STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065001	A. Building B. Wing	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lowry Hills Care and Rehabilitation	10201 E 3rd Ave Aurora, CO 80010

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 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide immediate access to any resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations and interviews, the facility failed to ensure immediate access for one (#4) residents out of six sample residents. Specifically, the facility failed to ensure Resident #4 had the ability to make and receive phone calls. Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, last revised December 2016, provided by the nursing home administrator (NHA) on 7/28/21 at 4:12 p.m., revealed in pertinent part, Federal and state law guarantee certain basic rights to all residents of this facility. These rights include: Access to a telephone, mail and email and be able to communicate in person and by mail, email and telephone with privacy. II. Resident #4 A. Resident status Resident #4, age 86, was admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included depression. The 6/25/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required limited to extensive assistance of one person for activities of daily living (ADL). B. Resident and representative interviews Resident #4 was interviewed on 7/15/21 at 10:35 a.m. She said she had a cell phone but it did not work. She said she had a telephone in her room but she was not able to make phone calls with it. She said every time she dialed the number, she got a busy signal. She said she had not been able to talk to her only living relative in over two weeks and was getting very worried. She said she told a staff member but they said her phone was working just fine and did not assist her to get ahold of her family member. (continued on next page)

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

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #4's representative was interviewed on 7/15/21 at 11:50 a.m. She said she had not been able to speak to the resident in several weeks. She said she was told the facility had changed their phone system and the residents could no longer receive phone calls in their rooms. She said she had to call the front desk and let them know she wanted to talk to the resident and they were supposed to have her call her back. She said the problem was that she was not able to get anyone at the front desk to answer most of the time and then they would never have the resident call her back. She said she has asked the facility numerous times about the phone situation but got no response. II. Facility posting On 7/14/21 at 11:55 a.m., a sign was observed to be posted on the East side of the building by the time clock and ice machine and another one at the [NAME] nurses station. It was dated 6/8/21 and read: All Nursing Staff: Do not turn down the volume or off on nursing station phones during shift. Phones are to be answered immediately. If every staff member is busy performing resident care and no one can answer the phone, the RN (registered nurse)/supervisor should check messages and call the person or facility back immediately. The RN/supervisor should take report. If a family member, resident should be notified of the call. These signs were observed to still be posted on 7/28/21. III. Staff interviews Registered nurse (RN) #1 was interviewed on 7/16/21 at 10:25 a.m. He said the facility had recently updated their phone system and now some of the phones in rooms worked and some did not. He said the 600 hall rooms all had their own phone line but he was not sure about the others. He said the residents were no longer able to receive phone calls in their rooms but he thought the front desk could transfer calls to their rooms. He said the resident's had to dial 9 before they could dial out. He said he was not sure if Resident #4 was aware of this. He said otherwise the resident could always use the phone at the nurse's station. The social service director (SSD) was interviewed on 7/16/21 at 11:18 a.m. She said some of the residents had cell phones and some had phones in their rooms but some may have to go to the nurses station to use the phone. She said she could help a resident get a cell phone if needed and she had personally allowed residents to use her cell phone to make phone calls. She said any video calls were done through the activities department. She said when a resident received a phone call, if they had a phone in their room, it could be transferred directly to the room, and otherwise the front desk would have to go get the resident to receive the phone call. She said she was not aware of any issues with the staff not answering the phones. The medical records (MR) person was interviewed on 7/16/21 at 4:02 p.m. He said he was also the receptionist at the front desk and visitation coordinator. He said some of the residents had phones in their rooms and some did not. He said the phones were old and breaking down. He said the facility recently got a new phone system that is not set up to be able to transfer phone calls to the resident's rooms. He said if the resident received a phone call, he would take a message and assist the resident to call the person back. He said he was not aware if the resident had to dial 9 before being able to dial out. He said the resident could always go to the nurses station to make a phone call if needed. (continued on next page)

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F 0562 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 7/16/21 at 2:53 p.m. He said the facility had just got a new phone system put in and he was not aware of any issues with residents being able to make or receive phone calls.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations, record review, and interviews, the facility failed to provide care and services to prevent the development and worsening of pressure injuries for two (#1 and #3) residents reviewed out of six sample residents. The facility failed to assess and monitor Resident #3's skin integrity on a routine basis and implement a care plan for skin integrity with interventions to prevent the development of pressure injuries even though the resident was a high risk. Facility staff had identified a break in Resident #3's skin integrity on 5/16/21 on the resident's knees but did not document an assessment of the area until 5/26/21 and did not implement any interventions to prevent further breakdown from occurring. Without preventative measures being put into place, the left and right knee wounds, which were avoidable, developed into unstageable pressure injuries by 6/10/21, approximately four week later. Furthermore, the facility also failed to identify the development of a pressure wound in a timely manner and implement effective interventions to prevent further progression of the wound for Resident #1. Findings include: I. Facility policy and procedure The Prevention of Pressure Ulcers/Injuries policy and procedure, last revised July 2017, provided by the nursing home administrator (NHA) on 7/28/21 at 4:02 p.m., revealed in pertinent part, Skin and Risk Assessment - Assess the resident for existing pressure ulcer/injury risk factors quarterly and upon any changes in condition. Conduct a comprehensive skin assessment upon admission and weekly. Inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living (ADLs). Prevention - Keep the skin clean and free of exposure to urine and fecal matter. Monitor the resident for weight loss and intake of food and fluids. Include nutritional supplements in the resident's diet to increase calories and protein. Choose a frequency for repositioning based on the residents mobility, the support surface in use, skin condition and tolerance, and the resident's stated preferences. At least every two hours or as needed, turn residents who require assistance in a position of comfort. Teach residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Support Surfaces and Pressure Redistribution - Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight and overall risk factors. II. Resident #3 A. Resident status (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #3, age less than 65, was admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included psychological developmental delay, arthritis and unspecified joint contractures. The 6/21/21 minimum data set (MDS) assessment revealed the resident had severely impaired cognitive function. The resident required extensive to total assistance of one to two people for all activities of daily living (ADLs). The resident was at risk for pressure ulcer development and had two unstageable pressure ulcers during the assessment period. B. Record review The 2/23/21 Braden Scale for predicting pressure ulcer risk revealed the resident was high risk with a score of 11. It indicated the following clinical suggestions: -Provide routine skin care; -Turn and reposition at least every two hours while in bed; -Evaluate/provide routine skin care as needed (PRN); -Evaluate oral care; -Feed resident meals; -Encourage small, frequent position changes; -Encourage meals; and, -Obtain order for physical therapy (PT)/occupational therapy (OT) consultation. Review of the record on 7/16/21 revealed the resident did not have a skin integrity care plan in place prior to 6/21/21, see below. A 5/16/21 shower sheet revealed the nurse was notified of skin tears between both of the resident's legs on her knees. Review of the record on 7/16/21 revealed no further documentation of the skin impairment to the resident's knees until 5/26/21, see below. The 5/25/21 weekly skin check revealed the resident had no skin conditions or changes, ulcers or injuries. It indicated the resident had no open areas or bruising. Review of the record revealed that prior to the 5/25/21 weekly skin check, the resident had not had a skin check done since 5/4/21. The resident's skin was checked three out of four weeks in January 2021, two out of four weeks in February 2021, one week out of five in March 2021 and two out of four weeks in April 2021. