area for Secondary Parkinson, Osteoarthritis of Knees affecting her mobility revised on 6/17/2021, the goal was to maintain the goal was to remain free of further signs and symptoms of discomfort or complications related to the Parkinson disease or osteoarthritis. One intervention initiated on 12/13/2017 without revision, read to encourage daily exercise, mobility as tolerated. No where in the care plan did it describe what the services daily exercises consisted of. An intervention initiated on 12/13/2017 without revision read, Encourage/provide gentle range of motion as tolerated with daily care. Another intervention initiated on 12/13/2017 without revision read, PT, OT treatment as ordered. May d/c when clinically appropriate. The care plan did not address what mitigating care and/or services would be provided since PT was not able to come to the facility. Under the focus area for acute/chronic pain initiated on 12/13/2017 an intervention directed nursing assistants to Observe and report changes in usual routine . decrease in functional abilities, decrease ROM .) Review of Quarterly MDS dated [DATE] revealed the facility coded the resident to have a functional limitation in both lower extremities. Review of all progress notes in the E-HR between 05/28/21 and 9/24/21 revealed a lack of notes addressing ROM, refusals of ROM or exercises, exercises, or any assessments in the resident's ROM ability or limitation. Resident 40: Review of the E-HR revealed the facility admitted R40 on 10/15/19. Current diagnoses included diabetes, pain, spondylolisthesis in the lumbar region (a spinal disorder in which a bone (vertebra) slips forward onto the bone below it), hypertension, chronic kidney disease, and hypothyroidism. Review of the Annual MDS assessment dated [DATE] and the Quarterly MDS dated [DATE] both revealed R40 had a functional limitation in the ROM affecting both lower extremities, and on upper extremity. During an interview on 09/20/21 at 01:24 PM, R40 described pain she had in her arms. The doctor wanted me to do exercise. She demonstrated a limitation in her ability to raise her arm and then said My arms hurt and rubbed them. Charge nurse LN2 was interviewed on 09/22/21 at 10:35 AM. LN2 confirmed there were restorative nurses' aides (RNA) working in the facility, however Physical Therapy was closed and the RNAs were assigned to work on the floor as nursing assistants. LN2 was interviewed later that same day at 02:15 PM. She stated that R40 had chronic shoulder pain and arthritis. She described The doctor wanted her to have ROM, back when PT were coming, she complained it hurt and refused, and gets mad at them. When asked about the restorative program again, she explained the PT department (from the hospital) use to come over (before the pandemic) and they provided oversight for the program. Since they stopped coming the RNAs could not continue to work without the supervision. Review of active orders revealed the following order: Encourage staff to work w/ patient for gentle ROM exercises as able and pendulum ROM as able daily dated 8/20/20. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes for the previous 6 months revealed occasional refusal for care unrelated to ROM or exercises (6/6/2021 at 07:06, 7/16/2021 at 20:17, and on 8/11/2021 at 03:36). The progress notes revealed a lack of documentation addressing ROM and any exercises. No assessments related to ROM under the assessment tab were found. A review of the tasks tab (where nursing assistants document care provided) revealed a lack of documentation related to ROM or exercises. A review of R40's care plan revealed there was not a focus area addressing the limited ROM. A focus area addressing self-care performance deficit [related to] impaired balance, limited mobility, pain . revision date 08/07/21 was reviewed. The goal was for R40 to maintain current level of function in activities of daily living (ADLs), revision date 7/21/21. Multiple interventions provided the plan for the following ADLs: bathing/showering, bed mobility, dressing, eating, oral care, personal hygiene, toilet use, and transfers. Additional interventions read, Monitor [R40] document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function and PT/OT evaluation and treatment as per MD orders. Nowhere in the care plan address the plan for functional limitations or exercises to prevent further decline. During an interview on 09/24/21 at 11:33 LN2 confirmed there was an order to encourage ROM. When asked where this was documented she stated, I don't think that's being done.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29087 Based on interview and record review the facility failed to ensure comprehensive care plans were developed by an interdisciplinary team to include the residents and their representatives. The facility did not routinely invite the residents and their representatives to participate in care planning meetings. This failure denied Resident 41's representative the opportunity to participate in the care planning process. The facility failed to revise the care plan for resident R36 to reflect current activities based on the resident's preferences and functional status. The facility failed to revise the care plan for resident R2 to regflect the current level of supervision needed to prevent falls. All residents were at risk for unidentified and unmet needs. Findings include; 1. During an interview on 9/20/21 at 2:05 PM, resident R41's family member F41 said the facility hardly ever called him/her. F41 said the facility did not invite family members to quarterly care conferences. F41 said R41 was single and family members wanted to participate in care planning on R41's behalf. During an interview on 9/21/21 at 1:19 PM Social Service staff SS2 said March 2020 was the last time the facility held care planning meetings with families participating. Family members have not been invited since. Care planning meetings are currently held on Thursdays. On 09/23/21 from 3:28 PM to 4:20 PM the facility MDS (minimum data set, a required assessment) registered nurse (MDS/RN) stated she coordinated completion of the MDS and care plans which required input from the interdisciplinary team. MDS/RN said she scheduled care conferences (meetings to evaluate and plan the resident's care) based on the MDS system which required MDS at prescribed intervals, annually, quarterly, and with a significant change in resident condition. MDS/RN said the facility had no RN to run the care conference program. MDS/RN said the facility relied on IHS across the street for some of the sentinel events such as falls, altercations with injury, and resident behavior. MDS/RN said The folks at IHS across street did not attend care conferences. MDS/RN stated the resident's primary care providers did not attend care conferences. MDS/RN said an RN nurse who lives out of state and works remotely served as the RN assessment Coordinator (RNAC). MDS/RN said RNAC called in and participated in care conferences by telephone only. RNAC wrote all of the care plans. MDS/RN said when the pandemic started, the facility stopped care planning meetings. In March 2021 the care conferences were resumed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R36's current care plan documented resident had limited activity involvement r/t (related to) musculosketel (sic) impairment, limited mobility and impaired dynamic balance r/t Trans Metatarsals Amputation bilaterally (removal of part of foot/bones located between the ankle and toes of each foot) . initiated and revised on 7/22/21 with goal of .will maintain involvement in social activities like food base activities, putting together puzzles and coffee social, as desired through my next review date. Interventions included .preferred activities are: Putting together Puzzles, food based activities, coffee/tea social, Catholic/Baptist Church, kickball, miniball toss and .prefers to watch DVD movies; Western, wrestling, UFC fighters, rodeo competitors and comedy in conference room or my own room, I do enjoy going to food based activities, sensory perception stimulation Review of Activities-Quarterly/Annual Participation Review, dated 4/29/21, most recently available activities update which was over five months ago, documented under section Describe the resident's attendance preferences and participation level with activities (group, event, 1:1) that resident remain in room majority of the time. Because of Covid-19 Pandemic, In-room activity visits, Residents alert, but unable to participate in activities, also turned his head around, and also hand gestures, can't do activity. Under section Describe resident's favorite activities, special accomplishments, and/or new interests the form documented that resident was alert watching television in his room, resident is bed bond, continue monitoring at this time. The previous Activities-Quarterly/Annual Participation Review form, dated 1/29/21 showed Due to Covid-19 responses, resident remains in his room a majority of the time. Resident participant in group exercise, Social distance during activity. Activities include ROM. The resident's current care plan did not match resident's current abilities, preferences and participation level per activity participation review form. Observation on 09/22/21 at 10:13 AM, 10:44 AM and 10:55 AM and 09/22/21 at 1:41 PM showed resident in room, lying in bed, awake. Observation on 09/23/21 at 9:36 AM showed CNA5 and UA6 providing cares to resident in resident's room. During an interview on 09/22/21 at 10:55 AM with Licensed Nurse (LN)7 providing Navajo interpretation, when asked what resident liked to do, what resident did for fun or pleasure, resident stated that he didn't know. I'm just here. LN7 stated that resident's pressure sore on his buttocks doesn't allow resident to tolerate a whole lot, we are still packing the wound and he can't tolerate being up in the wheelchair for too long. When asked if he was bored, resident shrugged his shoulders and had questioning look on his face. During an interview on 09/22/21 at 11:10 am Activities Coordinator (AC) stated that today was her third day back at the facility after five years elapse and was getting to know the residents on the Men's Unit. She stated that she was not very familiar with R36 but understood that he has room visits only and does not attend activities outside his room. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/21 at 11:19 AM Director of Nursing (DON) stated that she is very familiar with R36 and resident used to go to dining room and get out of his room but for the last several months because of his healing pressure injury on his buttock and urinary catheter leaking, resident has primarily stayed in his room and his bed because he is not able to tolerate being out of bed which makes it difficult for him to participate in activities. When asked if resident comes out of his room, DON stated that resident does not come out of room because of catheter leaking and he is practically wet all the time in certain positions with very frequent brief changes. When asked about R36's care plan showing activities including putting together puzzle, playing kickball or miniball toss, DON stated that it's been awhile since R36 has been involved in kickball or those types of activities. DON stated that AC just started and she will be addressing activities. DON stated that AC is our plan of correction. During an interview on 09/24/21 at 12:41 PM Activities Aide (AA) stated that she is responsible for developing and updating resident's care plan for activities. When asked about R36's activities, AA stated that resident used to play kickball and put together puzzles but that was before March 2020, before COVID and right now resident is totally in bed, he's on bed rest, if talk to him he responds but if I tell him to put favorite puzzle together, he just nods his head and is unable to do that. He has 1:1 visits. When asked when the R36's activities care plan was last updated, AA stated not too long ago, he was on my list but acknowledged that current care plan does not reflect resident's current functional ability/status or activities. 40844 3. Resident 2 Review of the Electronic Health Record (E-HR) revealed the facility admitted R2 on 10/25/2019, and readmitted her on 05/07/21 following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection ('C-diff' is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 05 which indicates severe impairment of cognitive abilities (intellectual activity such as thinking, reasoning, or remembering), and required extensive assistance with bed mobility and totally dependent for transfers. Observed R2 on 09/20/21 at 09:41 AM sitting in a wheel chair alone in her room. Observed R2 on 09/21/21 at 09:22 AM sitting in a wheel chair beside the bed alone in the room. Observed staff were in R2's room providing care on 09/21/21 at 10:04 AM. Observed Unit Aid (UA) 3 was in R2's room on 09/21/21 at 11:30 AM. Interviewed UA3 and she confirmed R2 was on isolation for chronic C-Diff. She stated, Every time [R2] gets tested she has that C-Diff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observed R2 alone in the room on 09/22/21 at 08:24 AM. Certified Nursing Assistant (CNA) 18 was preparing to enter the room. While interviewing CNA18 in the resident's room she mentioned a camera in the room was not facing the resident. I don't know maybe she had a change in her privacy status. When asked how she knows when there is a change to a resident's care plan she stated I think the DON will tell us. Observed a small white device sitting on the overbed table pushed against the wall at the foot of the bed. The device had a small lens that facing the water pitcher. After providing the resident care CNA18 positioned the camera device to face the resident. She stated they used a camera to monitor the resident in her room. [Cross reference F583] During an interview on 09/22/21 at 09:39 AM the Charge Nurse, Licensed Nurse (LN) 2 LN2 confirmed R2 was at risk for falls and had several falls in the facility. When asked about the camera she stated, That is a way we keep an eye on her sometimes. A review of the E-HR revealed R2 had 8 falls over the past 10 months. [cross reference F689]. MDS assessment tab in the E-HR revealed an overdue and incomplete quarterly assessment dated [DATE] [cross reference F638] and a comprehensive significant change MDS assessment dated [DATE]. A care plan review revealed a focus area addressing actual unwitnessed fall[s] with a revision date of 08/23/21 by MDSRN. This care plan included two goals, both revised on 08/11/21 by MDSRN. An intervention read, Assigned unit aide in [R2'] room during day shift for 1:1 monitoring for her safety d/t (due to) attempt to crawl out of the bed and high risk for falls. Date Initiated: 06/13/2021. There was not a revision date. Interviewed UA33 on 09/22/21 at 01:10 PM. UA33 confirmed she was assigned to work with R2 and assisted R2's CNA with things such as vital signs and transferring residents. When asked if she was assigned to provide one-to-one supervision for R2 she stated, Yeah, when I first came I was all the time with [R2], back when [R2] was on isolation. Not now. UA33 explained that she had returned to working in the facility around June, 2021. Review of the E-HR revealed a lack of documentation addressing when the one-to-one supervision was stopped. Physician orders revealed an active order for Contact precaution Cdiff (sic) dated 05/07/2021 and an active order Alert Charting-ABT 9Antiboitic therapy) for C-Diff. Readmission to Facility dated 08/23/2021. The uncompleted MDS dated [DATE] revealed in section O the resident had not been on isolation for active infectious disease during the 2 week look period. Section O was signed as completed on 08/23/21 by MDSRN. During a telephone interview with RNAC on 09/22/21 at 03:23 PM RNAC was asked about the one-to-one supervision intervention. She confirmed it was an old intervention, and should have been removed when the care plan focus area was revised in August. She stated it had been removed today.