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	10/14/2021

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on observations, interviews and record review, the facility failed to ensure care was provided for one (#68) of one resident out of 37 sample residents in a manner and in an environment that maintained or enhanced the resident's dignity and respect, in full recognition of his or her individuality. The facility failed to provide timely assistance and adaptive utensils for Resident #68, who was experiencing violent tremors while attempting to eat his meals. Staff failed to respond appropriately and in a timely manner to assist the resident in a dignified manner, causing the resident distress and psychosocial harm. Cross-reference F725 failure to provide sufficient nursing staffing, and F810 failure to provide adaptive eating utensils. Findings include: I. Resident #68 status Resident #68, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the September 2021 computerized physician orders (CPO), diagnoses included Parkinson's disease, chronic kidney disease, dysphagia (difficulty or discomfort in swallowing), gastro-esophageal reflux disease (GERD), muscle weakness, anemia, coronary artery disease (CAD), and hypertension (high blood pressure). The 9/20/21 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. He required extensive assistance for bed mobility, transfers, dressing, toilet use and personal hygiene. Eating assistance needs were not assessed. He required a mechanically altered diet (food that was altered to make it easy to chew and swallow). II. Observations (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Actual harm Residents Affected - Few	Resident #68 was observed on 10/11/21 at 11:50 a.m. eating lunch in the dining room. He had two sandwiches on a plate, no silverware, and two cups of fluid. He tried to eat the sandwich but he was experiencing continued, uncontrolled jerking movements to his extremities. The bread from the sandwich flung around the table because the resident could not control his jerking movements/tremors. He was sliding down in his wheelchair while trying to eat his lunch. Two staff members noticed he had a hard time holding his sandwich and he was sliding down in the wheelchair. The resident said please help me up and the staff members assisted him to sit up better in the chair. The sandwich was taken out of his hand and he was assisted out of the dining room. On 10/13/21 at 5:48 p.m. Resident #68 was in his room in his bed. The bed was elevated to about a 45 degree angle. He had a room tray in front of him with a plate of spaghetti with marinara sauce on the tray. He did not have any silverware, regular or adaptive, and did not have a plate guard on his plate. His dessert cup was on the ground on top of a fall mat with the contents spilled out on the mat. He called out help me, someone get me some silverware please, a fork, a spoon. He repeated this several times. He said Please, please, please, give me a fork and a spoon please. He continued to use his left hand to stir the spaghetti while repeating please, please and he ate the plate of spaghetti with his hands. The resident swayed continuously on his bed back and forth with his shoulders from the right to the left. His head shook continuously in yes/no motions. His hands, hair and shirt were red from the marinara sauce. His face from below his eyes to his neck were splashed with marinara sauce. His blanket and sheets had marinara sauce on them. -At 5:58 p.m. an unidentified staff member entered Resident #68's room and said, I heard you fell , why did you fall? Why did you fall out of your chair? She left the room at 6:01 p.m. She did not provide silverware, clean him from the spaghetti on his clothes or go get staff members to provide care. -At 6:07 p.m. the surveyor notified the director of nursing (DON) concerning the situation and asked for her assistance. The DON and surveyor entered the resident's room. The DON said the resident should not have been given food without silverware, and he needed special weighted silverware to help him eat because of having Parkinson's disease. She said staff should have noticed immediately that he could not eat his meal without silverware. She said the staff member who came in and asked him about his fall also should have helped him. The DON said she would clean the spaghetti off of his clothes, pick up the dessert off the floor, clean his hands, feed him, and make sure the situation never happened again. The DON said she would identify the staff member who did not provide the resident with care a few minutes before. III. Record review The 10/11/21 care plan interventions and tasks revealed the following: -Assist the resident while eating meals, i.e. nursing, CNA -Adaptive devices as recommended by therapy or physician. Monitor for safe use. Monitor/document to ensure appropriate use of safety/assistive devices. -Provide adaptive equipment for dining at meals and snacks: plate guard, weighted utensils, 2-handled cup with straw. (Cross-reference F810.) (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	The nursing progress note written by the interim