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A 5/26/21 skin/wound note revealed the resident had abrasions to bilateral lower extremities from friction, one on the right inner thigh and two on the left inner thigh. It indicated wound care was provided and a pillow was placed between the resident's thighs to avoid friction. A 5/27/21 weekly skin alteration (non-pressure) evaluation revealed the resident had three abrasions to her lower extremities, the left inner distal knee measured 2.1 centimeters (cm) by 1.2 cm by 0.1 cm, the left inner posterior knee measured 2.2 cm by 0.9 cm by 0.1 cm and the right knee measured 1.5 cm by 2.7 cm by 0.1 cm. It indicated the wounds were evaluated by the wound physician that day and treatment was to apply Santyl (an ointment used to remove dead tissue) and cover with a dry dressing daily. The 5/27/21 wound physician progress note revealed the following: -Wound #4, the left distal inner knee was an abrasion with an area of 2.52 square (sq) cm and a volume of 0.251 cubic cm. The wound bed had 70% slough (dead tissue) and 30% granulation (healing inner tissue) with a small amount of serosanguinous (fluid) drainage. -Wound #5, left proximal inner knee is an abrasion with an area of 1.98 sq cm and a volume of 0.198 cubic cm with 10% epithelialization (healing outer tissue), 80% slough and 10 % granulation with a small amount of serosanguinous drainage. -Wound #6, the right knee was an abrasion with an area of 1.05 sq cm and a volume of 0.405 cubic cm. The wound bed had 40% epithelialization, 10% slough and 50% granulation with a small amount of serosanguinous drainage. -All three wounds were surgically debrided to remove subcutaneous (the deepest layer of skin) along with devitalized tissue: slough, with the use of a curette. -Wound care for all three wounds included: cleanse with normal saline, apply Santyl and cover with a dry dressing daily and as needed (PRN). -Wounds #1 to #3 had previously been treated by the wound care physician and healed in May 2020 and November 2020, which showed the resident had the ability to heal and she was at high risk for developing pressure injuries. A 5/29/21 shower sheet revealed the resident had deep tissue injuries (DTI) to the inside of both knees. The 6/3/21 wound physician progress note revealed the following: -Wound #4, the left distal inner knee was deteriorating with an area of 3.57 sq cm and a volume of 0.357 cubic cm with 20% epithelization and 80 % granulation and a small amount of serosanguinous drainage. -Wound #5, the left proximal inner knee was deteriorating with an area of 4.4 sq cm and a volume of 0.44 cubic cm with 30% epithelialization, 70% granulation and a small amount of serosanguinous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound #6, the right knee was deteriorating with an area of 4.2 sq cm and a volume of 0.42 cubic cm with 40% epithelialization and 60% granulation with a small amount of serosanguinous drainage. -Wound care for all three wounds included: cleanse with normal saline, apply honey-gel and cover with a dry dressing daily and PRN. -The wheelchair cushion was evaluated. The 6/10/21 wound physician progress note revealed the following: -The left inner proximal knee and right knee wounds were reclassified as unstageable pressure injuries. -Wound #4 to the left distal inner knee continued to be classified as an abrasion was improving with an area of 1.32 sq cm and a volume of 0.132 cubic cm with 20% slough and 90% granulation and a small amount of serosanguinous drainage. -Wound #5 to the left proximal inner knee, now classified as an unstageable pressure injury, was deteriorating with an area of 4.2 sq cm and no measurable depth with 80% eschar, 10% slough and 10% granulation and a small amount of serosanguinous drainage. -Wound #6 to the right knee, now classified as an unstageable pressure injury, was deteriorating with an area of 5.7 sq cm and a volume of 0.57 cubic cm, with 20% slough, 80% granulation and a small amount of serosanguinous drainage. -All three wounds were surgically debrided to remove subcutaneous along with devitalized tissue: slough, with the use of a curette. -Wound care for the left distal inner knee included: cleanse with normal saline, apply honey and cover with a dry dressing daily and PRN. Wound care for the wounds to the left proximal inner knee and the right knee included: cleanse with normal saline, apply Santyl and cover with a dry dressing daily PRN. -Recommendations included: please place a pillow between legs to avoid pressure injury from contractures. According to the June 2021 CPO, an order was received on 6/10/21 to place a pillow between the resident's legs/knees every shift. The 6/17/21 wound physician progress note revealed the following: -Wound #4 to the left distal inner knee, continued to be classified as an abrasion, had no changes noted in the wound progression with an area of 1.5 sq cm and a volume of 0.15 cubic cm with 70% epithelization and 30% granulation and a small amount of serosanguinous drainage. -Wound #5 to the left proximal inner knee, classified as an unstageable pressure injury, had no change in wound progression with an area of 4.0 sq cm and no measurable depth with 30% eschar, 40% slough and 30% granulation and a small amount of serosanguinous drainage. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound #6 to the right knee, classified as an unstageable pressure injury, was improving with an area of 3.4 sq cm and a volume of 0.34 cubic cm, with 100% granulation and a small amount of serosanguinous drainage. -The wound to the left proximal inner knee, #5, was surgically debrided to remove subcutaneous along with devitalized tissue: slough, with the use of a curette. -Wound care for the left distal inner knee and right knee included: cleanse with normal saline, apply honey and cover with a dry dressing daily and PRN. Wound care for the wound to the left proximal inner knee included: cleanse with normal saline, apply Santyl and cover with a dry dressing daily PRN. According to the June 2021 CPO, the order for the pillow between the knees was discontinued and a new order was entered to place a knee separator between her knees every shift. The care plan, initiated 6/21/21, revealed the resident was at risk for pressure injuries/skin breakdown related to bowel and bladder incontinence, impaired mobility and contractures to the lower extremities with actual pressure to left knee and right knee. Interventions included: -Assist with positioning; -Wound team to follow; -Place knee separator between her knees; and, -Pressure reducing cushion to chair. Review of the record revealed the resident continued to be seen by the wound physician weekly and the resident's wounds were healed or improving with latest measurements on 7/15/21 being: -Wound #4 -healed -Wound #5 to the left proximal inner knee, classified as an unstageable pressure injury, was improving with an area of 2.47 sq cm and no measurable depth with 10% slough and 90% granulation. -Wound #6 to the right knee, classified as an unstageable pressure injury, was improving with an area of 0. 25 sq cm and no measurable depth, with 100% epithelialization. -The most current wound measurements show improvement or healing which showed these wounds were avoidable and had the ability to heal. The proper interventions were not implemented and followed consistently when the skin impairment was first identified on 5/16/21 in order to prevent the wounds from becoming unstageable on 6/10/21. III. Resident #1 A. Resident status (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #1, age less than 65, was admitted on [DATE] and discharged on [DATE]. According to the June 2021 computerized physician orders (CPO), diagnoses included aphasia (loss of ability to understand or express speech) following a cerebral infarction (stroke), unspecified joint contracture and obesity. The 6/8/21 minimum data set (MDS) assessment revealed the resident had severely impaired cognitive function. The resident required extensive to total assistance of one to two people for all activities of daily living (ADL). The resident was at risk for pressure ulcer development but did not have any pressure ulcers at the time of the assessment. B. Record review The 3/1/21 Braden Scale for predicting pressure sore risk revealed the resident was moderate risk with a score of 13. According to the form, a score of 15-18 was at risk, 13-14 moderate risk, 10-12 high risk and 9 or below very high risk. It indicated no clinical suggestions were made. The care plan, last revised 12/11/2020, revealed the resident had a potential/actual impairment to his skin integrity and is at risk for pressure areas and skin breakdown related to bowel and bladder incontinence and impaired mobility. Interventions included: -Apply protective barrier cream to peri-area after each incontinence and/or with morning and evening cares; -Avoid friction and shearing. Use turn sheet for repositioning; -Avoid scratching and keep hand and body parts from excessive moisture. Keep fingernails short; -Daily skin inspection during care. Notify the licensed nurse of skin integrity impairments; -Document education, verbalization of understanding and continued non-compliant choices; -Encourage good nutrition and hydration in order to promote healthier skin; -Encourage and assist as needed to turn and reposition when in bed; -Pressure relieving cushion to wheelchair and pressure relieving mattress to bed; -Provide loose fitting, easy to remove clothing; -Follow facility protocols for treatment of injury; -Keep skin clean and dry. Use lotion on dry skin; -Monitor for signs and symptoms of infections, do wound rounds; and, -Weekly licensed nurse skin assessment to include review/check of footwear. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 6/10/21 weekly skin check revealed the resident had no skin conditions, changes, ulcers or injuries. It indicated the resident had scratches to his bilateral arms, legs and chest and creams and antihistamines were being applied. According to a 6/16/21 skin/wound note written at 5:58 a.m., the resident had moisture associated skin disorder (MASD) on his buttocks. It indicated the wound was cleansed and covered with a foam dressing. A 6/16/21 skin/wound note written at 1:13 p.m. revealed the wound to the resident's buttocks had a skin flap and an open area on the coccyx with bleeding that was cleansed and a dressing applied. It indicated the resident was having increased weakness and was unable to assist with repositioning in bed. The note indicated the physician was notified and was to come into the facility to assess the resident. A 6/16/21 skin/wound note written at 3:37 p.m. revealed the resident was assessed by the physician and the physician had the resident sent to the emergency room for further evaluation. The 6/16/21 physician progress note revealed the resident appeared to have a large sacral skin ulcer, grade 2-3 and was in distress. It indicated the resident was transferred to the emergency room for evaluation. A clarification of this progress note was made on 7/14/21 to include: I just glanced at this wound and did not measure it or checked thoroughly for wound depth because the patient was in acute distress and it was apparent he needed transfer to the emergency room as soon as possible (ASAP). The 6/16/21 emergency room progress note revealed the resident had a stage 2 pressure ulcer to his coccyx with no tunneling noted. It indicated the surrounding tissue was sloughing and had notable erythema (redness). IV. Staff interviews Registered nurse (RN) #1 was interviewed on 7/16/21 at 10:25 a.m. He said he had been the wound nurse since August 2020 but he was not wound certified. He said weekly skin assessments should be done by the floor nurse and documented in the electronic medical record (EMR) weekly. He said he monitored all wounds in the building weekly along with the wound physician. RN #1 said anytime a new skin issue was identified, a risk management (incident report) was completed. He said he reviewed these daily and then went and assessed the wound himself. He said interventions to prevent breakdown included: frequent positioning, incontinent care and an up/down schedule. He said interventions he would put into place if a resident had a wound included: following wound care ordered by the physician, adding supplements for nutrition, continuing with frequent positioning and an up/down schedule. He said he would also involve therapy if needed to evaluate the resident's wheelchair and cushion. RN #1 said Resident #3's wounds started out as abrasions and because of her contractures, the wound developed into pressure areas. He said he thought the staff were using a separator in between the resident's knees to prevent them from rubbing together. He said the separator was started sometime at the end of June 2021. He said the wounds were improving. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	RN #1 said Resident #1 was a young guy that had a stroke and was primarily bed bound but he did not consider him at high risk for skin breakdown. He said the resident was sent out to the emergency room before he had an opportunity to assess the wound but he was told it was a stage 2 on his bottom. RN #1 said it was the MDS coordinator's responsibility to update the resident's care plan. Certified nurse aide (CNA) #1 was interviewed on 7/16/21 at 11:08 a.m. She said she tried to always observe the resident's skin when she was changing them but especially when she was bathing them. She said if she noticed any new skin issues she would call the nurse right away to assess the area. She said she tried to make sure her residents were kept clean and changed frequently and to off load areas using blankets or pillows. She said they tried to keep padding in between Resident #3's knees at all times since she had sores on both of them. The director of nursing (DON) was interviewed on 7/16/21 at 3:22 p.m. He said the nurses should be doing weekly skin assessments or more often if they were at high risk and the CNAs should be monitoring the resident's skin daily with care. He said the primary care physicians usually deferred all wound care to the wound physician and all wounds were reviewed by the wound physician weekly. He said they tried to make sure preventative measures and the proper documentation were in place but he was having to do re-education with the nurses on this. He said he felt like the staff had implemented interventions immediately for Resident #3 but did not document it. The DON said he interviewed the nurse that sent Resident #1 out to the hospital. She told him the resident had a small wound on his coccyx. He said he also interviewed the physician about the wound. He said the physician told him the wound had feces on it so he was just guessing the staging of the wound but did not really see it. He said the physician was more concerned about the resident being in distress. Licensed practical nurse (LPN) #1 was interviewed on 7/16/21 at 4:10 p.m. She said skin assessments were done weekly by the RN because LPNs were not allowed to assess but could inform the RN of any skin breakdown. She said all wounds in the facility were assessed by the wound nurse and physician weekly. She said interventions to prevent breakdown included: repositioning every two hours, change when needed, keep clean, and make sure the bed is made properly with no wrinkles. She said if a resident already had a wound, intervention to prevent further decline included: repositioning, monitoring the wound and providing wound care as ordered, keep the resident clean and dry and off-load the area of concern. She said it was the RN's responsibility to update the care plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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** 37661 Based on record review and interviews, the facility failed to ensure a safe environment and adequate supervision to prevent accidents for three (#2, #4 and #3) out of six sample residents. Specifically, the facility failed to: -Implement effective interventions after a fall to prevent a recurrence for Resident #2, #4 and #3; -Update the care plan in a timely manner with interventions to prevent further falls for Resident #2, #4 and #3; and, -Failed to ensure neurological assessments were completed after an unwitnessed fall for Resident #2. Findings include: I. Facility policy and procedure The Falls and Fall Risk, Managing policy and procedure, last revised March 2018, provided by the nursing home administrator (NHA) on 7/28/21 at 4:02 p.m., revealed in pertinent part, The staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The Neurological Assessment policy and procedure, last revised October 2010, provided by the NHA on 7/28/21 at 4:02 p.m., revealed in pertinent part, Neurological assessments are indicated: upon physician order; following an unwitnessed fall; following a fall or other accident/injury involving head trauma; or when indicated by the resident's condition. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted [DATE] and discharged [DATE]. According to the June 2021 computerized physician orders (CPO), diagnoses included acquired absence of left toes, generalized muscle weakness and physiological childhood developmental delay. The 4/16/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required extensive assistance of one to two people for his activities of daily living (ADL). The facility was unable to determine if the resident had any fall prior to admission. B. Record review 1. Fall risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/9/21 Fall Risk Assessment Tool revealed the resident was at risk for falls with a score of six. According to the Tool, a score of four or more was considered at risk for falling. The 4/10/21 Fall Risk Evaluation revealed the resident was at risk for falls with a score of 13. According to the evaluation, if the total score is 10 or greater, the resident should be considered at high risk for potential falls and prevention protocols should be initiated immediately and documented on the care plan. Clinical suggestions included rubber-soled shoes or non-skid slippers worn for ambulation. The fall care plan, initiated 4/10/21 revealed the resident was at a high risk for falls related to left lower extremity weakness. Interventions included: -Physical therapy to evaluate and treat as ordered or as needed; -Review information on past falls and attempt to determine the cause of falls; -Record possible root causes; -Alter or remove any potential causes if possible; and, -Educate resident/family/caregivers/interdisciplinary team (IDT) as to causes. 2. 