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview and record review the facility failed to ensure Resident (R) 40, one of 16 sampled residents, received services to replace eyeglasses in a timely manner. This failure had the potential R40's ability to see clearly. Findings: The Electronic Health Record (E-HR) revealed the facility admitted R40 on 10/15/2019. Diagnoses included Diabetes, Myopia (nearsightedness), Astigmatism (an imperfection in the curvature of the eye's cornea or lens), Presbyopia (an age-related condition where the eye's lens doesn't change shape as easily as it once did), and dry eye syndrome. During an interview on 09/20/21 at 01:43 PM R40 was observed to be wearing glasses. When asked about the glasses, she stated These are about 4 years old. She stated she had asked to have new ones after arriving at the facility. She said was not able to get them due to the offices all being closed after the COVID-19 pandemic started. During an interview with Licensed Nurse (LN) 2 on 09/24/21 at 11:33 AM, LN2 confirmed R40 had asked for new glasses. When asked about the follow up to that request, LN2 called [NAME] Clerk (WC) 77 over. WC77 stated R40 asked for glasses at the beginning of the COVID pandemic (The Public Health Emergency related to COVID-19 began in March of 2020). She stated she had mentioned it to the provider, and they were in the process of mailing out appointments. WC77 explained the eye care providers had started coming to the facility again as of May 2021. They come one time a month and see 6 residents, 3 males and 3 females. When asked how the decisions were made, what order residents were seen in, or if there was a list that residents were placed on when they request services, she indicated the eye care providers knew and had a list. Surveyor requested a copy of that list. The census of the female unit, Household 1, during the survey was 28. As of the time of the survey, at least 15 female residents had the opportunity to have an optometry visit. Review of the Annual Minimum Data Set (MDS) assessment dated [DATE], and the Quarterly MDS dated [DATE] bot revealed the resident's Brief Interview for Mental Status score was 15. A score of 15 indicated R40 had intact cognition. They also revealed R40 wore glasses. Care Plan review revealed the facility developed a care plan related to impaired vision on 10/30/19 and most recently revised on 05/20/21. The goal was for R40 to use appropriate visual devices (prescription eye glasses) to promote participation in activities of daily living (ADLs) and activities. Interventions included consultation with eye care practitioner as required revised on 10/30/19, and Ensure appropriate visual aids (eye glasses) are available to support [R40's] participation in activities. also revised on 10/30/19. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/21 at 12:03 PM the Director of Nursing (DON) was asked about her expectations for staff to plan for requested eye care. She stated there was not a specific policy addressing placing residents on list when they make requests. She explained the process is they should let WC77 know and she coordinates the appointments. Also, when the 60-day doctor visits come, the nurses are supposed to gather all concerns they may have to communicate with the physician. She agreed R40 should have been seen when the eye care providers started providing care in the facility. The facility did not provide the requested priority list of residents before the end of the survey. They did however arrange for R40 to be seen on 09/27/21 after the issue was presented by the surveyor.

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F 0686 Level of Harm - Minimal harm or potential for 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** 35588 Based on observation, interview and record review, the facility failed to ensure resident with pressure ulcers received necessary treatment and services to promote healing and monitor/evaluate pressure injury healing for 1 of 6 sampled residents (R) (R36) reviewed for pressure ulcer/injury. Facility did not consistently implement weekly wound measurements. This failure increased resident's risk for delayed healing and/or having pressure ulcer worsen with its associated complications of pain and infection. Findings include: Review of Resident 36's (R36) record documented the resident was admitted to the facility on [DATE] and most recent readmission was on 6/26/21 with diagnosis including heart failure, urinary tract infection, COVID-19 infection, pressure ulcer of right buttock stage 4, and dementia. R36's Minimum Data Set (MDS-assessment tool) dated 07/29/21 documented resident's brief interview of mental status score was 3, indicating severe cognitive impairment and was total dependent with activities of daily living, including bed mobility, transfers and personal hygiene. Review of facility policy, Wound Management and Skin Care, dated 07/2019, showed Wounds and skin care management with be consistent with the contemporary practice, promotes wound healing and is aligned with the infection control policy and procedures. Accurate wound assessment, documentation and product selection is key to promoting wound healing. Assessment is an on-going process of monitoring the wound and the resident's overall health and the evaluating whether the treatment plan is achieving the desired outcome. On the first page of the policy in the upper right hand corner a handwritten note #3/#4 * Add weekly skin checks on noc (night) shift was shown. Review on 9/22/21 of the Electronic Medical Record (EMR) Weekly Wound Measurements under the Assessment tab showed the following wound assessments since resident's 6/21/21 readmission back to the facility: 6/21/21, 6/28/21, 7/12/21 (7 days late from previous weekly assessment), 7/19/21, 7/26/21, 8/2/21, 8/16/21 (7 days late from previous weekly assessment), 9/10/21 (18 days late from previous weekly assessment) Observation on 09/21/21 at 2:12 PM showed Director of Nursing (DON) change R36's right ischial (sit bones or the curved bone forming the base of each half of the pelvis) wound dressing. Resident's wound was deep with area depressed. DON packed wound with plain packing strip and stated that approximately 10 cm was packed in wound cavity but overall the wound looks much better than before and surgeon's visit several days ago concurred the wound was improving. Observation on 09/22/21 at 8:33 AM showed Certified Nursing Assistant (CNA)5 and Medical Assistant (MA)1 providing incontinence care and right buttock dressing was dated 9/22/21 at 5am. Review of surgery outpatient physician progress notes, dated 09/15/21 at 4:48 PM, documented follow up for right ischial pressure sore showed the pressure sore significantly improved with healing in most of the cavity. No undermining or tunneling found with a 1.5cm opening in the area of residual wound, no redness and wound bed with healthy granulation of tissue. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 09/22/21 at 3:33 PM Licensed Nurse (LN)7 stated she was the charge nurse and reviewed R36's EMR and stated that weekly wound assessments would be documented under Assessment tab and there was no other documentation available for wound assessments. LN7 reviewed EMR and stated that the wound assessments should be weekly and she did not see wound assessments done weekly. LN7 stated that maybe Quality Assurance/Quality Improvement/Infection Preventionist Registered Nurse (QAQIICRN) may have more information. During an interview on 09/22/21 at 3:43 PM with DON and QAQIICRN, DON stated that the charge nurses were told they are responsible for weekly wound measurements, but it looked like this was not being done. During a concurrent interview and record review on 09/22/21 at 3:37 PM QAQIICRN reviewed resident's EMR and stated that she did not have any wound documentation or know where additional wound measurement assessments would be located. QAQIICRN stated that a staff member, who left in June or July, was doing wound measurements but QAQIICRN has not been doing wound measurements. The charge nurses were told they were responsible for the weekly wound measurements. QAQIICRN reviewed EMR and stated that last wound measurement was on 9/10/21 and wound measurement was not found for this week or the prior week and the previous measurement was on 8/16/21 and therefore wound measurements were not being done weekly but should have been. During an interview on 09/24/21 at 11:19 AM DON stated that she had sent text and EMR messages that wound measurements needed to be done weekly. DON also stated that this was also communicated via stand-up meetings and continuously told the charge nurses this. The facility did not have a wound nurse right. DON stated that she would be asking the nurse who does care plans and MDS to enter measure wound weekly as a treatment task on Monday day shift or Monday night shift if day shift was unable to carry it out so that it gets done.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on observation, interview and record review the facility failed to ensure 2 of 3 Residents (R) (R20 and R40) reviewed for limited range of motion (ROM), received services to prevent a further decrease in range of motion. This deficient practice had potential to affect 53 residents identified by the facility to have contractures. Findings include: A contracture is prolonged shortening of the muscle or other soft tissue around a joint preventing movement of the joint. The RAI (resident assessment instrument [MDS] manual): restorative nursing program (RNP) refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The goal of a RNP is to restore as much independence as possible and/or prevent declines in function. RNP services for decreased ROM and contractures may include ROM exercises, splinting, assistance, and with walking and transferring. RNP supervision is provided by a licensed nurse (RN or LPN). The RNP does not require a therapist. Residents were at increased risk of decline in ADL function such as walking, transferring, and ROM due to the pandemic which required social distancing. Residents spent long periods in their rooms in bed or chair. The facility stopped their Restorative Nursing Program when Physical Therapists (who provided oversite of the program) stopped coming to the facility in 2020 due to the public health COVID-19 emergency. The facility did not implement alternative interventions Resident 20 Review of the electronic health record (E-HR) revealed the facility admitted R20 on 05/15/2012. Current diagnoses included generalized muscle weakness, osteoarthritis of both knees, diabetes, dementia with behavioral disturbance, and chronic obstructive pulmonary disease (lung disease). Review of Annual Minimum Data Set (MDS) assessment dated [DATE] and the Quarterly MDS assessment dated [DATE] both revealed the facility coded the resident to have a functional limitation in both lower extremities. Active orders in the E-HR revealed an order dated 09/24/2019 and read, PT [Physical Therapy] for ROM [range of motion] per Neurology consults: start range-of-motion as they deem appropriate given contractures on exam. If there is progressive worsening despite maximal PT care, may need ortho eval if consideration for interventional care. Observed R20 on 09/21/21 at 01:57 PM lying in bed on her right side. The bed was in a low position and there was a grab bar installed on the side. Residents knees were bent. Nursing Assistant (NA) 85 came into R20's room during the observation. When asked if R20 received any ROM exercises, she stated that staff would attempt ROM however R20 refused the attempts. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the charge nurse, LN2 on 09/24/21 at 11:33 AM, LN 2 confirmed R20 had contractures. She is not able to fully extend her legs. When asked about staff facilitating ROM, she stated 'not on a daily basis. When asked where such documentation would be, she stated, I don't think that's being done. She explained that PT had not coming to the facility since the early 2020 when the pandemic started. When asked to describe how nursing assessed the limitations in a resident's range of motion, she stated there was not a formal assessment they used. Review of R20's care plan revealed three focus areas which touched on the resident's limited range of motion, however there was not a focus area which, addressed the limitation or provided staff with a plan to assess the limitation, and prevent further decline. [Cross reference F656]. Review of all progress notes in the E-HR between 05/28/21 and 9/24/21 revealed a lack of notes addressing ROM, refusals of ROM or exercises, exercises, or any assessments in the resident's ROM ability or limitation. Resident 40: Review of the E-HR revealed the facility admitted R40 on 10/15/19. Current diagnoses included diabetes, pain, spondylolisthesis in the lumbar region (a spinal disorder in which a bone (vertebra) slips forward onto the bone below it), hypertension, chronic kidney disease, and hypothyroidism. Review of the Annual MDS assessment dated [DATE] and the Quarterly MDS dated [DATE] both revealed R40 had a functional limitation in the ROM affecting both lower extremities, and on upper extremity. During an interview on 09/20/21 at 01:24 PM, R40 described pain she had in her arms. The doctor wanted me to do exercise. She demonstrated that a limitation in her ability to raise her arm and then said My arms hurt and rubbed them. Charge nurse LN2 was interviewed on 09/22/21 at 10:35 AM. LN2 confirmed there were restorative nurses' aides (RNA) working in the facility, however Physical Therapy was closed and the RNAs were assigned to work on the floor as nursing assistants. LN2 was interviewed later that same day at 02:15 PM. She stated that R40 had chronic shoulder pain and arthritis. She described The doctor wanted her to have ROM, back when PT were coming, she complained it hurt and refused, and gets mad at them. When asked about the restorative program gain, she explained the PT department (from the hospital) use to come over (before the pandemic) and they provided oversight for the program. Since they stopped coming the RNA could not continue to work without the supervision. Review of active orders revealed the following order: Encourage staff to work w/ patient for gentle ROM exercises as able and pendulum ROM as able daily dated 8/20/20. Review of progress notes for the previous 6 months revealed occasional refusal for care unrelated to ROM or exercises (6/6/2021 at 07:06, 7/16/2021 at 20:17, and on 8/11/2021 at 03:36). The progress notes revealed a lack of documentation addressing ROM and any exercises. No assessments under the assessment tab were found. A review of the tasks tab (where nursing assistants document care provided) revealed a lack of documentation related to ROM or exercises. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R40's care plan revealed there was not a focus area addressing the limited ROM. A focus area addressing self-care performance deficit [related to] impaired balance, limited mobility, pain . revision date 08/07/21 was reviewed. The goal was for R40 to maintain current level of function in activities of daily living (ADLs), revision date 7/21/21. Multiple interventions provided the plan for the following ADLs: bathing/showering, bed mobility, dressing, eating, oral care, personal hygiene, toilet use, and transfers. Additional interventions read, Monitor [R40] document/report PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function and PT/OT evaluation and treatment as per MD orders. No where in the care plan address the plan for functional limitations or exercises to prevent further decline. During an interview on 09/24/21 at 11:33 LN2 confirmed there was an order to encourage ROM. When asked where this was documented she stated, I don't think that's being done. Review of the facility's Census and Conditions form (CMS-672) revealed the current census was 58 residents. Of those 58 residents, 53 had contractures. An undated facility policy titled Range of Motion was provided to the survey team. The policy statement read, A doctor's written order is required. To assist with improvement or maintenance joint mobility. It outlined the procedures for performing ROM, special considerations, documentation requirements, definitions, and care planning steps. A requirement for PT to oversee the ROM activities was not present, however it did direct staff to Consult the physician or physical therapist for limitations or precautions for specific exercises. The Facility Assessment provided to the survey team was dated Feb. 2021. Under Services and Care We Offer Based on our Resident's Needs it read restorative nursing was a specific care provided in the Mobility section. During an interview with the CEO on 09/24/21 at 03:11 PM, he confirmed the program was limited since PT couldn't come out.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 40844 Based on observation, interview, and record review, the facility failed to have a system in place to ensure residents' environment remained as free of accident hazards as is possible. Specifically: 1. Postural support The facility failed to ensure one of three residents (Resident (R) 2) with orders for the postural support device was applied correctly. When staff secured the device behind R2's back and R2 repositioned themselves, the device became a strangulation threat posing a serious risk for death or serious harm due to potential for strangulation Furthermore, all three residents (R2, R7, and R31) were not assessed for appropriateness or safety of the device before implementation. This failure resulted in the identification of an Immediate Jeopardy. On 09/22/21 at 04:57 PM, the Director on Nursing and other administrative staff were notified of the Immediate Jeopardy. The facility presented a removal plan which was accepted on 09/23/201 at 09:10 AM. While onsite, it was determined the IJ was removed on 09/24/2021 at 11:15 AM; the deficiency remained at level 3, actual harm that is not Immediate Jeopardy. [Cross reference F604] 2. Thickened liquids The facility failed to have a system in place to ensure that all residents (Residents (R) 1, 7, 8, 22, 31, 32, 39, 41, 47, and 49) who had physician's orders for thickened liquids received the correct liquid consistency when receiving fluids. This failure placed residents at risk for choking and/or aspiration of liquids, which had the potential of causing serious harm or death. This failure resulted in the identification of an Immediate Jeopardy. On 9/23/2021 at 1:11 PM, the Director of Nursing and other administrative staff were notified of the Immediate Jeopardy. The facility presented a removal plan on 9/23/2021 at 2:47 PM, while onsite it was determined that the Immediate Jeopardy was removed on 09/24/21 at 10:09 AM; the deficiency remained at a level 3, actual harm that was not Immediate Jeopardy. 3. Falls The facility failed to ensure 4 of 5 sampled residents (Resident (R) 2, R23, R31 and R49) reviewed for accidents had a root cause review (a systematic process for identifying the cause of a problem and an approach for responding to the problem) for each fall they had, an investigation of the cause of the fall and interventions implemented to prevent reoccurrence of falls. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	These failures placed the residents at risk for repeat falls, which had the potential of causing serious harm. R2 sustained falls which resulted in actual harm of leg fractures and skin tears, and R23 sustained a fall which resulted in a hip fracture. After the fall, R23 was not assessed prior to being picked up from the floor, creating the potential for further injury. 4. Treatment carts unlocked The facility failed to ensure residents' environment were free from hazards, when treatment carts were left unlocked when unattended and/or out of view of the nursing staff. This failure allowed residents access to hazardous items (medicated creams, sharp objects, etc.), which placed residents at risk for avoidable incidents. Findings included: 1. Postural supports: On 09/22/21 at 08:24 AM, observed R2 was sitting in a wheel chair beside the bed. On this day, R2 had a white cloth device wrapped around their torso encompassing the wheel chair. Certified Nursing Assistant (CNA) 18 was preparing to enter the room and stated, I'm gonna put [R2] in bed. CNA18 described the white cloth device as a positioner which kept the resident upright. After donning (putting on) required PPE surveyor requested CNA18 ask R2 in their native language to remove the device. After looking at the device, CNA18 stated It is secured in the back, [R2] cannot take it off. Observed the device was positioned high on R2's upper chest, approximately 1 inch below the neck. CNA18 confirmed the device had shifted during use and was not applied correctly. She further described R2 as 'sometimes combative,' gesturing with her arms like she was struggling or hitting out. During an interview on 09/22/21 at 09:39 AM, the Charge Nurse, Licensed Nurse (LN) 2 was asked about the positioning device. She stated, It is something to hold [R2] in place. [R2] used to be one of those that climb out of the chair . It is almost like a restraint. [R2] wiggles and squirms. That is why it should be here (gestured to upper abdomen) . [R2] is actually capable of taking it off. Review of active orders in the electronic health record (E-HR) on 09/22/21, revealed an order for the positioner dated 03/30/21. It read, May use TORSO SUPPORT, to maintain body posture & positioning - attach & secure daily to ensure above. A review of assessment under the Assessments tab of the E-HR and progress notes revealed a lack of assessment prior to implementing the positioning device. Reviewed R2's care plan on 09/22/21. It revealed a focus area for the torso support positioning device. An intervention read, Apply [R2's] Self release torso support's Velcro strap in the front while seated in wheelchair so she can self release as needed. Date Initiated: 07/21/2021 The facility's policy, Torso Trunk Support (undated) indicated the device maintains proper body alignment and is used for upper torso postural support to prevent tilting and leaning. Under the procedure section of the policy, the following is noted, .2. Physical Therapy will assess resident to determine if Posey trunk support will be beneficial and safe for resident use . Manufacturer's instructions titled Posey Torso Support included the following contraindications, DO NOT use on a patient who is or becomes . combative, agitated . STOP USE AT ONCE: if the patient has a tendency to slide forward or down in the device . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 7 R7 had diagnoses that included dementia (memory problems), congestive heart failure (heart does not pump effectively), high blood pressure, and chronic kidney disease (gradual loss of kidney function). A Physician's Order, dated 7/14/2021, was reviewed for a Self-Release Torso Support to be applied while seated in a wheelchair. Resident requiring upper support to help reduce tilting, leaning, and falling from chair. On 9/20/20201 at 11:19 AM, R7 was observed in a wheelchair. R7 had on a posture device that had a seatbelt-like strap over his lap, which was held closed with a hook and loop fastener. There were also two straps that crossed on the back of the wheelchair back and came over the resident's shoulders and Velcroed to the seatbelt-like device. Review of R7's clinical record revealed no Physical Therapy assessment for the use of the torso support device. This was confirmed by the Director of Nursing on 9/22/2021, at approximately 6:00 PM during a group interview. Resident 31: R31 was readmitted to the facility with diagnoses that included dementia (memory problems), diabetes (high blood sugar), and Parkinson's disease (progressive nervous system disorder that affects movement-tremors, stiffness, or slow movement). Reviewed Physician's Order, dated 7/14/2021, for a Self-Release Torso Support to be applied while seated in a wheelchair. Resident requiring upper support to help reduce tilting, leaning, and falling from chair. A care plan was initiated on 7/14/2021, for the use of the Posey Self-Release Torso Support. The care plan indicated that the device should be used while R31 was seated in a wheelchair to achieve and maintain good body posture and body positioning. Review of R31's clinical record revealed no Physical Therapy assessment for the use of the torso support device. This was confirmed by the Director of Nursing on 9/21/2021, at approximately 6:00 PM during a group interview. The facility was notified of the IJ on 09/22/21 at 04:57 PM, in the presence of the DON, the Quality Assurance/Quality Improvement (QAQI) Nurse, the acting Assistant Director of Nursing (ADON), the Dietary Manager, and the Minimum Data Set (MDS) Assessent Nurse. During the meeting, the DON confirmed there were no assessments for use of the torso supports, and that it should be applied so that it is self-releasing (in the front). The DON acknowledged the risk of strangulation was present when applied improperly. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility submitted a plan to remove the immediacy of the IJ, which the survey team found acceptable on 09/23/21 at 09:10 AM. The plan included discontinuing the devices, having affected residents assessed by therapy for appropriate device use, implementing monitoring/reporting of the residents every 15 minutes for proper body alignment and comfort, updating the care plan and If additional residents require assistive devices, an assessment will be initiated by nursing and care plan committee prior to application with a doctor's order and PT Evaluation. All staff were to be trained on the plan of removal. Review of documents submitted by the facility revealed R2, R7, and R31 had all been referred to Physical Therapy for a safety assessment, orders for the torso positioners had been discontinued, care plans updated with the removal of the devices, and implantation of the 15-minute safety checks, and training for all staff was completed. 2. Thickened Liquids: The facility's Mechanically Altered Diets and Thickened Liquids policy, with a revised date of 09/16/2018, indicated the following under the Procedure section 3. Food and Nutrition Services should thicken liquids to proper consistency, i.e., juice, milk, coffee, soup, and water. Pre-thickened juice, milk, and water may be desirable where the budget permits. (Send thickened water on each tray.) .4. When thickened water at bedside is required, there are two methods for thickening: a. Send an empty pitcher of a contrasting color on the breakfast carts. Following manufacturer's instructions, send pre-portioned thickeners in covered souffle cups marked 'nectar,' 'honey,' or 'spoon-thick' or b. Send a minimum of 8 oz thickened water or thickened flavored water on each tray and between meals three times daily on the nourishment cart. The bedside water pitcher would not be used The facility policy further documented that when a resident has an order for thickened liquids and also needs additional calorie and protein supplementation, recommend using the Special Nutrition Program. The 2 cal/ml med pass does not thicken well. Two cal/ml med pass is generally acceptable as nectar thick but should be reviewed and approved by the speech therapist. According to form CMS-672, the facility had 45 residents that received mechanically altered diets (pureed and chopped) of that number 10 residents also received thicken liquids. The lists that were posted in the kitchenettes on both units identified the following residents as receiving thickened liquids: Resident 1--Nectar thick liquids Resident 7--Nectar thick liquids Resident 8--Honey thick liquids Resident 22--Nectar thick liquids Resident 31--Nectar thick liquids Resident 32--Nectar thick liquids Resident 39--Nectar thick liquids (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 41--Nectar thick liquids Resident 47--Nectar thick liquids Resident 49--Nectar thick liquids Resident 31 Resident (R) 31 was readmitted to the facility on [DATE] with diagnoses that included dementia (memory problems), diabetes (high blood sugar), and Parkinson's disease (progressive nervous system disorder that affects movement-tremors, stiffness, or slow movement). An Annual Minimum Data Set (MDS-mandated assessment tool) dated 7/12/2021, revealed that R31 scored a 5 on the Brief Interview for Mental Status (BIMS-a structured evaluation aimed at evaluating cognition). A score of 5 revealed severe cognitive impairment. Under the functional status section, R31 was assessed to require supervision (oversight, encouragement, or cueing) with setup help only for eating. Under the Swallowing/Nutritional Status section, the assessment indicated that R31 had no signs and symptoms of possible swallowing disorder. Under the oral/dental status section, the assessment indicated the resident had no natural teeth or tooth fragment(s). R31 had Physician's orders for the following: * Order date 9/3/2021,120 cc (cubic centimeters) Med Pass 2.0 twice daily *Order date 1/9/2021, Consistency Carbohydrate (CCHO) diet, Pureed texture, Nectar consistency.(Pureed texture is a diet in which all foods have a soft, milk-shake consistency. The diet consists of foods that are smoother and easier to swallow (no chewing). Nectar thick liquids are thicker than water and fall slowly from a spoon.) A progress note, Communication with Physician, dated 2/8/2021, indicated the following, Assessment (RN)/Appearance (LPN) .Cooperative with care and med[ications] administration .Eating: Eats independently with setup at mealtimes, snack time prn (as needed). Requiring more encouragement and supervision as well. Appetite poor to fair . A Registered Dietician note, dated 8/5/2021, indicated it was an annual review. The assessment included the following information: Current diet CCHO, puree with nectar thick liquids, Supplement: Med Pass 60 120 cc BID (twice daily). Continue to serve diet as ordered, offer snacks PRN (as needed), offer supplements as ordered, honor preferences, offer alternatives as needed, monitor for changes in labs, meds, weights, and intake. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R31 had a care plan for therapeutic mechanical altered diet related to poor dentition (condition of teeth), and increased needs related to wound healing with an initiation date of 4/25/2020, and a revision date of 7/19/2021. The interventions included the following: diet as ordered CCHO, puree with nectar thick liquids. There was an additional care plan related to potential fluid deficit due to poor intake of foods and fluids, dated 2/13/2021. The intervention for this plan of care included: encourage [R31's name] intake of meals/fluids, monitor for signs of dehydration, encourage [R31's name] to drink fluids of choice, ensure [R31's name] has access to fluids at bedside and requires nectar consistency and offer and assist with fluid intake, and [R31' name] needs (assistance/encouragement/supervision) with fluid intake in order to meet daily requirements. An observation on the Men's unit in the kitchenette on 9/21/2021 revealed a note posted on the wall. The note indicated Resident Diet Type. The posting revealed 4 of the 30 residents on the unit required thickened liquids. The posting indicated that R31 was to receive Thickened Nectar. On 9/21/2021 at 11:30 AM, R31 was seated in the dining room waiting for the noon meal to be served. A staff person was observed going from table to table offering the residents either coffee or hot tea. R31 was served coffee, R31 picked up the cup and took a sip of the un-thickened hot coffee. On 09/22/2021 at 10:32 AM, observed the interim Assistant Director of Nursing (IADON) passing R31's medications. The AIDON poured medication into medication cup and poured 120 cc of med pass (Hormel 2. 0 Med Pass) nutritional supplement into plastic cup. The pills were not crushed and thickener was not added to med pass supplement. The IADON gave the medication and Med Pass 2.0 to the resident. R31 was observed in the dining room on 9/22/2021, at approximately 11:47 AM. The resident was seated at a table that indicated Feeder. R31 was observed feeding himself pureed food from a divided scoop dish. Also, placed near R31 was a cup of coffee and a small glass of juice. Neither of the beverages were thickened. At the end of the meal, a Styrofoam cup with a lid was placed in front of R31. A Certified Nursing Assistant (CNA) who was seated at the table (feeding another resident) indicated it was thickened milk. This surveyor commented that the other fluids were not thickened, the CNA did not address this question but continued to assist another resident. On 9/23/2021 at 8:53 AM, observed the Director of Nursing (DON) passing R31's medications. The DON prepared medications outside the resident's room. The DON placed seven pills into a medication cup, including large calcium pills, and poured 120 cc of med pass (Hormel 2.0 Med Pass) nutritional supplement into plastic cup, The pills were not crushed and thickener was not added to the med pass supplement. Upon entering the resident's room, R31 was observed lying in bed. The DON raised the head of the bed so resident's position changed from lying to about a 30-degree sitting position. The DON placed the pills into R31's mouth and then placed a plastic cup with the med pass supplement near the resident's mouth. R31 started coughing after a few sips of med pass supplement. R31 moved his body and legs towards the edge of the bed where the DON was standing and the DON assisted the resident to sit at the edge of the bed with the resident's feet on the ground while he continued to cough. As R31 coughed, the DON reached for a water pitcher with straw that was on top of side table against the wall across from the resident's bed. The DON placed the straw in R31's mouth. R31 took sips and coughed for a bit more then stopped coughing. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/23/2021 at 9:35 AM, R31's room was observed. On the dresser, was a large cup with clear liquid, a lid and a straw. At 10:10 AM, Unit Aide (UA)7 was asked about the water at the resident's bedside. UA7 stated that at the start of his shift he replaced the water at the residents' bedside with a clean cup and fresh water. UA7 stated that all residents received regular water and then staff would thicken the water when offering a resident (who required thickened liquids) a drink. UA7 was asked how staff knew which residents were to receive thickened liquids, UA7 indicated there was a list posted in the kitchenette. UA7 confirmed there was nothing in the residents' rooms indicating what consistency of fluids the resident should receive. On 9/23/2021 at about 8:50 AM, observed the DON passing medications and med pass nutritional supplement to R1. The DON crushed R1's medications and thickened R1's med pass nutritional supplement and then placed crushed medications and thickened med pass onto spoon and spooned into R1's mouth. The DON further stated that R1's eMAR shows it is okay to thicken liquids to decrease coughing. The DON stated that R1 coughs when he drinks and R1 is scheduled to see therapy today. When asked if other residents get their med pass thickened, DON stated that she could not recall. When asked if R31 gets his med pass thickened, DON said no. When asked about R31's coughing during med pass, DON stated that R31 has Parkinson's and sometimes his swallowing isn't that great, he may have a swallowing delay, and they should probably crush his medications. The DON stated that R31's medications were not crushed. The DON stated the water at R31's bedside was not thickened and further stated I don't thicken his liquids. The DON reviewed R31's eMAR and stated his diet order, dated 1/1/21, was for a carbohydrate consistent diet, nectar thick, and R31 should have received nectar thick liquids. When asked how would staff passing medications know that resident should be receiving nectar thick liquids, the DON stated it depended on who entered the order [in the eMAR] and if that information was shared or not. The DON further stated R31 doesn't usually cough, he'll tell you what he wants. He makes his needs known. It's really hard because we don't have PT (physical therapy), OT (occupational therapy), and I.H.S. (Indian Health Services) decreased their capacity to see residents. During an interview on 9/23/2021 at 9:35 AM, with the DON and Quality Assurance/Quality Improvement/Infection Preventionist Registered Nurse (QAQI), when asked how do you know which residents receive thickened liquids? The DON stated they go by the orders on the resident's treatments which is listed on the eMAR (electronic Medication Administration Record). On 9/23/2021 at 1:11 PM, the DON), IADON, MDS nurse, and QAQI nurse were notified Immediate Jeopardy was identified when R31 received regular consistency liquids when he was supposed to receive nectar thick liquids, per a Physician's Order. On 9/23/2021 at 3:28 PM, CNA31 was asked about the Kardex binder. CNA31 indicated the binder had a copy of each residents' care plan information in it. R31's Kardex, which was located in the Kardex binder, was reviewed. At the top of R31's Kardex, Under the Eating/Nutrition section, dated As of 1/13/21 there was no indication R31 required thickened liquids or a pureed diet. On 9/23/2021 at about 1:08 PM, the IADON was asked about medication pass observation on 9/22/21, and confirmed that she did not crush R31's medication or thicken the med pass supplement. The IADON stated that regular non-thickened water was in the water pitcher in resident's rooms and staff did not thicken water for R31. On 9/23/2021 at approximately 4:00 PM, LN7 was interviewed. LN7 indicated R31 required a pureed diet and nectar thick liquids due to having no teeth and he had some swallowing issues. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/24/2021 at 2:57 PM, during a concurrent interview and record review, the DON stated the Hormel brand med pass 2.0 referred to 2 calories per milliliter, and had not been reviewed, approved or accepted as nectar thick for use in the facility as outlined in the facility policy On 09/24/2021 at 3:03 PM during an interview with the Dietary Manager (DM) the DM stated the facility did not have a speech therapist and she was not aware Hormel med pass 2.0 had been reviewed by a speech therapist for meeting the requirements of a nectar thick liquids diet order, as outlined in the facility's policy. On 09/27/2021 at 7:30 AM Pacific standard time Medical Director (MD) stated that he was not aware of immediate jeopardy (IJ) situations last week in the facility. The MD stated that he was called about resident coughing, but did not know it was related to IJ concerns with R31consuming non-nectar thick, regular thin liquids. The MD stated facility staff should be following physician orders, including diet orders for nectar thick consistent liquids, including during medication pass. 3. Falls: The facility policy entitled Falls and Fall Risk Managing (undated) indicated that Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to reduce falls, reduce injury, try to minimize complications from falling and identify patient at risk for falls. Under the Procedures section of the policy, directed .1. The staff with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions .4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Under the Monitoring section the following was indicated, 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling .3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. If needed, the Attending Physician will help the staff reconsider possible causes that may not previously have been identified . The policy also included what actions staff should take after a resident fall. These actions included completing an incident form and checking the care plan and redo Fall Scale with IDT [interdisciplinary team]. Resident 2 Review of the Electronic Health Record (E-HR) revealed the facility admitted R2 on 10/25/2019, and readmitted her on 05/07/21, following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection ('C-diff' is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment, dated 05/18/21, revealed a BIMS score of 05 which indicated severe impairment of cognitive abilities (intellectual activity such as thinking, reasoning, or remembering), and she required extensive assistance with bed mobility and totally dependent for transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation and concurrent interview on 09/21/21 at 11:30 AM, R2 was sitting in a wheel chair beside the bed. Unit Aide (UA) 3 confirmed R2 was on isolation for C-diff. Observed bruising on R2's left hand and elbow area and asked UA3 about it. She stated R2 was combative at times, and was hitting at the wall today getting up. She confirmed she used lift to transfer the resident. On 09/22/21 at 08:24 AM, observed R2 sitting in a wheel chair beside the bed. On this day, R2 had a white cloth device wrapped around their torso encompassing the wheel chair. Certified Nursing Assistant (CNA) 18 was preparing to enter the room and stated, I'm gonna put [R2] in bed. CNA18 described the white cloth device as a positioner which kept the resident upright. After donning (putting on) required PPE surveyor requested CNA18 ask R2 in their native language to remove the device. After looking at the device, CNA18 stated It is secured in the back, [R2] can not take if off. Observed the device was positioned high on R2's upper chest, approximately 1 inch below the neck. CNA18 confirmed the device had shifted during use and was not applied correctly. She further described R2 as 'sometimes combative' gesturing with her arms like she is struggling or hitting out. CNA18 also stated that they used a camera to monitor the resident in her room. [Cross reference F583] During the same observation and interview, CNA18 demonstrated the approaches she used to minimize the risk of falls when in bed. Observed as she utilized the lift to transfer the resident to the bed. The bed was positioned against the far wall in the room and did not have any siderails. After situating the resident comfortably in bed, she lowered the bed to the lowest position and placed a mattress on the floor beside the bed, and then placed 2 smaller floor mats by the edge of the mattress. CNA18 stated I guess [R2] might wiggle off the bed. She set the camera lens to face the resident while in bed before leaving the room. During an interview on 09/22/21 at 09:39 AM, the Charge Nurse, Licensed Nurse (LN) 2 was asked about the positioning device. She stated, It is something to hold [R2] in place. [R2] used to be one of those that climb out of the chair . It is almost like a restraint. [R2] wiggles and squirms. that is why it should be here (gestured to abdomen) . [R2] is actually capable of taking it off. LN2 confirmed R2 was at risk for falls and had several falls in the facility. She indicated the mattress and the then the floor mats should be positioned next to the bed when R2 was in bed. When asked about the camera she stated, That is a way we keep an eye on her sometimes. She described the resident threw herself over the bed, that is how she got that injury. A review of the E-HR revealed the resident had 8 falls over the past 10 months: 11/25/20 Fall An Incident Note dated 11/25/2020 at 03:05 read, Entered room and observed resident on the floor next to bed. Laying in pronation position on stomach. Skin tear sustained to Right elbow (1.8 X 1.2cm). Head to toe assessment completed. The assessment revealed no additional injuries. A fall risk scale titled MORSE FALL SCALE was also completed which scored the resident as High Risk. R2's care plan focus area for actual unwitnessed fall listed this fall. A new intervention, initiated on 11/28/2021, was to use a chair alarm. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interdisciplinary team (IDT) investigation of the fall evaluating and analyzing the hazard risks with a root cause review was absent from the medical record. 11/30/20 Fall An Incident Note dated 11/30/2020 at 18:22, read, Writer got called to Room . to check on resident . who had an unwitnessed fall and found on the floor near big window; Entered room and noted resident laying on her back on top of her Hoyer lift pad and her wheelchair was parked near/behind her head; States she tried to scoot across to get into her recliner chair and her Hoyer lift pad just slipped down with her onto the floor. An assessment revealed no new injuries. A non-slip pad was placed in the wheel chair to prevent slipping out. A fall risk scale titled MORSE FALL SCALE was also completed which scored the resident as High Risk. R2's care plan focus area for actual unwitnessed fall listed this fall. No new interventions were identified during the record review. An interdisciplinary team (IDT) investigation of the fall evaluating and analyzing the hazard risks with a root cause review was absent from the medical record. 