nursing home administrator on (INHA) on 10/13/21 at 8:10 p. m. revealed: The resident was assessed for needs for adaptive equipment or preferences during dining. Resident was asked if he would be comfortable eating in the dining room and he said he preferred to eat in his room. He agreed to the nurse's suggestion to eat in a private restorative dining area. Occupational therapy to evaluate the resident's needs and positioning in the dining area. IV. Resident interview Resident #68 was interviewed on 10/14/21 at 8:40 a.m. He said he was having a very good morning. He said breakfast was delicious. He said he did not remember eating spaghetti the previous evening. V. Staff interviews The interim nursing home administrator (INHA) was interviewed on 10/14/21 at 10:30 a.m. She said the facility had begun an investigation into what happened last night with Resident #68. She said he agreed last night to eat in the restorative dining room and he did well eating there that morning. She said the resident also agreed to move to a room closer to the nurse's station so that he could get more assistance. She said the facility would use the situation that happened last night as a learning tool to teach staff about multitasking and how it can be a distraction to resident cares. She said last night the DON came to her and they took care of the situation with the resident immediately. She said the resident was not treated with dignity and the staff needed to treat everyone with dignity and respect.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on observations and interviews, the facility failed to provide a safe, clean, comfortable and homelike environment for four (#51, #58, #64 and #77) out of 37 sample residents, and in two of two shower rooms. Specifically, the facility failed to: -Ensure rooms and bathrooms were clean for Residents #51, #58, #64 and #77; -Ensure towels and washcloths were available in the residents' rooms; and -Ensure the shower room fans and faucet heads were not broken and shower stalls were useable. Findings include: I. Facility policy The Resident Rooms and Environment policy was provided by the regional nurse consultant (RNC) on 10/14/21 at 1:00 p.m. It read in pertinent part, The facility provides residents with a safe, clean, comfortable, and homelike environment. Facility staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. II. Resident rooms and linens A. Resident #51 Resident #51, age 65, was initially admitted on [DATE] and was readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included unsteadiness on feet and chronic obstructive pulmonary disease (COPD). The 9/7/21 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 limited assistance with bed mobility, supervision with transfers, extensive assistance with dressing. Resident interview and observation Resident #51 was interviewed on 10/12/21 at 9:18 a.m. He was sitting in his wheelchair in his room. He said the housekeepers (HKs) did not clean his room daily. The floor was observed to have a brown stain. The bathroom floor had a dried brown stain around the commode. There were multiple dark brown stains under the toilet seat. The bathroom smelled like urine. There were no towels or washcloths in the room/bathroom. Resident #51 said there were not enough towels and washcloths in the facility. He said when he washed his face, there was no towel available for him to use. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident #58 Resident #58, age 75, was initially admitted on [DATE] and was readmitted on [DATE]. According to CPO, diagnoses included muscle weakness and chronic pain. The 9/13/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with bed mobility, transfer and bathing. Resident interview and observation Resident #58 was interviewed on 10/11/21 at 10:41 a.m. He said the HKs did not clean his room daily. He said most of the time the HK would come into his room and just remove the trash and leave. His room was not clean. There were dirty towels on the floor. The bath room had feces on the floor and around the toilet bowl. There was a tissue with dried feces behind the toilet on the floor. The bathroom smelled like feces and urine. The resident was upset that his room was not clean. There were no towels or washcloths in the room/bathroom. The resident said there were not enough towels and washcloths. He said sometimes he had to use a paper towel to wipe his face. C. Resident #64 Resident #64, under age 65, was admitted on [DATE]. According to the CPO, diagnoses included muscle weakness and anxiety disorder. The 9/15/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance with bed mobility, limited assistance with transfers and total dependence for bathing. Resident interview and observation Resident #64 was interviewed on 10/11/21 at 1:55p.m. She said the HKs did not clean her room properly. There were multiple dried brown stains on the floor at the foot of the bed. The bathroom floor had a dried brown stain around the commode and under the toilet seat. There were no towels or washcloths in the room/bathroom. She said the staff said there were not enough towels and washcloths in the facility. She said