4/21/21 fall A 4/21/21 health status note revealed the resident was assessed and had bruises on both of his knees and redness on his face and neurological assessments were started. -The note did not indicate if the resident had fallen. A 4/21/21 incident report revealed the resident was found sitting on the floor with his back against the front of his bed and he said he fell trying to use the bedside table as support to get into his wheelchair but the table broke. -It did not indicate any interventions were initiated to prevent a fall from reoccurring. -The facility was unable to provide the neurological assessments for this fall. The 4/21/21 Fall Risk Evaluation revealed the resident was at risk for falls with a score of 12. It indicated clinical suggestions were to use rubber-soled shoes or non-skid slippers for ambulation and to utilize a toileting program. -These were not added to the resident's care plan. The care plan was updated on 4/29/21 to include: -Call light to be placed within reach at all times; and, -Room is to be well-lit and clutter free. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. 5/4/21 fall A 5/4/21 health status note revealed the floor certified nurse aide (CNA) informed the nurse the resident was on the floor. It indicated the resident had no injuries and neurological assessments were initiated. The facility was unable to provide the neurological checks for this fall even though progress notes indicated they were being done (cross-reference F842 for failure to have accurate medical record). The 5/4/21 incident report revealed the resident stated he tried to transfer from his bed to the wheelchair and when he turned he missed the chair and fell . -No interventions were put into place following the fall to prevent another fall from occurring. -The care plan was not updated at this time with any new interventions. 4. 5/5/21 fall A 5/5/21 health status note revealed the resident was found on the floor in his room next to his bed. It indicated he has redness and swelling on the left side of his forehead with a scratch, neurological assessments were initiated and the bed was put in the lowest position. -The facility was unable to provide the neurological assessments for this fall even though the progress notes indicated they were being done. A 5/5/21 occupational therapy (OT) treatment encounter note revealed the therapist provided education on safe transfers and requesting assistance when completing transfers to facilitate increased safety awareness and decreased falls. It indicated the resident was receptive to the education and was able to demonstrate use of proper call light to ask for assistance with all transfers. -The care plan was not updated at this time with any new interventions. 5. 5/7/21 fall A 5/7/21 health status note (late entry done on 5/8/21 at 1:50 p.m.) revealed the resident was found sitting on the floor and stated he was trying to transfer from his wheelchair to his bed and lost his balance. It indicated the resident denied hitting his head and had no injuries. -The note did not indicate if neurological assessments were initiated which were to be completed for unwitnessed falls (see RN #1 interview below). A 5/7/21 health status note revealed the resident was found on the floor that morning sitting next to his wheelchair. It indicated the resident was reinforced to use his call light. -The note did not indicate if neurological assessments were initiated. -The facility was unable to provide neurological assessments for this fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 5/7/21 OT treatment encounter note revealed the resident was provided education for safe transfers and to ask for assistance. It indicated the resident was able to demonstrate the ability and understanding of the location of his call light. -The care plan was not updated at this time with any new interventions. 6. 5/9/21 fall A 5/9/21 health status note revealed the resident was found on the floor that morning with no injuries and neurological checks were initiated. It indicated the resident was educated about the use of the call light and his bed was put in the lowest position. -No new effective interventions were put into place to prevent further falls. -The facility was unable to provide neurological assessments for this fall. -The care plan was not updated at this time with any new interventions. 7. 5/10/21 fall A 5/10/21 health status note revealed the resident was found lying on the floor that morning with no new injuries and neurological checks were initiated. -It did not indicate if any new interventions were put into place to prevent the resident from falling again. The 5/10/21 incident report revealed the resident was found lying on the floor on his back and the resident said he was trying to transfer himself from the bed to the wheelchair when he fell . It indicated the resident was educated about the use of the call light and the bed was put in the lowest position. -The facility was unable to provide neurological assessments for this fall. -The care plan was not updated at this time with any new interventions. The fall care plan was updated on 5/12/21 to include the following: -Lab work requested by the physician to rule out physiological reasons for recent falls; -Educated on use of the call light for assistance before attempting to transfer; -Bedside table replaced after recent fall self-transferring; -Educated regarding asking for help before transfers and ensuring bed is in the lowest position at all times; and, -Highlight the call light with neon tape to make it more easily visible by the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. 5/20/21 fall A 5/20/21 health status note revealed the resident was lying on the floor when the nurse arrived to the room and the resident stated he tried to get up and lost his balance and fell to the right side of the wheelchair. It indicated the resident had no injuries and neurological assessments were initiated. -It did not indicate if any new interventions were put into place to prevent the resident from falling again. The 5/20/21 incident report revealed the resident was yelling in the hallway and when the nurse arrived in the room, the resident stated he slipped out of his wheelchair. It indicated the resident had no injuries and neurological assessments were initiated. -It did not include any interventions to prevent the resident from falling again. -The facility was unable to provide neurological assessments for this fall. -The care plan was not updated with this fall or any new interventions to prevent another fall from occurring. 9. 5/21/21 fall A 5/21/21 health status note revealed the resident was found sitting on the floor next to his bed and the floor was wet. It indicated the resident had a bloody nose, a bruised, reddened area to his right forehead and an abrasion to his left knee and neurological assessments were initiated. -It did not indicate if any new interventions were put into place to prevent the resident from falling again. The 5/21/21 incident report revealed the resident was heard screaming help and was found sitting on the floor next to his bed. It indicated he had a nosebleed, bruised, reddened area to his right forehead and an abrasion to his left knee. -It indicated first aid was given however no interventions were put into place to prevent the resident from falling again. -The facility was unable to provide neurological assessments for this fall. -The care plan was not updated with this fall or any new interventions to prevent another fall from occurring. 10. 5/24/21 fall A 5/24/21 incident report revealed the resident was found sitting on the floor with his pants partially up and the resident stated he was trying to pull his pants up and fell , hitting his head on the floor. It indicated the resident had an abrasion to his right forehead with slight swelling and neurological assessments were initiated and within normal limits. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of the record on 7/16/21 revealed no documentation in the resident's progress notes on 5/24/21 describing this fall only that the resident was on follow up for a fall and safety measures were in place. It did not describe what the safety measures were. -The facility was unable to provide neurological assessments for this fall. A 5/24/21 OT treatment encounter note revealed the resident was found down on the floor and it took four people to get him upright and safely in the wheelchair. It indicated the resident became agitated when being told how he could have been safer. -No interventions were put into place to prevent further falls from occurring and the residents care plan was not updated. 11. 6/14/212 fall A 6/14/21 health status note revealed the resident was found on the floor next to his bed after trying to transfer himself from the bed to the wheelchair. It indicated the resident had no injuries and neurological assessments were initiated. -It did not indicate any new interventions were put into place to prevent further falls. The 6/14/21 incident report revealed the resident stated he was trying to transfer himself from the bed to the wheelchair and he fell . It indicated the resident was educated to use the call light. -The facility was unable to provide the neurological assessments for this fall. A 6/14/21 at risk note revealed the resident was reviewed in risk for falls and room modifications were to be done. -The care plan was updated on 6/14/21 to include: Call, don ' t fall signs placed in room as a visual reminder to use call light to request assistance. III. Resident #4 A. Resident status Resident #4, age 86, was admitted [DATE]. According to the July 2021 CPO, diagnoses included congestive heart failure (CHF), weakness, and unsteadiness of feet and a history of falling. The 6/25/21 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. The resident required limited to extensive assistance of one to two people for ADLs. The resident had one fall since the prior assessment with injury, not major. B. Record review 1. Fall risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 4/9/21 fall risk evaluation revealed a score of one, indicating the resident was not a fall risk. The care plan, last revised 2/7/21, revealed a potential for falls/injury due to the history of a knee replacement and unsteady gait at times with a history of falls. Interventions included: -Encourage to request assistance for transfers and/or ambulation; -Encourage the use of non-skid footwear during transfers and ambulation; -Ensure the resident's room is well-lit and clutter free; -Have call light within reach; -Resident is an extensive one-person assist with all transfers and toileting; -Provide safety reminders as needed; -Staff will remind, educate and encourage therapy, call bell use and safety during her stay to help improve functional mobility and minimize risk for falls. Staff will encourage her participation and treatment with therapy to help her return to a higher level of functional mobility; and, -Therapy to inspect and evaluate the resident's commode. 