12/04/20 Fall An Incident Note dated 12/4/2020 at 15:59, read, CRAWLED OUT OF BED (SUPERFICIAL SKIN TEAR TO CHEST): 2:55 PM, heard resident was yelling, this writer went to check on resident in her room, resident was in bed side lying position, bed was lowest in position and blue mattress (soft padding) to both side of floor Head to toe assessment done. Noted skin tear (superficial, skin flap present 7 cm X 3.4 cm, oozing, no active bleeding) to the resident's chest. Upon Palpation resident c/o tail bone pain but no other obvious injury reported. PROM [Passive range of motion] extremities at baseline and denies pain. The note additionally described recent changes in the resident's behavior and mental status. A physician was called and report of the event, injuries, changes in behavior, and recent falls was given. An order was received to transport the resident to the emergency room (ER) for further evaluation, and this was done. A follow up note dated 12/04/2020 at 21:19, revealed the resident had been admitted to the hospital. A MORSE FALL SCALE was also completed which scored the resident as High Risk. A Nursing Progress note dated 12/6/2020 at 14:43, revealed the resident returned to the facility from the hospital. R2's care plan focus area for actual unwitnessed fall listed this fall. A new intervention initiated on 12/05/2021 read to place a mattress beside the bed when the resident was in bed. An interdisciplinary team (IDT) investigation of the fall evaluating and analyzing the hazard risks with a root cause review was absent from the medical record. 01/21/21 Fall An Alert Note dated 01/21/2021 at 16:31, read, Resident was found on the supine position on the floor in front of [wheel chair]. An assessment revealed Bruising to left elbow and bump anterior to lower leg and R2 was sent to the ER for further evaluation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A follow up note dated 01/21/2021 at 21:31, revealed R2 had been admitted to the hospital for fracture of left leg and a urinary tract infection. A MORSE FALL SCALE was also completed which scored the resident as High Risk. Resident's care plan focus area for actual unwitnessed fall listed this fall. A new intervention initiated on 01/23/2021 read, requires close monitoring to prevent further fall incident. Follow fall precautions. It did not define what close monitoring was, or how this was different from what the staff were doing. An interdisciplinary team (IDT) investigation of the fall evaluating and analyzing the hazard risks with a root cause review was absent from the medical record. 02/09/21 Fall A Post Fall MORSE FALL SCALE dated 02/09/21 at 12:25, was completed and revealed the resident was high risk for falls. Progress notes were reviewed and a corresponding note describing a fall was absent. Resident's care plan focus area for actual unwitnessed fall listed this fall. Two new interventions were initiated on 02/10/2021. One was to lower the bed, and use floor mattress and the other read, continue 15 min. safety checks. An interdisciplinary team (IDT) investigation of the fall evaluating and analyzing the haza [TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on record review, observations, review of Centers for Medicare & Medicaid (CMS) Quality State Oversite (QSO) document, and interviews the facility failed to ensure three Medical Assistants (MA) 3, MA2 and MA4, out of a sample of four, were certified/licensed to perform personal care and skin care/treatments for residents. The facility failed to ensure one Certified Nursing Assistant (CNA)30 performed a transfer, per plan of care for one (Resident (R) 23) and as a result, R23 fell and sustained a hip fracture. CNA30 also failed to leave R23 on the floor after a fall, so a licensed nurse could perform a complete assessment on the resident and identify potential injuries. Findings include: 1.Review of a CMS document titled QSO 21-17-NH DATE dated April 8, 2021 UPDATED:05/10/2021, indicated .Training and Certification of Nurse Aides (42 CFR S483.35(d)) To help nursing homes address staffing shortages during the pandemic, CMS provided a blanket waiver for the nurse aide training and certification requirements at 42 CFR S483.35(d) (except for requirements that the individual employed as a nurse aide be competent to provide nursing and nursing related services at 42 CFR S483.35(d)(1)(i)), specifically to permit nurse aides to work for longer than four months without having completed their training. This waiver allows facilities to employ individuals beyond four months, in a nurse aide role even though they might have not completed a state approved Nurse Aide Training and Competency Evaluation Programs (NATCEP) .However, we are clarifying how federal regulations can be applied to nurse aides working under the blanket waiver and help enable these individuals to become certified nurse aides (CNAs). Federal regulations at 42 CFR S483.152(a) and (b) require that NATCEP participants take 75 hours of training in certain areas that are critical for performing their role as a CNA, such as . basic nursing skills .Lastly, nurse aides must still successfully pass the state's competency exam per 42 CFR S483.154. Additionally, CMS waived the requirements that prohibit a nursing home from using any individual working in the facility as a nurse aide for more than four months unless they complete certain requirements (per 42 CFR S483.35(d)(1)). nurse aides will have up to four months from the end of the blanket waiver to complete the required training and certification, we strongly encourage states and nurse aides to explore ways to complete all the training and certification requirements as soon as possible. Review of the Certified Nursing Assistants website (https://www.cnalicense.org/by-state/arizona) indicated, . Before you can become a Certified Nursing Assistant in Arizona, you must fulfill the certification requirements as mandated by the Arizona State Board of Nursing. First of all, Arizona requires all prospective CNAs to complete state-approved training. Then, they must pass both sections of the CNA certification exam with acceptable scores. Persons who complete these basic requirements will be issued a certificate by the Arizona State Board of Nursing. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Arizona statute 32-1456 indicated . A medical assistant may perform the following medical procedures under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner. Take body fluid specimens.Administer injections.The board by rule may prescribe other medical procedures which a medical assistant may perform under the direct supervision of a doctor of medicine, physician assistant or nurse practitioner on a determination by the board that the procedures may be competently performed by a medical assistant. Without the direct supervision of a doctor of medicine, physician assistant or nurse practitioner, a medical assistant may perform the following tasks.Billing and coding. Verifying insurance. Making patient appointments.Scheduling. Recording a doctor's findings in patient charts and transcribing materials in patient charts and records. Performing visual acuity screening as part of a routine physical.Taking and recording patient vital signs and medical history on medical records. The board by rule shall prescribe medical assistant training requirements. A person who uses the title medical assistant or a related abbreviation is guilty of a class 3 misdemeanor unless that person is working as a medical assistant under the direct supervision of a Doctor of Medicine, physician assistant or nurse practitioner. Review of a paper document titled Job Description Medical Assistant, undated under a section titled Duties and Responsibilities failed to address the state specific requirements identified under the Arizona statute and the requirement having direct supervision of a Doctor of Medicine, physician assistant, or a nurse practitioner. Review of a paper document titled Job Description Certified Nursing Assistant dated June 2011 indicated, . provides the client with personal care and grooming. Certificate of CNA training and transcript. a. Review of the paper personnel record for MA3 indicated MA3 was hired on 05/10/21 and he was not hired with the credentials of a Certified NA (training and education/certification by the Arizona Board of Nursing). There was evidence to show MA3 completed a MA program on 03/16/21. Review of a facility paper document titled, Medical Assistant, and included in MA3's personnel record, dated as signed 05/10/21 indicated MA3 was not provided demonstration and return of personal care for a resident by a licensed nurse. During an interview on 09/24/21 at 10:55 AM, MA3 stated he was hired approximately four months ago to work as a MA and was not a Certified NA. MA3 confirmed he performed skin care/treatment and personal care to the residents he was assigned to. An observation was conducted on 09/24/21 at 11:00 AM, MA3 performed skin treatment to (Resident (R) 55, and applied physician prescription medications to his chest, back and to his scalp. MA3 applied ammonium lactate to R55's chest and back and fluocinonide to the resident's scalp. After this observation MA3 provided a list of skin treatments he was assigned to on the men's unit. b. Review of the paper personnel record for MA2 indicated MA2 was hired on 11/04/19 and she was not hired with the credentials of a Certified NA. There was evidence to show MA2 completed a MA program on 10/16/11. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/24/21 at 10:38 AM, MA2 stated she was a certified medical assistant and presented her laminated MA certificate card. MA2 stated she can apply bacitracin ointments and hydrocortisone cream to the residents if there was a physician order. MA2 stated she performs personal care for the residents and stated she did not receive training on conducting personal care, such as demonstration and return, for the residents. MA2 confirmed she was not a certified NA. c. Review of the paper personnel record for MA4 indicated MA4 was hired on 09/13/17 and she was not hired with the credentials of a Certified NA. There was evidence to show MA4 completed a MA program on 05/11/17. During an interview on 09/22/21 at 12:58 PM, MA4 stated she has worked for the facility for the past four years. MA4 stated she performs accuchecks and applies topical skin treatments for the residents. MA4 stated nurses gives the direction for skin treatments for the residents. MA4 confirmed she performed personal care for the residents, specifically if the resident had a catheter, she would also perform personal care. MA4 stated she used to be a certified NA in the past and no longer has that certification. During an interview on 09/22/21 at 2:01 PM, the Director of Nursing (DON) confirmed she hired MA3 and MA3 and they were not a certified NA. The DON stated the MAs were not performing personal care unless the resident urinates or has a bowel movement during skin care/treatment. The DON stated the use of MAs has been happening for the past 14 to [AGE] years. The DON stated there was no physician on the premises and the Medical Director was out. During an interview on 09/24/21 at 8:43 AM, the DON stated it was her understanding the MAs had a federal waiver in place and the lead certified NA and the charge nurse handle competencies for the MAs. During an interview on 09/23/21 at 4:28 PM, the Quality Assurance/Performance Improvement (QAPI) nurse stated there were no competencies for the MAs and there were no policies in place that addressed delegation of tasks to a MA. 1. Review of a paper document titled Job Description Certified Nursing Assistant dated June 2011 indicated, . Maintains a safe environment for the resident.Demonstrates safe transfers, positioning and turning of residents using effective body mechanics. Review of a facility document titled Acknowledgement Policies, for NA30 and dated 08/13/21, failed to indicate a fall precaution policy was provided to NA30. Review of the electronic medical record (EMR) nursing Progress Notes, under tab Prog Notes, dated 09/08/21 R23 sustained a witnessed fall. Specifically, the progress notes indicated certified NA30 assisted R23 from the toilet to her chair and fell . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/23/21 at 9:46 AM, NA30 confirmed she was the staff member who assisted R23 from the toilet to the resident's chair. NA30 stated she had to step away from R23 to move a bedside table that was stuck in front of the resident's chair so the resident could sit in her chair. NA30 stated the resident fell during this time. NA30 stated she then picked R23 up from the floor and placed her in the chair and then alerted the nurse to the fall. NA30 stated she was never instructed not to move a resident after a fall. stated she was not provided any post training after the fall incident. NA30 stated she worked at the facility for four weeks and had to leave because of school responsibilities. During an interview on 09/23/21 at 3:54 PM, the Human Resource Coordinator stated NA30 began her employment on 08/13/21 and her last day of work was on 09/13/21. The Human Resource Coordinator confirmed there was no evidence in NA30's orientation/training on how to properly transfer a resident. During an interview on 09/23/21 at 2:46 PM, Licensed Practical Nurse (LPN)5 confirmed NA30 picked R23 off the floor and placed the resident in a chair. LVN5 stated she informed NA30 to leave a resident on the floor after a fall. A subsequent interview was conducted on 09/23/21 at 4:54 PM, NA30 stated she did not use a gait belt on R23 during the transfer. NA30 stated a gait belt was typically on the resident's walker, but it was not there the day of the fall. NA30 stated the facility never instructed her to use a gait belt with R23. NA30 stated contact guard assistance (hands on the resident) meant to watch a resident during a transfer. NA30 after the resident fell , she put her arms under R23 and lifted her up from the floor and placed her in a chair. During an interview on 09/24/21 at 8:56 AM, the DON stated her expectation for nursing was to do a full assessment on the resident and the NA30 was not to pick R23 up and move the resident after a fall. The DON stated contact guard meant to have hands on the resident and to use a gait belt during a transfer.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40844 Based on interview and record review the facility failed to maintain procedures for the monthly drug regimen review that ensured each review was received and followed up. When the facility changed Administrative Nursing staff in April of 2021, a system to ensure the Consulting Pharmacist (CP) reviews were received by the Director of Nursing (DON) was not established. This failure affected 2 of 5 residents (Resident (R) 18 and R49) reviewed for unnecessary medications. The deficient practice had the potential for irregularities in resident's medication regimen to continue and potentially negatively impact their health. Findings: Resident 18: Review of the Electronic Health Record (E-HR) revealed the facility admitted R18 on 10/07/2019. Diagnosis included Diabetes, chronic kidney disease, gastro-esophageal reflux disease, and dementia with behavioral disturbance. A CP recommendation for 01/2021 was found in the E-HR. It recommended the physician review and determine if a taper for 2 psychotropic medications (Seroquel 25mg and Sertraline 25 mg) was indicated or contraindicated at this time. A hand-written note under follow up read, Sent to MD 3/2/21. The physician responded 'No change' on 03/04/21. A second CP recommendation for 04/2021 was found in the E-HR. It recommended the same two psychotropic medications (Seroquel 25mg and Sertraline 25 mg) were due for a taper review. The physician responded on 5/5/21, R18 was tolerating and to continue the medications. No other CP recommendations were found in the E-HR. Requested all drug regimen review reports and recommendations by CP for R18 on 09/23/2021. The facility provided the following documents and/or reports: 01/2021 - CP reviewed and made recommendations consistent with those found in the E-HR. 03/2021 - CP reviewed and made no recommendations 05/2021 - CP reviewed and made no recommendations 06/2021 - Two letters from the CP to the physician, neither was signed by the physician. The first one read, Last taper of Seroquel from 25mg to 12.5mg as successful on 5/28/20. Suggest trial taper to 12.5mg qod (every other day) and observe. Goal is to use the minimum effective dose. The second letter recommended tapering omeprazole from 20 mg daily to 10 mg daily citing New guidelines suggest evaluating risk vs benefit when deciding to keep patients on PPI (Proton pump inhibitors (PPIs) are medicines that work by reducing the amount of stomach acid) long term and provided the rational. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/2021 - CP reviewed and recommended reviewing the psychotropic mediation Sertraline 25 mgs at this time. An unsigned copy of the letter to the physician was included. The facility was unable to provide any recommendations for 02/2021 or 08/2021. Additional review of the E-HR revealed no change in the medications RC had made recommendations for. Active orders read, QUEtiapine Fumarate (generic for Seroquel) Tablet Give 12.5 mg by mouth at bedtime for depression. Omeprazole Capsule Delayed Release 20 MG Give 1 capsule by mouth one time a day for reflux/dyspepsia Sertraline HCl Tablet 25MGGive 25 mg by mouth at bedtime Review of the undated policy titled Drug Regimen Review read, Drug Regimen Review consist of reviewing and analyzing prescribed medication therapy and medication use, including nursing documentation of medication ordering and administration. The Consultant Pharmacist reviews the medication regimen of each resident at least monthly. Finding and recommendations are reported to the Administrator, Director of Nursing, the Primary Physician, and the Medical Director, where appropriate. Under the reporting procedure it outlined the process. a. For recommendations to the primary physician, the CP provides the recommendations to both the physician and the DON within 7 days. The physician response is to be provided to the facility within one month of receiving the recommendation. The facility is to keep a copy of the report until the physician signed copy is returned. The signed copy is to be returned to the CP and filed by the facility. b. For nursing documentation review, the CP provides the review within 7 working days. Nursing personnel provide a written response within two weeks after the report is received. A copy of the report is kept by the facility until the response is returned. The response is provided to the CP and filed by facility. During an interview with the DON on 09/24/21 at 09:39 AM she was made aware of the missing medication regimen reviews for R18, as well as the unsigned recommendations to the physician. She stated she had tasked the Quality Assurance Quality Improvement (QAQI) nurse to follow up on the recommendations. She confirmed QAQI had not been trained in the process prior to being tasked with the duty. While discussing the process for managing the drug regimen reviews the DON stated she was not sure who the CP was sending the reports to after the change in administration. She agreed the process was disorganized. The facility did not have a book or a file where the incoming reports were kept and tracked for completion. Surveyor requested any documentation showing follow up for the June and July recommendations to the physician, and any reports/follow up for the missing month of February or August of 2021. Additional documentation was not provided. 35588 Resident 49 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 49's (R49) record documented the resident was admitted to the facility on [DATE] and most recent readmission was on 6/28/21 with diagnosis including heart disease, heart failure and kidney tumor. R49's Minimum Data Set (MDS-assessment tool) dated 08/08/21 documented resident's brief interview of mental status score was 5, indicating severe cognitive impairment and required limited assistance with bed mobility, walking in room and hallway did not occur during the seven-day look-back period, extensive assistance with transfer, toilet use and personal hygiene. Review of R49's electronic medical record (EMR) did not show documented evidence of medication regimen reviews. During the period of 9/21/21 to 9/23/21 several requests were made to DON and QAQI nurse for monthly medication regimen reviews (MRR) for R49 for the time period of January 2021 to August 2021. During an interview on 09/23/21 at 11:35 AM QAQI nurse stated that the only MRR found for R49 was dated January 2021 and she did not know anything about MRR and deferred any further questions to DON. During an interview on 09/23/21 at 11:40 AM DON stated that the staff member who received the MRRs from the CP left in June or July. DON stated that CP has remote access to the EMR and thinks he does the MRR, but she hasn't seen any MRRs since she has been the DON since April 2021. DON stated that she will email CP now and see if he has MRRs. During an interview on 09/23/21 at 12:04 PM QAQI nurse stated that DON has MRRs for April 2021 and August 2021 and DON has made contact with the CP for the other months. During an interview on 09/23/21 at 5:08 PM QAQI nurse stated that DON just received all of the monthly reviews for the residents and she will provide this information. During an interview on 09/23/21 at 5:37 PM QAQI nurse confirmed what she provided on on R49, and the facility only has what was provided. MRRs were not provided for February 2021 or June 2021. During an interview on 09/24/21 at 9:50 AM CP stated that he was able to get all MRRs to DON and there was no identified irregularity for the resident. Outstanding concern remains that MRRs were not sent timely to DON as outlined in the facility policy and MRRs were only received by the DON after the surveyor brought this to the facility's attention.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 40844 Based on observation, interview, and record review; decisions made in administering the facility failed to ensure effective and efficient use of administrative nurses to implement key programs such as Infection Prevention and Control, Quality Assurance and Performance Improvement (QAPI) program, and Emergency Preparedness Plan. The facility failed to ensure adequate licensed nurse staff to monitor and supervise care provided by nursing and medical assistants which placed residents in immediate jeopardy related to improper use of restraints and failure to provide care in accordance with physician orders. These failures were directly related to facility decision and expectation that administrative nurses perform administrative functions while assigned to provide direct resident care and supervision of staff. These failures contributed to adverse resident outcomes that included resident abuse and falls with serious injury. (refer to F600, F604, F689) Findings include: The CEO participated in an interview on 9/24/21 at 3:11 PM. CEO said he came out of retirement and returned to the facility January 4th to serve as CEO for the facility. When asked to describe his role, CEO said, financial and added it was his job to ensure a safe physical environment. CEO stated most of his time was spent writing grants for funding proposals. During an interview on 9/24/21 at 9:00 AM the Director of Nursing (DON) said she was employed by the facility full time as the DON. When asked if she worked on the floor (serving as nurse providing direct care) DON said yes. DON stated she worked on the floor 36 hours per week and spent 4 hours per week on administrative functions as DON. The facility census was 58. The DON reported she needed more administrative time to complete her duties as Director of Nursing. In an interview on 9/24/21 at 1:45 PM Quality Assurance/Quality Improvement nurse (QAQI) said she currently filled multiple nursing administration positions include QAQI nurse and infection control nurse. QAQI said she understood implementation of the infection Prevention and Control Program should be a priority as the nation experienced a declared public health emergency related to the COVID-19 pandemic. QAQI said she knew for months that she needed to develop a water management plan to reduce Legionella risk and needed to complete the emergency preparedness plan. QAQI said she worked on the floor providing direct resident care at least 4 of 5 days each week. QAQI said she was unable to supervise or evaluate resident care and was unable to complete assigned administrative tasks. QAQI said she was unable to implement the infection control program due to lack of time. (refer to F880, F881 and E004). QAQI expressed concern about potential for harm to residents. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CEO said he relied on the nursing management team to address the day to day concerns and to perform many administrative functions in the facility because his focus was financial. CEO stated he was aware the administrative nurses worked multiple shifts each week providing direct resident care to residents which took them away from supervision of staff and administrative functions. CEO acknowledged this impacted critical programs such as QAPI, Infection Control, Safety, residents rights, and orientation and training of staff. CEO said he was aware the administrative nurses could not perform all assigned administrative duties due to staffing. CEO said the facility continued to face a staffing shortage and nurse recruitment efforts were thus far unsuccessful.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 40844 Based on interview, record review and findings of past four years of recertification surveys the Governing Body failed to ensure the appointed or designated person or persons carried out responsibilities to establish and implement policies, procedures, and programs to effectuate and sustain safe operations in the facility and promote quality of care for each resident. The Governing Body is responsible and accountable for the QAPI program. The Governing Body was not actively engaged in the QAPI program. The governing Body's failure to ensure safe management and operations of the facility contributed to repeated and continued noncompliance with the Medicare and Medicaid Long Term Care regulations which contribute directly or indirectly to substandard quality of care and resident harm. Findings include Review of surveys conducted by Centers for Medicare and Medicaid Services (CMS) during the past four years revealed a pattern of continued noncompliance related to: Failure to establish and maintain an emergency preparedness plan, cited during four consecutive recertification surveys; 9/29/201, 9/13/2019, 11/17/20, and the current survey 9/27/21 (reference E004). Failure of facility to ensure a safe environment and failure to provide supervision and safety devices to prevent accidents, cited 9/29/17 with immediate jeopardy identified, cited 3/15/19 environmental hazards with immediate jeopardy identified, cited 9/12/20, and the current survey 9/29/21 with immediate jeopardy identified in two areas. (reference F689) Failures associated with Infection Prevention and Control cited 9/29/17, 3/15/19, 9/20/20 and the current survey 9/27/21. The facility failed to allocate sufficient staffing resources to supervise and implement the infection prevention and control plan during the COVID-19 pandemic and Public Health Emergency. (reference F725, F880, and F881). Failures associated with implementation of the Quality Assurance and Performance Improvement (QAPI) Plan, QAPI committee, and QAPI activities cited 9/29/17, 3/15/19, 9/10/20, and the current survey 9/29/21. (reference F867 and F 868). The CEO participated in an interview on 9/24/21 at 3:11 PM. CEO said he came out of retirement and returned to the facility January 4th to serve as CEO for the facility. When asked to describe how the Governing Body provided oversight for the facility, CEO said the board was appointed based on tribal law. The board consisted of four members each representing a different agency. CEO said the board had not convened a legal meeting because they could not get a quorum. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CEO said he was not appointed as permanent administrator/CEO he said he was year to year. CEO said with limited funds, a permanent administrator had not been trained yet. When asked to describe his role, CEO said, financial and added it was his job to ensure a safe physical environment. CEO stated most of his time was spent writing grants for funding proposals. When asked about his involvement in Quality Assurance and Performance Improvement (QAPI) committee and activities, CEO said administrative nurse QAQI was responsible for the program. QAQI ran the QAPI meetings and the CEO sat on the committee. When asked to describe what type of reporting he provided the board, CEO said QAQI submitted a report of what she needed and what improvements were made. CEO stated the last two quarterly QAPI meetings were cancelled because QAQI was assigned to work on the floor as a charge nurse in addition to and concurrently with her administrative duties.