sometimes when she washed her face, there was no washcloth available for her to use to dry her face so she would use the paper towel. D. Resident #77 Resident #77, under age 65, was initially admitted on [DATE] and readmitted on [DATE]. According to the CPO, diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure. The 9/15/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance with bed mobility, limited assistance with transfers and total dependence for bathing. Resident interview and observation (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 was interviewed on 10/11/21 at 1:00 p.m. She said her room was not clean. There were brown stains on the floor in her room. There were dark brown stains around the commode and under the toilet seat. There were no towels or washcloths in the room/bathroom. She said she felt her room was not homelike and that HKs needed to clean her room/bathroom daily and do a better job when cleaning. She said she would get upset when she washed her face and there were no washcloths available to dry her face. E. Staff interviews The environmental director (ED) was interviewed on 10/13/21 at 10:53 a.m. She said she was in charge of housekeeping. She said when the housekeepers were hired, they received training on how to clean the residents' rooms. She said the housekeepers should clean all rooms daily. She said sometimes when the HK goes to clean the resident's room, the resident would be sleeping and the HK would leave and sometimes not go back to clean. She acknowledged that some of the rooms were not cleaned properly. She said she observed Resident #58's bathroom. She said the bathroom was not clean. She said there were dried feces around the commode and on a tissue on the floor. She said no room should look like that. She said the floor was stinky and she cleaned the room herself. She said she would provide education to housekeepers that all rooms and bathrooms should be cleaned daily. She said the housekeepers should not just remove the trash but should also clean the rooms. She said if a resident was sleeping at the time the HK went to clean the room, the HK should go back when the resident was up to clean the room. The interim nursing home administrator(INHA) was interviewed on 10/14/21 at 4:30 p.m. She said she had been in her position for about two weeks. She said it was identified that the residents' rooms were not being cleaned properly. She said the rooms were not clean because of the chemicals and mops the housekeepers were using. She said new chemicals and mops were ordered for cleaning. She said the resident rooms should be clean properly and education would be provided to the housekeepers on how to clean. 43135 III. Shower rooms On 10/12/21 at 4:20 p.m. a tour of the East and [NAME] resident shower rooms was conducted with the director of nursing (DON). Out of the two shower rooms, which contained four shower stalls total, only one shower worked when turned on. A. East shower room The shower room had one exhaust fan and it was unable to be turned on. The exhaust fan switch was a metal plate the size of a light switch plate on the wall with a two inch screw sticking out of its middle. The screw was unable to be turned. There was no knob in the shower room to put on the screw so the fan could be turned on. The shower room had two shower stalls. Each stall had tiled walls and was large enough to have a resident stand in or sit in a shower chair. One shower stall was used to store lift equipment and three boxes. The water was unable to be turned on. The other shower stall had a hose which hung from the top of the stall and touched the floor. The shower hose did not have a shower head attached to it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. [NAME] shower room The shower room had one exhaust fan that was unable to be turned on. The exhaust fan switch was a metal plate the size of a light switch plate on the wall with a two inch screw sticking out of its middle. The screw was unable to be turned. There was no knob in the shower room to put on the screw so the fan could be turned on. The shower room had two shower stalls. Each stall had tiled walls and was large enough to have a resident stand in or sit in a shower chair. One shower stall was used to store four large cardboard boxes, and a white plastic two tiered cart which contained towels and shampoos. The water was unable to be turned on. The other shower stall was a working shower stall. C. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 10/12/21 at 4:24 p.m. She said the fans had been broken in the showers for months. She said the only way for staff to turn on a fan in the shower room would be to carry a pair of pliers in their pockets to turn the screw that stuck out of the wall. She said what should be a knob to turn a fan on was only a large straight screw that came out of the wall. She said she did not use the fans in the shower rooms and it was hot in the shower room when residents took showers. She said both showers in the East shower room did not work. She said the one where the lift was stored was a broken shower stall and the other did not have a shower head on the hose. She said all 80 residents must use the [NAME] shower room where one shower could be turned on. She said in the [NAME] shower room one shower stall was used for storage because it was broken. She said the other shower stall in the [NAME] shower room worked. She said of the four showers in the facility only one was able to be used for several months. The maintenance director (MTD) was interviewed on 10/12/21 at 4:48 p.m. He said there were no knobs to turn the fans on in both East and [NAME] shower rooms. He said he would order the exhaust fan knobs and get them fixed in both shower rooms. He said he did not know how long the fans were unusable. He said when he used a pair of pliers he could turn the metal stem that stuck out of the wall to get fans to work. He said he did not expect the staff to carry a pair of pliers to turn on the fans. He said both shower stalls in the East shower room were unusable. He said one of the East shower room ' s shower heads was broken and the other shower was broken and used for storage. He said only one shower in the [NAME] shower room worked. He said all 80 residents used the one working shower. He said he would get the fans and the other three showers fixed as soon as possible. He said he did not know if staff had notified him in writing that the showers and fans were broken. The DON was interviewed on 10/12/21 at 4:33 p.m. The DON said she was unaware the fans in both shower rooms were unable to be used. She said she was unaware out of four shower stalls only one was working. She said all of the showers needed to be in working order. She said staff gave some residents their showers and some residents were independent and could shower on their own. She said she would make sure the showers and exhaust fans were in working order in both shower rooms from now on.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on observations, record review and interviews, the facility failed to ensure two (#42 and #72) of two residents reviewed out of 37 sample residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. Specifically, the facility failed to: -Notify the physician when Lasix (a diuretic) and potassium (supplement) medications were refused or missed for Resident #42, and -Notify the physician when Buspar (an antianxiety medication) and Labetalol (an antihypertensive medication) were left at Resident #72's bedside without a self-administration assessment and were administered late. Findings include: I. Facility policy The Medication Administration General Guidelines Policy, dated 2007, provided by the interim nursing home administrator (INHA) on 10/14/21 at 10:50 a.m., read in pertinent part: When two consecutive doses of a vital medication are withheld or refused, the physician is notified. Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified. The Self-Administration of Drugs policy, revised November 2010, provided by the INHA on 10/14/21 at 10:50 a.m., read in pertinent part: Residents in the facility who wish to self administer their medication may do so, if it is determined that they are capable of doing so. Nursing staff review the bedside medication record on each nursing shift, and they will transfer pertinent information to the medication administration record (MAR) kept at the nursing station, appropriately noting that the doses of medication were self-administered. II. Resident #42 A. Resident status Resident #42, age 73, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnoses included coronary artery disease (CAD), heart failure, diabetes and bipolar disorder. The 9/1/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required supervision with set up for transfers, bed mobility, toileting, hygiene, dressing and eating. She had no rejection of cares. B. Observation and interviews (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42 was interviewed on 10/13/21 at 8:10 a.m. She said she had not refused her medications (as charted below in the medication administration record). Licensed practical nurse (LPN) #1 was observed during medication pass on 10/13/21 at 8:16 a.m. to offer lasix and potassium medications to Resident #42. The resident refused the medication. She said she did not like to take the medication because it made her go to the bathroom too much. The LPN documented in the medication administration record (MAR) that the resident refused the medication. C. Staff interview Licensed practical nurse (LPN) #1 was interviewed on 10/13/21 at 8:20 a.m. She said Resident #42 refused the lasix and potassium medications almost every day. She said she notified the physician a few weeks ago but did not call every time the resident refused. The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said the physician was notified every time a medication was missed or a resident refused. She said she was not aware Resident #42 refused the lasix or potassium. She said re-education was given to the nurses about missed or refused medications. D. Record review The October 2021 CPOs for Resident #42 revealed the following orders: -Lasix 40 milligrams (mg), give one tablet one time a day for congestive heart failure. The order start date was 8/24/21. -Potassium Chloride