2. 4/15/21 fall A 4/15/21 health status note indicated the resident was found sitting on the floor in the restroom and the resident stated she missed the toilet and fell . It indicated the resident had no injuries and neurological assessments were started. A 4/15/21 fall risk evaluation revealed a score of 6, indicating the resident was not a fall risk. -Review of the record on 7/14/21 revealed no new interventions were put into place to prevent another fall from occurring and the care plan was not updated. 3. 4/16/21 fall A 4/16/21 health status note revealed the resident was being transferred to a shower chair from her wheelchair by a CNA with the use of a gait belt, when the resident's legs gave out and she was lowered to the floor. -It indicated there were no injuries, however no new interventions were put into place to prevent a recurrence. A 4/16/21 change of condition evaluation revealed the resident had a fall. No further description was given. It indicated the resident would continue to be monitored. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 4/17/21 therapy service screen revealed the resident was referred for services due to a fall however the resident was already on occupational therapy caseload. It indicated the therapist verified proper installation of a toilet riser and offered the resident a commode instead but the resident declined. Another 4/17/21 therapy service screen revealed the resident was referred for services due to a fall and would be scheduled for an evaluation by physical therapy. A 4/21/21 physical therapy (PT) evaluation and plan of treatment revealed the resident required skilled services to minimize falls. It indicated services were provided until 5/20/21. -Review of the record on 7/14/21 revealed the care plan was not updated with any new interventions to prevent the resident from falling again. 4. 6/9/21 fall A 6/9/21 health status note revealed the resident was found on the floor in a pool of blood from a cut to her right upper forehead. It indicated pressure was applied and the resident was sent to the emergency room for evaluation. A 6/10/21 health status note revealed the resident returned from the hospital with no change in her plan of care. A 6/10/21 IDT note revealed the residents recent fall was reviewed and recommendations included environmental modifications and a screen for a transfer assistive device to increase the resident's independence. A 6/11/21 therapy service screen revealed the resident was referred for a fall and during the interview, the resident stated she fell asleep and fell forward. It indicated PT and OT would reevaluate and work on transfers. A 6/16/21 OT progress note revealed the bedside table was padded up and the resident was working on activities to increase postural control due to frequent falls. The residents care plan was updated on 7/14/21 (over a month later and during survey) to include: -After fall on 6/9/21, therapy to do environmental modification and the bed to be evaluated for transfer assistive device to aid independence; -Educate on the importance of using call light to ask for assistance with toileting; and, -Educate staff on following a toileting schedule. IV. Resident #3 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3, age less than 65, was admitted on [DATE]. According to the July 2021 CPO, diagnoses included physiological and psychological childhood developmental delay with a history of falling. The 6/21/21 MDS assessment revealed the resident had severely impaired cognitive function. The resident required extensive to total assistance of one to two people for all ADLs. The resident had no falls since the prior assessment. B. Record review 1. Fall risk A 2/23/21 Fall Risk Evaluation revealed the resident was at risk for falls with a score of 12. It indicated rubber-soled shoes or non-skid slippers should be worn for ambulation and a toileting program should be utilized. (A score of 10 or greater is considered high risk) The care plan, last revised 1/24/2020, revealed the resident was at risk for falls related to a history of fall related to the diagnosis of osteoarthritis and delayed mental development. Interventions included: -Anticipate and meet the resident's needs; -Assess risk for falls- complete the Fall Risk Assessment that will identify the risk for falls on admission, quarterly, annually and with any change of condition.; -Be sure the call light is within reach and encourage the resident to use it for assistance as needed; -Educate family about safety reminders and what to do if a fall occurs; -Follow facility fall protocol; -Physical therapy to evaluate and treat as ordered or as needed; -Needs activities that minimize the potential for falls while providing diversion and distraction; and, -Needs a safe environment with a reachable call light and personal items within reach. 2. 6/15/21 fall A 6/15/21 health status note revealed the resident's roommate informed the nurse the resident was lying on the floor next to her bed. It indicated the resident had no injuries and neurological assessments were started. -It did not indicate if any interventions were put into place to prevent the resident from falling again. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 6/15/21 change of condition evaluation revealed the resident had a fall. It indicated the resident was to be monitored closely. -No further description was given regarding the fall. A 6/15/21 Fall Risk Assessment Tool revealed the resident was at risk for falls with a score of 5. (A score of 4 or more is considered at risk for falling) -Review of the record on 7/16/21 revealed the facility did not implement any new interventions after the resident fell to prevent another fall from occurring and the care plan was not updated. V. Staff interviews Registered nurse (RN) #1 was interviewed on 7/16/21 at 10:25 a.m. He said when a resident fell , they should be assessed by an RN before moving them and they should be sent out to the emergency room for further evaluation if needed. He said the nurse should begin neurological assessments if the resident hit their head or if the fall was unwitnessed and these would continue for 72 hours. He said new interventions were initiated by the IDT team in the morning after the fall unless it was on a weekend and then the weekend supervisor should try and implement something right away. He said new interventions should be reviewed with the physician to obtain an order if needed. He said the intervention should be put on the task list for the CNAs and it should be passed along verbally to the oncoming shift at shift change. He said therapy was also notified anytime a resident fell so they could be evaluated if needed. He said the MDS person was responsible for updating the care plan. CNA #1 was interviewed on 7/16/21 at 11:08 a.m. She said if a resident fell , she would immediately get the nurse and follow the instructions given by the nurse. She said she did not know who was responsible for implementing new interventions after a resident fell . She said she just tried to keep their bed in the lowest position at all times and make sure their call light was close to them. Licensed practical nurse (LPN) #1 was interviewed on 7/16/21 at 4:02 p.m. She said whenever a resident fell , she immediately contacted the supervisor to have the RN do an assessment. She said the resident should not be moved until they were assessed by the RN. She said the RN usually did the risk management, implemented new interventions and updated the care plan. She said the new interventions were usually verbally communicated to the floor staff. She said neurological assessments were done if the fall was unwitnessed or the resident hit their head and were initiated by the RN. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to manage and monitor the administration of psychotropic medications for four (#5, #6, #2 and #3) out of six sample residents. Specifically, the facility failed to: -Ensure consents were obtained prior to psychotropic medications being administered for Resident #5, #6, #2 and #3; -Ensure behavior monitoring and tracking was being documented routinely to justify the need for psychotropic medications for Resident #5, #6 and #2; and, -Monitor hours of sleep for the use of a hypnotic for Resident #2. Findings include: I. Facility policy and procedure The Medication Monitoring -Psychotropic Monitoring policy and procedure, last revised 6/21/17, provided by the nursing home administrator (NHA) on 7/28/21 at 4:02 p.m. revealed in pertinent part, The interdisciplinary team should continue to recommend non-drug means such as behavioral interventions, environmental modifications, or alternative approaches to care to assist in the treatment or modification of the resident ' s behavior, whenever clinically appropriate. Each resident receiving a psychotropic agent is monitored for: a. Episodes of behavior being treated and/or manifestation of the disordered thought process b. Adverse reactions and side effects c. Appropriateness of drug selection and dosage d. Potential for a gradual dose reduction, if drugs are used to manage behavior, stabilize mood or treat a psychiatric disorder. II. Resident #5 A. Resident status Resident #5, age 66, admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included metabolic encephalopathy (brain dysfunction due to a metabolic or toxic cause), psychoactive substance abuse, and poisoning by heroin. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 6/20/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent with bed mobility, walking in the room or corridor, locomotion on the unit and eating. She required supervision of one person for transfers, locomotion off the unit and for toileting. She required limited assistance from one person for dressing and personal hygiene. The resident received anti-anxiety medication four out of seven days during the assessment period. B. Record review According to the June 2021 CPO, the resident had an order for lorazepam 0.5 milligrams by mouth every 12 hours as needed (PRN) for mild agitation, ordered 6/9/21. The order did not have a 14 day stop date. The medication was discontinued on 6/30/21, 21 days after it was ordered. According to the June 2021 medication administration record (MAR), lorazepam was administered eight times in the 21 days it was ordered. Review of the record on 7/14/21 revealed there was no consent signed by the resident or the resident ' s representative prior to the lorazepam being administered, notifying the resident of the risks and benefits of taking a psychoactive medication. Further review revealed there was no behavior monitoring or tracking for the use of the lorazepam and the use of the anti-anxiety medication was not re-evaluated by the physician after 14 days. III. Resident #6 A. Resident status Resident #6, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the July 2021 CPO, diagnoses included schizophrenia. The 4/12/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. No behaviors were exhibited during the assessment period. The resident required supervision to limited assistance of one person for his ADLs. The resident did not take any psychotropic medications during the assessment period. B. Record review The July 2021 CPO revealed the resident had orders for quetiapine fumarate 25 mg give 0.5 tablet by mouth two times a day for schizophrenia, ordered 7/1/21. Review of the record on 7/14/21 revealed there was no consent signed by the resident or the resident ' s representative prior to the quetiapine being administered, notifying the resident of the risks and benefits of taking a psychoactive medication. Review of the record revealed no behaviors were being monitored or tracked for the use of the psychotropic medication. IV. Resident #2 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #2, age less than 65, was admitted on [DATE] and discharged [DATE]. According to the June 2021 CPO, diagnoses included bipolar disorder and lack of physiological childhood development. The 4/16/21 MDS assessment revealed the resident had mild cognitive impairment with a BIMS score of 12 out of 15 and exhibited no behaviors during the assessment period. The resident required the extensive assistance of one to two people for his activities of daily living (ADL). B. Record review According to the June 2021 CPO, the resident had the following orders: -Ability (an antipsychotic) 15 mg give one tablet by mouth one time a day for anxiety, ordered 4/9/21; -Melatonin 3 mg give one tablet by mouth at bedtime for insomnia, ordered 4/9/21; -Zolpidem (a hypnotic) 5 mg give one tablet by mouth at bedtime for insomnia, ordered 4/13/21; and, -Lithium (an antipsychotic) 300 mg give one capsule by mouth two times a day for bipolar, ordered 5/18/21. Review of the record on 7/14/21 revealed there was no consent signed by the resident or the resident ' s representative prior to any of the psychotropic medications being administered, notifying the resident of the risks and benefits of taking a psychoactive medication. Review of the record revealed no behavior monitoring or tracking for the use of any of the psychotropic medications was put into place until 6/2/21. Hours of sleep were not monitored with the use of a hypnotic to determine its effectiveness and on-going need for the medication. V. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the July 2021 CPO, diagnoses included anxiety, insomnia and psychological developmental disorder. The 6/21/21 MDS assessment revealed the resident had severely impaired cognitive function. The resident required extensive to total assistance of one to two people for all ADLs. The resident received antipsychotic and antidepressant medication seven out of seven days during the assessment period and no gradual dose reduction had been attempted. B. Record review The July 2021 CPO revealed the resident had the following orders: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Trazodone (an antidepressant) 100 mg give one tablet by mouth one time a day for insomnia, ordered 6/14/2020; and, -Zyprexa (an antipsychotic) 2.5 mg give one tablet by mouth one time a day for anxiety, ordered 6/14/2020. Review of the record on 7/14/21 revealed there was no consent signed by the resident or the resident ' s representative prior to any of the psychotropic medications being administered, notifying the resident of the risks and benefits of taking psychoactive medications. VI. Staff interviews Registered nurse (RN) #1 was interviewed 7/16/21 at 10:25 a.m. He said consent needed to be obtained for any psychotropic medications before they were administered. He said the nurse that took the order was responsible for obtaining the consent. He said the floor nurse was responsible for determining what behaviors needed to be monitored. He said behavior monitoring was documented on the resident ' s medication administration record (MAR) by the nurses and was documented by the certified nurse aides (CNA) under tasks in the electronic record. He said psychotropic medications were reviewed monthly by the social services department. He said anytime a resident was on a sleep medication, the nurses should be monitoring the hours of sleep to determine the effectiveness of the medication. The social service director (SSD) was interviewed on 7/16/21 at 11:18 a.m. She said consents were needed for all psychotropic medications and should be obtained before administering the medication. She said she was checking the dashboard in the resident ' s electronic record to see if any residents were started on a psychotropic medication so that she could follow up and make sure everything was in place to monitor the medication. She said the nursing staff was responsible for ensuring the consent was signed prior to administering the medication. She said the pharmacist was immediately notified of the order for the psychotropic medication and the pharmacist was responsible for determining and developing what behavior monitoring should be done and reviewed the medications monthly. She said the interdisciplinary team (IDT) reviewed the medications quarterly. She said behavior tracking should be done every shift by the nursing staff and was documented on the resident ' s MAR. Licensed practical nurse (LPN) #1 was interviewed on 7/16/21 at 4:10 p.m. She said consents should be obtained for any psychotropic medications before administering the medication even if it was verbal consent from the resident ' s representative. She said she would make a progress note indicating the consent was obtained. She said the admitting RN or the RN supervisor determined what behavior needed to be monitored and tracked. She said behaviors were tracked every shift and were documented on the resident's MAR. She said hours of sleep were monitored for any resident on medication for insomnia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 7/16/21 at 3:22 p.m. He said all psychotropic medications needed to have a consent signed upon admission or at the time the order was written. He said the nurse who took the physician order for the psychotropic medication was responsible for obtaining the consent before administering the medication. He said the nurse taking the order should also implement immediate behavior tracking based on their assessment and then the social service staff and the MDS coordinator should follow up and make any adjustments necessary. He said the IDT was also reviewing any changes made to psychotropic medications according to the 24 hour report (an internal document used by the staff daily to report changes or concerns) . He said hours of sleep should be monitored for any resident on sleep or hypnotic medication. VII. Facility follow-up On 7/15/21 the facility obtained consents for all psychotropic medications for the above residents and uploaded them into the resident ' s electronic record by 7/16/21. On 7/16/21 at 2:53 p.m., the NHA, DON and other IDT members presented a performance improvement plan (PIP) for the management system for psychotropic medications that the facility identified a concern with on 6/17/21. The facility had identified consents were not being obtained or uploaded consistently, they identified the need to revamp their psychotropic committee and meeting and initiate/enforce stop dates for PRN medications. They indicated this was an ongoing process with many components being put into place by the committee. -However, the consents and behavior tracking were not being consistently implemented based on the residents identified in the citation (see above).