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 40844 Based on interview, record review and findings of past four years of recertification surveys the facility failed to implement and maintain the Quality Assurance and Performance Improvement (QAPI) program. The facility failed to ensure the QAPI program was adequately resourced to include staff time. Failure to maintain the QAPI program placed all residents at risk for injury or illness related to adverse events such as falls and abuse and at increased risk for infection. Findings include: S483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing. S483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical skills. CMS enacted several temporary emergency blanket waivers which were intended to provide nursing homes with flexibility to respond to the COVID-19 pandemic. The blanket waivers had a retroactive effective date of March 1, 2020 through the end of the emergency declaration. CMS is modifying certain requirements in Quality Assurance and Performance Improvement (QAPI) at 42 CFRS483.75. Specifically, CMS is modifying S483.75(b) - (d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the public health emergency (PHE). Review of surveys conducted by Centers for Medicare and Medicaid Services (CMS) during the past four years revealed a pattern of continued noncompliance related to: Failures associated with Infection Prevention and Control were cited 9/29/17, 3/15/19, 9/20/20 and the current survey 9/27/21. The facility failed to allocate sufficient staffing resources to supervise and implement the infection prevention and control plan during the COVID-19 pandemic and Public Health Emergency. (reference F725, F880, and F881). Failures associated with implementation of the Quality Assurance and Performance Improvement (QAPI) Plan, QAPI committee, and QAPI activities were cited 9/29/17, 3/15/19, 9/10/20, and the current survey 9/29/21. (reference F867 and F 868). Review of Form 802 the facility provided during the survey revealed 6 residents (R49, R28, R19, R20, R5, and R2) sustained falls with injury in past 90 days. During the current survey deficient practice was determined for 4 of 5 residents (R2, R23, R31 and R49) reviewed for falls. [Cross reference F689] (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/24/21 at 10:02 AM the Director of Nursing (DON) said regarding falls; We know what to do, we don't have a solid process. DON said the incident report went to the Quality Assurance Performance Improvement nurse (QAQI) to initiate investigation and to prevent further falls. DON said the facility would like to have a meeting; where we just go over falls, but we are not there yet. Infection Control: In an interview on 9/24/21 at 1:45 PM QAQI said she currently filled multiple nursing administration positions including QAPI, infection control nurse, and trainer. QAQI said she understood implementation of the infection Prevention and Control Program should be a priority as the nation experienced a declared public health emergency related to the COVID-19 pandemic. QAPI said she worked on the floor providing direct resident care at least 4 of 5 days each week. QAQI said she was unable to implement the infection control program and QAPI program due to lack of time. QAPI expressed concern about potential for harm to residents. During an interview on 09/24/21 at 2:44 PM, QAQI stated there was no surveillance of infections, tracking, trending, monitoring, and the correcting of infections. QAPI nurse stated there was no information available to show this process. The QAPI nurse stated she was typically working on the floor and did not have the opportunity to develop this program. Additionally, QAQI stated she has not measured/monitored the use of antibiotic use and the outcomes for the facility. The QAPI nurse stated the last time the antibiotic stewardship program was completed was in 2019. The QAPI nurse stated there was no mapping to identify clusters of infections within the facility. [Cross reference F880, F881] The CEO participated in an interview on 9/24/21 at 3:11 PM CEO said he came out of retirement and returned to the facility January 4th to serve as CEO for the facility. When asked about his involvement in Quality Assurance and Performance Improvement (QAPI) committee and activities, CEO said administrative nurse QAQI was responsible for the program. QAQI ran the QAPI meetings and the CEO sat on the committee. CEO stated the last two QAPI meetings were cancelled because QAQI was assigned to work on the floor as a charge nurse in addition to administrative duties that included QAQI and Infection Control. Interviewed QAQI on 09/24/21 at 04:37 PM about the QAPI program. She described the program had started meeting again in 2021. She confirmed there were no QAPI meeting in 2020 [cross reference to F868]. When asked about the transition process from the previous QAQI nurse, she stated the position was unfilled and the only record she had was one meeting that occurred in Feb. 2021. During the 2nd Quarter of 2021 she described the QAPI program had started to work on a process and improvement goals for each department. She gave an example of a hand hygiene process improvement they initiated after identifying there were a lot of UTI (urinary tract infections). We haven't been able to get back to it. She stated this was due to working on the floor. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When asked if the QAPI committee had identified any of the concerns the surveyors had identified, such as the strangulation risk to residents when positioning devices were not assessed prior to use and applied as restraints (refer to IJ on 09/22/21 at 04:57 PM, and F604), the risk to residents requiring thickened liquids (refer to IJ on 9/23/2021 at 1:11 PM), the two residents (R49 and R58) who suffered abuse by another resident (refer to F600), the lack of a restorative nursing program (refer to F688), or the lack of management of the drug regimen reviews (refer to F756), she stated they had not.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 40844 Based on interview and record review the Quality Assurance Process Improvement (QAPI) committee did not meet at least quarterly to evaluate and coordinate QAPI activities. This failure had the potential to affect all residents in the facility. Findings: During an interview on 09/24/21 at 04:37 PM the Quality Assurance/Quality Improvement (QAQI) nurse concurrently reviewed the QAPI records with the surveyor. There was no record of any QAPI meetings presented to the surveyor for 2020. QAQI stated there were no meetings in 2020. When asked about the transition process from the previous QAQI nurse, she stated the position was unfilled and the only record she had was one meeting that occurred in Feb. 2021 (1st Quarter 2021). During the 2nd Quarter of 2021 she described the QAPI program had started to work on a process and improvement goals for each department. QAPI records confirmed three meetings during the 2nd Quarter of 2021 held on, 4/7/21, 5/26/21, and 6/30. When asked there had been or was scheduled any meeting during the 3rd Quarter of 2021 she stated there were none. She explained she had been assigned to working on the floor providing direct care to residents. The Chief Executive Officer (CEO) stated in an interview on 09/24/21 at 03:11 PM, the last two QAPI meetings were cancelled because QAQI was assigned to work on the floor as a charge nurse in addition to administrative duties that included QAQI and Infection Control.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, interviews, and record review, the facility failed to establish and maintain an infection prevention and control program (IPCP) to provide a safe environment to prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: 1. Develop a system for recording incidents, surveillance, tracking and trending, identified under the facility's IPCP and the corrective actions taken by the facility. 2. Ensure staff adhered to standard precautions (hand hygiene) and prevention of cross contamination for one resident (Resident (R) 55) observed for skin care and treatment and for three residents (R7, R27, and R2) observed for peri-care/incontinence care. 3. Wash hands for the required length of time to remove any potential infectious agents from them after providing care to resident (R2) with Clostridium difficile (multidrug resistant organism) 4. Clean and disinfect shared medical equipment, per disinfectant's manufacturer's instructions for contact time, after and between use on resident (R45) for 1 of 1 observation for cleaning/disinfection shared medical equipment. 5. Implement a water management program in accordance with industry standards to reduce the risk of growth and spread of Legionella and other waterborne disease producing pathogens (germs) in the building water system putting residents at risk to contract a potentially life-threatening waterborne illness. These failed practices had the potential to affect the 58 residents residing in the facility and increased the risks of infections for residents with its associated discomfort and complications. Findings include: 1.Review of a document titled, Centers for Disease Control (CDC). National Healthcare Safety Network (NHSN).Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities. dated 01/20, indicated, .Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff and visitors. Information collected during surveillance activities can be used to develop and track prevention priorities for the facility. When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled Infection Control, dated 07/26/13 indicated .Reporting and tracking a resident's infection is to be accomplished by charge nurse as soon as there are any symptoms or indications of infection.Tracking is done by the DON (Director of Nursing) and Quality Assurance Coordinator. All data available in this area is configured to track trends, practices and problems to be addressed by using the various reports available from the stat (immediately) listing reports in the Reports area. During an interview on 09/24/21 at 2:44 PM, the Quality Assurance Performance Improvement (QAPI) nurse who was also the interim Infection Control Preventionist (ICP) stated there was no surveillance of infections, tracking, trending, monitoring, and the correcting of infections. QAPI nurse stated there was no information available to show this process. The QAPI nurse stated she was typically working on the floor and did not have the opportunity to develop this program. 2. Review of a facility policy titled Hand Hygiene, dated July 2019, indicated .Proper hand hygiene is the number one way to prevent the spread of infection.After contact with a patient's intact skin.Change gloves during patient care if moving from contaminated body site to a clean body site.Decontaminate hands after removing gloves. During an observation on 09/24/21 at 10:55 AM, Medical Assistant (MA) 3 was observed to perform hand hygiene with alcohol-based hand sanitizer. MA3 then reached into the treatment cart and pulled out a bottle of ammonium lactate (treats itchy skin) and squeezed part of its contents into a plastic medication cup. MA3 then reached into the treatment cart and retrieved a bottle of fluocinonide (a medication to treat certain skin conditions such as eczema). MA3 then donned a pair of fresh gloves and entered the room of R55. The resident granted permission of this observation. At 11:03 AM, MA3 took the baseball cap off R55 and then applied the fluocinonide to the resident's scalp. MA 3 then went to the bedside table in which the cup of ammonium lactate was initially placed. MA3 did not doff the gloves previously used from his first application of medication to the resident's scalp. MA3 then raised the front of R55's shirt and applied the fluocinonide to the resident's chest, lowered his shirt and then the resident leaned forward in his wheelchair. MA3 then lifted the back of R55's shirt and applied the fluocinonide to his back. MA3 then doffed his gloves. During an interview on 09/24/21 at 11:06 AM, MA 3 stated he was to perform hand hygiene prior to donning his gloves and doffing his gloves. MA3 confirmed he did not perform hand hygiene between skin treatments for R55's skin and should have done so. 29642 The facility's Hand Hygiene policy dated 07/2019 documented that the purpose of the policy was for Effective hand hygiene removes transient microorganisms, dirt, and organic material from the hands and decreases the risk of cross contamination from patients, patient care equipment and the environment. the Procedure section directs staff that, A. Indications for Handwashing .After removing gloves .Gloves and Hand Hygiene . 1. Wear gloves when contact with blood or other potentially infectious materials (other body fluids, secretions, and excretions) .2. Change gloves during patient care if moving from a contaminated body site .4. Decontaminate hands after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/21/2021 at 10:15 AM, Certified Nursing Assistant (CNA) 24 was observed to transfer R7 from his wheelchair to the toilet using the sit-to-stand lift. After the resident had used to the toilet, CNA24 lifted the resident up and provided perineal care (cleaning the private areas of a resident). After completing the care, CNA24 maneuvered the resident to a shower chair. Without changing gloves and completing hand hygiene CNA24 began to gather items needed for the resident's shower. These items were touched with the same gloves the CNA used to provide perineal care with. After completing the R7's shower, CNA24 was asked about the process and when it would be required to change gloves. CNA24 acknowledged that she should have changed gloves and did hand hygiene after providing perineal care. During an interview with the Director of Nursing (DON) on 9/24/2021 at approximately 10:00 AM, the DON stated she would expect staff to perform hand hygiene after removing gloves. 35588 Resident 27 incontinence care During a concurrent observation and interview on 09/20/21 at 8:19 AM observed Unit Aide (UA)5 assisting R27 onto platform of sit to stand (mechanical device that aids from sitting to standing position) and then moving device over the toilet. UA5 positioned device over the toilet and then removed R27's briefs, bundled briefs and then discarded in trash bin. A few moments later, R27 could be heard urinating and UA5, using same pair of gloves, picked up new briefs and wipes. When asked, UA5 stated that the briefs she removed from resident was soiled. After R27 completed his toileting, UA5 helped resident to standing position and then using same pair of gloves, placed clean brief on resident, pulled up resident's pants, touched, repositioned resident's wheelchair closer, and then repositioned resident's shirt and pants. When asked how she prevented dirty gloves from contaminating clean brief and resident's clothing, UA5 stated that she should have changed her gloves, but didn't. UA5 stated that she should have changed her gloves three times during cares but only changed her gloves once at the end. During an interview on 09/24/21 at 12:48 PM Quality Assurance/Quality Improvement/Infection Preventionist Registered Nurse (QAQIICRN) stated that staff should be changing gloves during incontinence care when going from dirty to clean tasks to prevent contamination of clean objects. Staff should also be changing gloves and doing hand hygiene between glove changes. Resident 45 shared medical equipment (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 09/21/21 at 9:03 AM Certified Nursing Assistant (CNA)5 was assisting R45 in his room using the sit to stand (mechanical device that aids from sitting to standing position). R45's hands were on the device. After resident was removed from sit to stand, CNA5 moved device towards room entrance and was observed retrieving PDI super sani bleach, orange top, wipes and wiped down sit to stand handles and areas where resident hands were placed. Immediately after wiping, CNA5 wheeled sit to stand down the hall to shower/tub room. Within 37 seconds after wiping, the sit to stand surfaces were dry to touch. Upon request, CNA5 touched sit to stand and confirmed it was dry. When asked if surfaces wiped needs to remain wet for a period of time, CNA5 stated that it dries pretty quickly, dries by the time sit to stand is brought to the tub room and dries within 1-2 minutes. CNA5 stated that the sit to stand is wiped down because it is used on other residents and we need to keep it clean. CNA5 stated that sit to stand is used on 4 residents (R5), (R45), (R7), (R22) on the Men's Unit. It was also observed on 09/20/21 at 8:19 AM that sit to stand was used with (R27). CNA5 and surveyor reviewed PDI container label, EPA registration number, 9480-8, which showed To clean, disinfect and deodorize: use a wipe to remove heavy soil Unfold a clean wipe an thoroughly wet surface. Treated surface must remain visibly wet for a full four (4) minutes. Use additional wipe(s), if needed to assure continuous 4 minute wet contact time. When asked if sit to stand remained wet for four minutes after use by resident and before use on another resident, CNA5 said no. During an interview on 09/24/21 at 12:48 PM Quality Assurance/Quality Improvement/Infection Preventionist Registered Nurse (QAQIICRN) stated that shared medical equipment such as sit to stand devices should be cleaned after resident use and between