extended release 10 milliequivalents (meq), take one tablet one time a day for hypokalemia (low potassium). The order start date was 2/23/21. The August 2021 MAR revealed Resident #42 refused lasix medication two times. The September 2021 MAR revealed Resident #42 refused lasix medication 16 times and potassium chloride 10 times. The October 2021 MAR revealed Resident #42 refused lasix medication 14 times and potassium chloride eight times. There was no care plan for congestive heart failure or hypokalemia with medication use, or medication refusals, for Resident #42. The regulatory physician note dated 8/19/21 for Resident #42 revealed no medication changes. The health status note dated 8/24/21 at 11:46 a.m. read in pertinent part, (Resident #42) prefers taking medications by dividing morning medication early before seven a.m. and late a.m. around 10 or 11a.m. Spoke with the doctor and he said it was ok to change medication time per resident preference. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The health status note dated 10/2/21 at 12:32 p.m. read in pertinent part: Contacted the doctor office regarding (Resident #42's) continued decline of potassium chloride and lasix. Message left on the answering machine to return the call if there were any new orders. The health note dated 10/13/21 at 1:49 p.m. (during the survey) read in pertinent part: Contacted the doctor office about (Resident #42's) continued decline of potassium and lasix. Provider requested a facetime visit with the resident and informed the supervisor. Record review revealed no other doctor contacts for refusal of medication for Resident #42 and no evidence of facility follow up. III. Resident #72 A. Resident status Resident #72, age 65, was admitted on [DATE]. According to the October 2021 CPO, pertinent diagnoses included stroke, hypertension, diabetes and post traumatic stress disorder. The 9/22/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required supervision assistance with one person for toileting and hygiene. He was independent with dressing, transfers and eating. He had no behaviors. B. Observations and interviews Resident #72 was observed on 10/11/21 at 2:55 p.m. to have a medication cup with three pills on his bedside table. He said he took the medication for his blood pressure and he would take it soon. He said he procrastinated and forgot to take them. He said the nurse took his blood pressure today. He said the nurses left the medications on his table and he would eventually take them. Registered nurse (RN) #1 was interviewed on 10/11/21 at 3:10 p.m. She said the medication in the cup was Buspar (antianxiety) medication and Labetalol (blood pressure medication). She said Resident #72 took his medication on his own at times. She said when she went to give him his medication at noon, she went to get him some hot coffee and forgot to check to see if he took the medication. She said Resident #72 took the medication at 3:10 p.m. on this day (10/11/21) in front of the nurse, three hours after the medication was due. She said residents were assessed for self-administration of medication, but she was not sure if Resident #72 had an assessment or not. C. Record review The October 2021 CPOs for Resident #72 revealed the following orders: -Buspirone tablet five milligrams (mg), give one tablet by mouth three times a day for anxiety. The order start date was 6/12/21. -Labetalol tablet 300 mg, give two tablets by mouth three times a day for hypertension, hold the medication when the systolic blood pressure was less than 110. The order start date was 6/10/21. Resident #72's MAR revealed the medication was checked off by RN #1 as administered at noon. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse notes for Resident #72 revealed no documentation of the medication given late, being self-administered, or that any physician was notified. The hypertension care plan for Resident #72, revised on 4/23/21, read in part: Give the anti hypertensive medication as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate (tachycardia) and effectiveness. Report significant changes to the medical doctor. The antianxiety medication care plan for Resident #72, revised on 1/24/2020, read in pertinent part: (Resident #72) will demonstrate fewer episodes of anxiety by review date. Administer medications as ordered. See medication record. Monitor for effectiveness and side effects. -No assessment for self-administration, or care plan for self-administration of medications, was found in the resident's medical record. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 10/13/21 at 4:30 p.m. She said the facility had no residents who self administered medications. She said all residents were given and took their medications in front of a nurse. The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said Resident #72 did not take medication on his own. She said since 10/11/21 education was provided to the nurses on administering medications at the time due. No medication was to be left at the bedside. She said Resident #72 had not been assessed for self-administration.