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to ensure one (#5) out of six sample residents were free of significant medication errors. Specifically, the facility failed to ensure: -Resident #5 received the correct dose of oxycodone; and, -Resident #5 received OxyContin as ordered by the physician. Findings include: I. Professional reference According to [NAME], [NAME] & [NAME], Clinical Nursing Skills & Techniques, 8th ed. 2016, pp 480-489: To prevent medication errors follow the six rights of medication administration consistently every time you administer medications. Many medication errors are linked in some way to an inconsistency in adhering to the six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation -Medication errors often harm patients because of inappropriate medication use. Errors include inaccurate prescribing; administering the wrong medication, by the wrong route, and in the wrong time interval; and administering extra doses or failing to administer a medication . -When an error occurs, the patient's safety and well-being become the top priority . II. Resident #5 A. Resident status Resident #5, age 66, admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included cellulitis and arthritis to the right shoulder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/20/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent with bed mobility, walking in the room or corridor, locomotion on the unit and eating. She required supervision of one person for transfers, locomotion off the unit and for toileting. She required limited assistance from one person for dressing and personal hygiene. The resident took pain medication routinely and as needed for complaints of frequent pain. B. Record review 1. Wrong dose According to the June 2021 CPO, the resident had orders for oxycodone 10 milligrams (mg) one tablet every four hours as needed for pain, ordered 6/9/21. This order was changed on 6/23/21 to oxycodone 5 mg one tablet by mouth every six hours as needed for pain. Review of the controlled drug receipt/record/disposition form for the resident's oxycodone 10 mg, received from the pharmacy on 6/18/21, revealed the resident received doses of the 10 mg oxycodone after the dose had been decreased to 5 mg on 6/23/21. Doses were signed out of the medication cart on 6/24/21 at 8:30 p. m., and on 6/26/21 at 11:49 a.m. and 4:00 p.m. The June 2021 medication administration record revealed the 10mg doses of oxycodone signed out of the medication cart on 6/24/21 at 8:30 p.m. and on 6/26/21 at 4:00 p.m. were not documented as being administered. The 10 mg dose of oxycodone signed out of the medication cart on 6/26/21 at 11:49 a.m. was documented on the MAR as a 5mg tablet being administered instead. -No incident reports were completed for these medication errors. 2. Omitted medications According to the July 2021 CPO, the resident had orders for OxyContin ER (extended release) 10 mg one tablet by mouth twice a day, ordered 6/10/21. According to the June 2021 MAR, the resident received the OxyContin ER 10 mg twice a day with no missed doses. Review of the controlled drug receipt/record/disposition form for the residents OxyContin 10 mg, received from the pharmacy on 6/14/21, revealed only one tablet was signed out of the medication cart per day on 6/17, 6/18, 6/19 and 6/21/21 in the morning and on 6/22/21 in the evening. No OxyContin tablets were signed out of the medication cart on 6/20/21. This indicated the resident did not receive the medication as ordered by the physician on the evenings of 6/17, 6/18, 6/19, 6/21 or the morning of 6/22/21 and the resident did not receive any OxyContin on 6/20/21. -Review of the resident's record revealed no documentation indicating why the medication was not administered as ordered. -No incident reports were completed for these medication errors. III. Staff interviews (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 7/16/21 at 10:25 a.m. He said when a nurse was administering medication, they should always follow the five rights of medication administration, which included: the right resident, the right medication, the right dose, the right route and the right time. He said medications were signed out on the resident's MAR and narcotic count sheet after they were given to the resident, in case the resident refused the medications, then it could be documented. Licensed practical nurse (LPN) #1 was interviewed on 7/16/21 at 4:10 p.m. She said there were six rights to medication administration but was only able to name four of them. She said narcotics were signed out when they were removed from the medication cart but they were not signed out as being administered on the MAR until after the resident took them. She said anytime a medication error was identified, the physician should be notified right away. The director of nursing (DON) was interviewed on 7/16/21 at 3:22 p.m. He said the nurses should be following the five R's of medication administration: the right resident, right medication, right dose, right route and right time. He said medications, including narcotics, should be signed out when they were removed from the cart. He said when a medication error was identified by the medication nurse an incident report should be completed and the physician and supervisor notified. IV. Facility follow up On 7/16/21 at 2:53 p.m. the nursing home administrator (NHA) presented a performance improvement plan (PIP) that the facility had implemented the previous day (7/15/21) for an improved medication management system when the medication errors were identified. He said he was educating the nurses on completing a risk management (incident report) whenever a medication error was identified and ensuring that proper notifications were made and interventions were put into place to prevent a recurrence. He said the interdisciplinary team (IDT) would review this daily, Monday thru Friday, until full compliance was achieved.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to provide laboratory services as ordered and promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of the clinical reference range for notification of a practitioner for two (#5 and #6) out of six sample residents. Specifically, the facility failed to ensure: -Laboratory tests were completed as ordered for Resident #5 and #6; -Wound cultures were obtained for Resident #5 as ordered; and, -Orders for STAT (immediate) laboratory tests were completed in a timely manner for Resident #6. Findings include: I. Facility policy and procedure The Lab and Diagnostic Test Results policy and procedure, last revised September 2012, provided by the nursing home administrator (NHA) on 7/28/21 at 4:02 p.m., revealed in pertinent part, The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The laboratory, diagnostic radiology provider or other testing source will report test results to the facility. II. Resident #5 A. Resident status Resident #5, age 66, admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included cellulitis (skin infection). The 6/20/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent with bed mobility, walking in the room or corridor, locomotion on the unit and eating. She required supervision of one person for transfers, locomotion off the unit and for toileting. She required limited assistance from one person for dressing and personal hygiene. The resident had open lesions, surgical wounds and skin tears. B. Record review The July 2021 CPO revealed the following: -Complete blood count (CBC) with differential and comprehensive metabolic panel (CMP) to be drawn as routine today, ordered 6/15/21; and, (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Obtain a culture and sensitivity of the bilateral lower leg wounds, be sure and label as right or left, ordered 6/30/21. A 6/30/21 physician progress note revealed the resident had cellulitis of the right lower limb. It indicated the wound care team was to be consulted and cultures were to be done. Review of the record on 7/16/21 revealed no laboratory results for the CBC and CMP ordered 6/15/21 and no documentation of the wound cultures being obtained. Results of the cultures could not be found in the resident ' s record. III. Resident #6 A. Resident status Resident #6, age less than 65, was admitted [DATE] and readmitted on [DATE]. According to the July 2021 CPO, diagnoses included chronic kidney disease (CKD). The 4/12/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. He required supervision to limited assistance of one person for his activities of daily living (ADL). B. Record review Review of the July 2021 CPO revealed an order was received on 7/2/21 at 11:53 a.m. for a STAT (immediate) basic metabolic profile (BMP) for CKD. A 7/2/21 health status progress note revealed a BMP stat lab order was placed and the lab requisition form had been completed. According to the laboratory results report, the specimen was not collected until 7/3/21 at 11:03 a.m. (almost 24 hours after it was ordered STAT). According to these results the resident's blood urea nitrogen (BUN) and creatinine were elevated (these labs show kidney function). The report indicated the results of these laboratory results were reported to the facility on [DATE] at 2:03 p.m. There was no documentation in the resident's record of the 7/3/21 laboratory results being received or if the physician had been notified of the laboratory results until 7/4/21, greater than 48 hours after they had been ordered STAT. According to the July 2021 CPO, a telephone order was received on 7/4/21 at 5:54 p.m. to repeat a BMP on Tuesday 7/6/21. Review of the residents