resident use. When asked about PDI bleach wipes contact time, QAQIIPCN stated that contact time varies by organism but stated that 4 minute contact time should be used to kill all organisms and contact time means that surface wiped needs to be kept wet for 4 minutes. QAQIICRN stated that we teach contact time and will reinforce it and housekeeping also orients staff on contact time. QAQIICRN agreed that four minutes was a long contact time for busy nursing staff and stated that the facility also has oasis 499 which has a quicker kill/contact time, but the facility has a large supply of PDI bleach wipes. On 09/22/21 at about 5:00 PM request was made for facility policy on cleaning and disinfection of reusable medical equipment, no policy was provided as of 9/24/21 at 7:00 PM. 40844 5. Review of the Electronic Health Record (E-HR) revealed the facility readmitted R2 on 05/07/21 following a hospitalization . The diagnosis tab in the E-HR list included a current clostridium difficile infection (C-diff is a bacterium that causes severe diarrhea and inflammation of the colon), heart failure, major depressive disorder, right above the knee amputation, and encephalopathy (a general term that describes a disease that damages the brain). Nursing notes revealed the resident had a history of falls. A comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a BIMS score of 05 which indicates severe impairment of cognitive (intellectual activity such as thinking, reasoning, or remembering) abilities. Observed R2 sitting in a wheel chair beside the bed on 09/20/21 at 09:41 AM. A sign on the door read Contact Precautions(a type of isolation precautions) and personal protective equipment (PPE) was stationed outside the door. R2's room was on the Household 1 unit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and concurrent interview on 09/21/21 at 11:30 AM, R2 was sitting in a wheel chair beside the bed. Unit Aide (UA) 3 stated she used a lift to transfer R2 from the bed to the wheel chair, and confirmed R2 was on isolation for C-diff. On 90/22/21 at 08:24 AM observed Certified Nursing Assistant (CNA) 18 provide personal care to R2. CNA18 donned (put on) a gown and gloves and wore a face mask before entering the room. R2 was sitting up in wheel chair and CNA18 stated she going to put R2 back in bed. A mechanical lift was utilized to transfer the resident from the wheel chair into the bed. Once in bed, CNA18 proceeded to remove a wet brief and provided peri-care (cleaning the private areas of a patient/resident). Following completion of the care, CNA18 covered the resident with a blanket, lowered the bed by touching the bed controls, positioned a mattress and floor mats beside the bed, touched activity supplies in the room, and positioned a monitoring camera device in the room before removing the gloves and washing her hands in the bathroom with soap and water. While washing her hands she lathered the soap for approximately 7 seconds before rinsing. When interviewed immediately following the observation CNA18 confirmed she had not performed HH after the peri-care and had lathered her hands for less than 15 seconds. When asked if she was aware that hand hygiene with soap and water was preferred for the C-Diff organism, she said she was not, and did not have a specific reason for using that method. A flyer published by the CDC was posted near R2's bathroom. Under the heading SPREAD it read, C-Diff spreads . when people don't wash their hands with soap and water. 29087 5. Reference: Centers for Medicare and Medicaid Services (CMS) survey and certification memo Ref: S&C 17-30-Hospitals/CAHs/NHs revised 06.09.2017; subject: Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD). The bacterium Legionella can cause a serious (fatal in 1 of 10 cases) type of pneumonia called LD in persons at risk. Outbreaks have been linked to poorly maintained water systems in buildings with large or complex water systems including long-term care facilities. Transmission can occur via aerosols from devices such as showerheads. CMS noted multiple outbreaks in hospitals and long-term care facilities as reported by the CDC (Centers for Disease prevention and Control) and state and local authorities. CMS expects Medicare certified healthcare facilities to have water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens (infect susceptible individuals) in building water systems in accordance with the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) published industry standards. The CDC toolkit (https://www.cdc.gov/legionella/maintenance/wmp-toolkit.html) was developed to facilitate implementation of the ASHRAE Standard. On 9/20/21 between 10:00 AM and 3:30 PM, the facility Maintenance Supervisor (MS) accompanied on an observation tour of the facility. In a mechanical room, the facility had 3 large water storage tanks and two smaller hot water heaters. MS stated the three large water tanks held 1,500 gallons each and the hot water heaters held 200 gallons each for a total 4,900 gallons of water. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/21/21 at 9:00 AM the facility Maintenance Supervisor (MS) provided documentation of maintenance, inspection, and testing of facility fire life and safety systems. Documentation of the facility water management program was requested but not provided. MS stated the facility did not have a water management plan. MS said a while ago he was assigned to do a water system assessment and write up a water plan but he had not gotten to it yet. MS said he knew it had to be done, but he has not had time. In an interview on 9/21/21 at 9:50 AM the Director of nursing confirmed the facility had no water management plan for Legionella prevention. In an interview on 9/23/21 at 3:00 PM Quality Assurance/Quality Improvement Staff (QAQI) said she also served as the facility infection control nurse. QAQI confirmed the facility did not conduct a risk assessment to identify areas in the water system where Legionella could grow and spread, did not develop policies and procedures to reduce the risks of Legionella, and did not develop and implement a water management program.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on interview, record review, and review of facility policy, the facility failed to maintain an infection prevention and control program (IPCP) that included a functional antibiotic stewardship program. This failure had the potential to affect all 58 residents of the facility. Findings include: Review of the facility's policies titled Antibiotic Stewardship Program, dated June 2019 indicated .It is the policy of Dr. Guy [NAME] Sr. Care Home to implement an Antibiotic Stewardship Program (ASP) that will promote appropriate use of antibiotics while optimizing the treatment of infections, and at the same time reducing the adverse events associated with antibiotic use. This policy is intended to limit antibiotic resistance, while improving treatment efficacy, resident safety, and reducing treatment-related costs utilizing McGreer's (a process to identify true infections for antibiotic use) criteria.ASP activities in post-acute facilities include these basic elements: leadership commitment, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data, education for clinicians, nursing staff, residents and families about antibiotic resistance and opportunities for improvement.Review infections and monitor antibiotic usage patterns on a regular basis.Obtain and review antibiograms for institutional tends [sic] of resistance.Monitor multi-drug resistant organisms.Report monthly or quarterly as appropriate, the number of antibiotics prescribed.Microbiology laboratory provider will submit a facility-specific antibiogram on a regular basis.Facility will designate who will collect and review antibiotic stewardship data.Auditing antibiotic usage as related to specific clinical syndromes, e.g. urinary tract.Structured feedback to prescribers and nurses.Tracking/Trending/Monitoring.Reporting. During an interview on 09/23/21 at 9:00 AM, the Quality Assurance/Performance Improvement (QAPI) nurse, who was the interim Infection Control Preventionist (ICP) stated she has been in the interim position of ICP since July 2021. The QAPI nurse stated as soon as an antibiotic was prescribed by the physician, she stated the staff will alert others by e-mail. The QAPI nurse stated much of the information is shared verbally among the staff. The QAPI nurse stated the antibiotic stewardship program was based on McGreer's criteria. The QAPI nurse stated she has not measured/monitored the use of antibiotic use and the outcomes for the facility. The QAPI nurse stated the last time the antibiotic stewardship program was completed was in 2019. The QAPI nurse stated there was no mapping to identify clusters of infections within the facility. The QAPI nurse stated the person in the position of the ICP would be the reporting source and currently there was no process in place to communicate antibiotic use and any corrective action taken. The QAPI nurse stated the Consultant Pharmacist conducted an in-service a few months ago and went through a format to use on antibiotic stewardship. The QAPI nurse stated the facility was hit with staffing issues and there has been no time to initiate this process. The QAPI nurse was asked if they had test results collected, cultures and where to locate the antibiogram and the QAPI nurse stated she has not had the opportunity to collect this data. During an interview on 09/24/21 at 9:50 AM, the Consultant Pharmacist confirmed there was no antibiotic stewardship program at the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035242	A. Building B. Wing	09/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dr Guy Gorman Sr Care Home	Highway 191 & Hospital Road Chinle, AZ 86503

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 29087 Based on interview and record review the facility failed to implement an effective process or program to provide training for all staff to include, at a minimum, training on abuse, neglect, exploitation, misappropriation of resident property, and dementia management, that is appropriate and effective, as determined by staff need and the facility assessment (as specified at S483.70(e). The facility did not post the required notice to inform staff of rights regarding protection from retaliation for reporting allegations of abuse. Findings include: Human Resources Coordinator (HRC) was interviewed at 9:00 AM on 9/24/21 regarding training of staff and orientation of newly hired employees. HRC said she completed the human resources part and each department head provided the rest of the orientation. For example, Maintenance did a safety walk and went over fire procedures and dietary went over diets if the new hires were direct care staff. HRC said nursing provided the abuse training, the Director of Nursing (DON) or the Quality Assurance nurse (QAQI) goes over some policies with the new nursing staff. Regarding abuse training for non-nursing staff; HRC said the full abuse training was for direct care staff only. HRC said; she gave a copy of the abuse policy to new staff to review. HRC said ensured acknowledgement forms were placed in the personnel files to show the new staff received the policy. HRC said she did not go over the abuse policy with staff but she did tell new staff how to do incident reports. HRC provided copies of the orientation checklist for CNA (Certified Nursing Assistant) and for MA (Medical Assistant). Page 3 titled, Certified Medical Assistant Orientation, Director of Nursing; had 21 items each with a box to note date and initials with a signature and date line at the bottom of the page for Employee and for Teacher. Items 4 through 21 had the notation in bold red lettering; PRINT/READ. Item 7 read, PRINT/READ Abuse Policy, and item 13 read PRINT/READ Management of Verbal and or Physical Aggressive Behavior Policy. An additional section for the DON on page 5 listed five facility policies and Procedures (P&P) that included 1. CNH Abuse of Resident by staff and 2. CNH Policy Management of Verbal and or Physical Aggression. The CNA checklist contained the same. When asked about online or other training methodologies; HRC said online (proprietary name R) training was used at the discretion of the manager. HRC added, the facility obtained R access very recently and she did not know how much it was actually used. During an interview on 9/24/21 at 3:30 PM the Quality Assurance Nurse (QAQI) said the facility did not have a process in place to provide ongoing training to their staff about abuse and neglect, dementia management, and resident abuse prevention. QAQI said the facility currently had no assigned or designated staff trainer or staff development coordinator and she was filling in only on key functions. QAQI said the only training provided to the staff since she started in February was hand hygiene and some training related to COVID-19. QAQI said no records of training prior to her arrival were available. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regarding abuse prevention training, QAQI reported the abuse prevention section was her responsibility and either she or the DON provided newly hired nursing staff a copy of the abuse prevention policies and procedures as well as reporting requirements and process for reporting. QAQI said the expectation was that the employee reviewed the printed documents and signed an acknowledgment that they received and read the documents. QAQI said she did not go over the materials with each employee. QAQI confirmed, the facility did not administer a written test or skills check to ensure understanding of the abuse and neglect prevention requirements, reporting requirements, and policies, and procedures. The printed documents provided to the staff did not include training related to abuse and dementia. QAQI said each non-nursing department head gave the abuse prevention policy to their employees. QAQI said she was not involved with the non-nursing departments because they did not provide hands on care and they had limited contact with the residents compared to nursing staff. QAQI said the facility did not provide annual or on-going abuse prevention training for current staff. QAQI said the facility recently signed a contract to use the R online learning and educational offerings which included abuse prevention. QAQI said the R system abuse class had not been put out. QAQI said the R contract started in late July but she had multiple administrative duties assigned to her as well as working on the floor multiple shifts each week, so she had no time to get the R system fully operational. QAQI said the only R training the facility used so far was hand hygiene. The facility policy titled; ABUSE POLICY indicated 2. Training; The facility, through orientation and on-going sessions related to abuse prohibition practice such as: *appropriate interventions to deal with aggressive and/or catastrophic reactions of residents *How staff should report their knowledge related to allegations without fear of reprisal *how to recognize signs of burnout, frustration, and stress that may lead to abuse *What constitutes abuse, neglect, and misappropriation of resident property. 2. Observation of the corridors, common areas, staff break rooms and nurse stations revealed no posting to inform the employees of their right to be free of retaliation for reporting allegations of abuse.