record on 7/16/21 revealed no documentation to indicate the BMP was collected on 7/6/21 and no results were found in the record. There was no documentation in the resident's record of the resident refusing the lab draw. IV. Staff interviews (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 7/15/21 at 10:25 a.m. She said the wound culture for Resident #5 had not been done because the staff did not know how to collect it or what container to put the specimen in. She said the wound nurse was contacting the wound clinic to get clarification and the specimen would be collected that day but the results would not be back for several days. RN #1was interviewed on 7/16/21 at 10:36 a.m. He said he had been the wound nurse at the facility since August 2020 but he was not certified. He said he was not aware of the order for a culture of Resident #5's bilateral lower extremities until it was brought to his attention on 7/15/21. He said he contacted the wound physician and got clarification however they were waiting on the laboratory to send the correct swabs to collect the specimen. He said the orders should have been clarified when they were first received and the specimen collected at that time. RN #1 said laboratory specimens were collected Sunday thru Thursday but if a lab was ordered STAT, the floor nurse should call the laboratory to schedule it and it should be done within four to five hours. He said it was the floor nurses responsibility to ensure the orders were followed through with and that the results were obtained and followed up on. Licensed practical nurse (LPN) #2 was interviewed on 7/16/21 at 4:10 p.m. She said laboratory specimens could be collected on any weekday by the contract company. She said if a STAT order was received, the supervisor would call the laboratory and make an appointment for the laboratory to come to the facility as soon as possible. She said she had never had an order to obtain a STAT lab so she did not know how quickly it was completed. She said she expected it would be done the same day it was ordered. She said it was the supervisors or the charge nurses responsibility to follow up on any laboratory results. The director of nursing (DON) was interviewed on 7/16/21 at 3:22 p.m. He said the nurse receiving the orders for the labs was responsible to ensure the specimens were obtained and the nurse receiving the results of the labs was responsible for following up on the results. He said if the staff did not know how to collect a specimen, they should have called the physician or laboratory to get clarification. The DON said if STAT labs were ordered, the floor nurse or the supervisor should call the laboratory to schedule it and it should be done within two to four hours and the floor nurse should follow up to ensure the results are obtained and reported to the physician in a timely manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to maintain an accurate medical record for three (#5, #2, and #6) residents out of six sample residents. Specifically, the facility failed to: -Accurately document Resident #5's use of pain medication; -Keep accurate record of Resident #5's controlled substances; -Document neurological assessments for Resident #2 and maintain the assessments in the clinical record; and, -Obtain a copy of Resident #6's x-ray results. Findings include: I. Facility policy and procedure A policy in regards to maintaining resident records was requested from the facility. A policy on Release of Information was provided, but not on maintaining the record. II. Resident #5 A. Resident status Resident #5, age 66, admitted [DATE]. According to the July 2021 computerized physician orders (CPO), diagnoses included cellulitis (skin infection) and arthritis to the right shoulder. The 6/20/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent with bed mobility, walking in the room or corridor, locomotion on the unit and eating. She required supervision of one person for transfers, locomotion off the unit and for toileting. She required limited assistance from one person for dressing and personal hygiene. B. Record review 1. Inaccurate documentation According to the July 2021 CPO, the resident had an order for oxycodone 5 milligrams (mg) give one tablet by mouth every six hours as needed for pain, ordered 6/23/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065001	A. Building B. Wing	07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lowry Hills Care and Rehabilitation	10201 E 3rd Ave Aurora, CO 80010

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the June 2021 medication administration record (MAR) the resident received oxycodone 5 mg one tablet on 6/27/21 at 12:30 a.m., another 5 mg tablet at 12:32 a.m. (two minutes later) and another 5 mg tablet at 2:14 a.m. (less than two hours after the other two tablets had been documented as being administered. Review of the controlled drug receipt/record/disposition form for Resident #5's oxycodone revealed only one 5 mg tablet was signed out as being removed from the medication cart on 6/27/21 at 12:32 a.m. indicating the documentation on the resident's MAR was inaccurate. Comparison of the resident's June 2021 MAR with the controlled drug record for the resident's oxycodone 5 mg revealed doses of the medication were documented on the MAR as being administered but were not signed out of the medication cart on the controlled drug record. This occurred on 6/25/21 at 2:30 a.m., 6/26/21 at 11:49 a.m., 6/27/21 at 12:30 a.m., 12:32 a.m., 2:14 a.m. (see above) and 10:59 a.m.; and on 6/29/21 at 7:16 a.m. This indicated the documentation on the MAR was inaccurate. Further comparison of the June 2021 MAR against the controlled drug record for the resident's oxycodone 5 mg revealed tablets were signed out of the medication cart but were not documented as being administered on the MAR. This occurred on 6/25/21 at 2:00 p.m., 6/29/21 at an unknown time, and on 7/1/21 at 6:00 p.m. 2. Missing documentation According to the June 2021 CPO, the resident had orders for oxycodone 10 mg one tablet every four hours as needed, ordered 6/9/21 and discontinued 6/23/21. -The facility was unable to provide the controlled drug receipt/record/disposition form for the resident's oxycodone 10 mg from 6/9/21 until 6/22/21. III. Resident #2 A. Resident status Resident #2, age less than 65, was admitted [DATE] and discharged [DATE]. According to the June 2021 computerized physician orders (CPO), diagnoses included acquired absence of left toes, generalized muscle weakness and physiological childhood developmental delay. The 4/16/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required extensive assistance of one to two people for his activities of daily living (ADL). According to the assessment, the facility was unable to determine if the resident had any falls prior to admission. B. Record review Review of the resident's record on 7/16/21 revealed the resident had 10 unwitnessed falls from the time of his admission on 4/9/21 until he was discharged on [DATE] (cross-reference F689 for failure to ensure resident safety). According to progress notes, neurological assessments were initiated after each fall, however the facility was unable to provide neurological assessments for any of the resident's falls while he was in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065001	A. Building B. Wing	07/28/2021

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #6 A. Resident status Resident #6, age less than 65, was admitted [DATE] and readmitted on [DATE]. According to the July 2021 CPO, diagnoses included chronic kidney disease (CKD). The 4/12/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. He required supervision to limited assistance of one person for his activities of daily living (ADL). B. Record review The July 2021 CPO revealed the resident had an order for a two view cervical spine x-ray for pain, ordered 4/8/21. -Review of the resident's record on 7/16/21 revealed the report for the x-ray ordered on 4/8/21 was not in the resident's record. V. Staff interviews Registered nurse (RN) #1 was interviewed on 7/16/21 at 10:25 a.m. He said once laboratory or x-ray results were received, the results were noted and reported to the physician, then placed in the medical records box at the nurses station to be scanned into the residents electronic medical record (EMR). He said the nurses had a link to the laboratory and could download results. RN #1 said when neurological assessments are completed after 72 hours they should go into the medical records box to be scanned into the resident's EMR. The DON was interviewed on 7/16/21 at 3:22 p.m. He said once the results had been noted and reported to the physician, they should be placed in the medical records file to be uploaded into the resident's record. He said once neurological assessments were complete they should go in the medical records box to be uploaded into the resident's record. The DON said it had been identified during the survey that narcotic count sheets were not being uploaded into the resident's medical records and the facility initiated a performance improvement plan (PIP) which indicated that the DON or designee would review all narcotic count sheets, Monday through Friday, and do a weekly audit to ensure an accurate account of all narcotics was being done. The medical records (MR) staff was interviewed on 7/16/21 at 4:02 p.m. He said he tried to collect the items in the medical records boxes at the nurses station daily but at least three times a week. He said he received all lab results, x-ray results and any other paperwork that needs to be scanned into the resident's record. He said he used to scan in the narcotic count sheets but now they were being given to the DON.