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on observations, record review and interviews, the facility failed to provide assistance with activities of daily living (ADLs) to ensure the highest practicable quality of life and care, for five (#51, #58, #63, #64 and #77) of six residents reviewed out of 37 sample residents. Specifically, the facility failed to: -Provide regular showers to Residents #51, #58, #63, #64 and #77 who needed assistance with ADLs; and -Provide nail care for Residents #51 and #58. Residents said during interviews that they requested baths and nail care and did not receive the assistance they needed. Residents #51, #58 and #63 said they could smell themselves it had been so long since they bathed. Resident #64 said she did not want to put on clean clothes because she felt dirty. Resident #77 said she wore a cap because she did not want anyone to see her stringy, greasy hair. Cross-reference F725, sufficient nursing staff Findings include: I. Facility policy The Bath/Shower/Tub policy, revised February 2018, was provided by the regional nurse consultant (RNC) on 10/14/21. The policy read in pertinent part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. II. Resident #51 A. Resident status Resident #51, age 65, was initially admitted on [DATE] and was readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included unsteadiness on feet and chronic obstructive pulmonary disease (COPD). The 9/7/21 minimum data set (MDS) assessment revealed the resident had moderately cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required limited assistance with bed mobility, supervision with transfers, extensive assistance with dressing and supervision with personal hygiene. Bathing assistance needs were not specified. It documented bathing activity did not occur. B. Resident interview and observation (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #51 was interviewed on 10/12/21 at 9:18 a.m. The resident's clothes had dried food stains. His fingernails were long with dried black substance under his fingernails. He said he had not received a shower for about two weeks. He said his shower days were Wednesdays and Fridays. He said the staff said there was not enough staff. He said when he asked the staff to assist him to cut his nails, the staff said there was not enough time because they had a lot of residents to take care of. He said he could smell himself. C. Record review The comprehensive care plan, initiated on 5/1/19 and revised on 7/15/19, identified Resident #51 had an activity of daily living (ADL) self-care deficit related to severe stenosis in his back. Intervention included: Resident #51 required assistance adjusting clothing, clean self, transfer onto toilet, transfer of toilet and at times required supervision; and weight bearing assistance to turn and reposition. He also required physical assistance with transfers. -The care plan failed to include the resident's preference for showers, how often he would like showers/baths and what assistance was required. The resident's bathing/shower record was requested on 10/13/21. It was not provided by the facility. III. Resident #58 A. Resident status Resident #58, age 75, was initially admitted on [DATE] and was readmitted on [DATE]. According to the October 2021 CPO, diagnoses included muscle weakness and chronic pain. The 9/13/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with bed mobility, transfer and bathing. -However, Resident #58 had an ADL-deficit care plan and per interview needed staff assistance with bathing (see interview and record review below). B. Resident interview and observation Resident #58 was interviewed on 10/11/21 at 10:41 a.m. He said he had not received showers for two weeks. He said he would ask the certified nurse aide (CNA) to give him a shower but the CNA would tell him there was not enough staff to assist with showers. The resident's fingernails were long. He said he needed his nails trimmed, but no one would assist him. He said he could smell himself. He said his shower days were Mondays and Thursdays. C. Record review The care plan, initiated on 9/15/21, identified Resident #58 had ADL self-care deficits related to falls and decreased mobility. Interventions included: Encourage resident to discuss feelings about self-care deficit; encourage resident to participate to the fullest extent possible with each interaction and bathing/showering: avoid scrubbing and pat dry sensitive skin. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The care plan failed to include the resident's preference for showers, how often he would like shower/bath and what assistance was required. Review of the bath/shower record revealed the resident had one shower on 9/29/21 since his readmission, out of 10 opportunities. IV. Resident #63 A. Resident status Resident #63, under age 60, was admitted on [DATE]. According to the October 2021 CPO, diagnoses included muscle weakness and chronic pain. The 9/15/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required extensive assistance with bed mobility, supervision with transfer and one staff physical help with bathing. B. Resident interview and observation Resident #63 was interviewed on 10/11/21 at 11:56 a.m. He said he had been in the facility for about a month and had not received a shower or bath. His hair appeared to be greasy and sticky. He said sometimes he would use the wet wipes in his room to do his own bath but it did not clean him very well. He said his hair was greasy because he had not washed his hair since admission. He said when he asked the staff, they would promise to give him a shower the next day because they did not have enough staff to do showers. He said he could smell himself. C. Record review The care plan, revised on 9/2121, identified Resident #63 had ADL self-care deficits related to peripheral vascular disease, cellulitis, neuralgia, lymphedema, anemia, major depressive disorder, muscle weakness, vitamin D deficiency and chronic pain. Interventions included: Encourage resident to discuss feeling about self-care deficit; and encourage resident to participate to the fullest extent possible with each interaction and bathing/showering: avoid scrubbing and pat dry sensitive skin. -The care plan failed to include the resident's preference for showers, how often he would like showers/baths and what assistance was required. The bath/shower record was requested on 10/14/21. It was not provided by the facility. Review of the point of care documentation (where CNAs document) revealed the resident's showers days were Wednesdays and Saturdays Nine opportunities for showers were missed. V. Resident #64 A. Resident status Resident #64, under age 65, was admitted on [DATE]. According to the October 2021 CPO, diagnoses included muscle weakness and anxiety disorder. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 9/15/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance with bed mobility, limited assistance with transfers and total dependence with bathing. B. Resident interview and observation Resident #64 was interviewed on 10/11/21 at 1:55p.m. She said she had not received a shower since last Thursday. She said she was scheduled to receive a shower two times a week but was not sure on which days. She said when she asked the staff to give her a shower, staff would tell her there was not enough staff to provide shower. She said even a bed bath she would appreciate. She said she did not put on clean clothes because she felt dirty. C. Record review The care plan, revised on 9/20/21, identified Resident #64 had ADL self-care deficits related to rhabdomyolysis (breakdown of muscle tissue that releases a damaging protein into the blood), history of falling, protein calorie malnutrition, major depressive disorder, pressure ulcer to buttock, hypothyroidism, cramps and spasms, orthostatic hypotension, post traumatic stress disorder (PTSD), and anxiety disorder. Interventions included: encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, and encourage the resident to use a bell to call for assistance. -The care plan failed to include the resident's preference for showers, how often she would like showers/baths and what assistance was required. The bath/shower record documented the resident had two showers since admission (9/9/21) on the following dates: 9/15/21 and 9/30/21. Review of the point of care documentation revealed the resident did not have assigned days for showers/baths. VI. Resident #77 A. Resident status Resident #77, under age 65, was initially admitted on [DATE] and readmitted on [DATE]. According to October 2021 CPO, diagnoses included chronic obstructive pulmonary disease (COPD) and heart failure. The 9/15/21 MDS assessments revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance with bed mobility, limited assistance with transfers and total dependence with bathing. B. Resident interview and observation (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #77 was interviewed on 10/11/21 at 1:00 p.m. She said since admission to the facility, she had received two showers. She said she was not told about her shower days. She said when she asked the CNA to give her a shower, the CNA would tell her that there was not enough staff and that she had a lot of residents to take care of. She was observed to wear a cap. She said she wore the cap because her hair was greasy and stringy and she did not want anyone to see her hair look like that. She said for the texture of her hair, she would like her hair washed every day. C. Record review The care plan, initiated on 9/30/21, identified Resident #77 had ADL self-care deficits related to activity intolerance, disease process and COPD. Interventions included: encourage the resident to discuss feelings about self-care deficit, encourage the resident to participate to the fullest extent possible with each interaction, and encourage the resident to use a bell to call for assistance. -The care plan failed to include the resident's preference for showers, how often she would like shower/bath and what assistance was required. The bath/shower record documented the resident had one shower since admission (9/23/21), on 9/29/21. Review of the point of care documentation revealed the resident did not have assigned days for showers/baths. VII. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 10/12/21 at 9:42 a.m. She said staffing had been a major issue at the facility. She said sometimes she would work alone with 35 residents and some residents needed assistance with Hoyer (mechanical) lifts which required two staff assistance. She said a lot of residents who were scheduled for showers did not receive showers because there was not enough staff. She said Residents #58, #64 and #77 did not receive showers the day she worked because she was working short. She said she did not have the time to give showers. She said she had complained to the administration regarding working short all the time. She said she did not feel anything had been done. Agency certified nurse aide (ACNA) #1 was interviewed on 10/12/21 at 1:10 p.m. She said staffing had been a problem. She said last Thursday she was the only CNA that worked on the three halls, with 35 residents, for seven hours before she got help. She said residents did not get showers. She said residents who needed assistance with the Hoyer lift did not get out of bed because she needed another staff to assist her. She said it was not safe for one CNA to have 35 residents. She said it happened frequently. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 10/13/21 at 10:43 a.m. She said she had been in her position for two weeks. She said when she started in her position, she identified that residents were not receiving showers. She said she was aware that staffing was a challenge. She said she visited with residents and asked them about their preferences for showers. She said she implemented a new way to monitor and track residents' showers. She said she created a form for each unit with the resident's name and shower days. She said the staff assigned to each unit were responsible for providing showers to the residents. She said she instructed the CNAs to put all completed shower sheets in her box, which she would review every morning to ensure showers were given. She said she instructed the nurses on the shift to follow up with CNAs to ensure showers were given for those residents who were scheduled for showers. She said if the resident refused to shower, the CNA should document and report it to her. The interim nursing home administrator (INHA) was interviewed on 10/14/21 at 4:30 p.m. She said she had been in her position for about two weeks. She said it was identified that staffing issues were a major concern and that residents were not receiving showers. She said they had been hiring and offering bonuses to attract employees to apply. She said hiring was ongoing. The facility failed to ensure residents received assistance with showers and personal hygiene.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interviews, the facility failed to keep residents as free from accident hazards as possible for one (#56) of five residents reviewed for accidents out of 37 sample residents. Resident #56 required a mechanical lift for transfers and two staff for transfers. On 8/10/21 she was transferred by staff with the mechanical lift and caused an injury above the resident's eyebrow. The facility did not conduct an investigation and did not provide additional training to the staff on mechanical lift transfers to prevent further injury. Due to the facility failures, the resident was lowered to ground after she was improperly transferred with the mechanical lift on 8/24/21. Findings include: I. Facility policy The Fall and Accident Prevention policy, revised on 7/27/2020, provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:50 p.m., read in pertinent part: It is the policy of the facility to prevent injuries, falls, accidents and incidents and eliminate preventable occurrences, practices, or systems, which negatively impact residents and or residents care and environmental hazards whenever possible. All facility staff will be provided with ongoing education on safe practices. The director of staff development will conduct the training. The facility will establish routine monitoring systems to assess, correct, and modify safety risk factors. II. Resident #56 status Resident #56, age 89, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnoses included peripheral vascular disease, hypertension and dementia. The 9/10/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired and unable to perform a brief interview for mental status (BIMS) score. She required extensive care with two people for transfers, bed mobility, toileting, hygiene and dressing. She required extensive assistance from one person for eating. She used a Hoyer (mechanical) lift for transfers. III. Record review The activities of daily living care plan revised 12/29/16, for Resident #56, read in pertinent part Resident #56 required assistance with activities of daily living and mobility related to cognitive deficits and left handed contracture. She had the total assistance of two people with transfers and a hoyer lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall care plan, revised on 12/1/2020 for Resident #56, read in pertinent part: Resident #56 will be free of any major injury related to falls through the next review date. She had anti-tippers on her wheelchair for safety. If a resident falls, observe for signs and symptoms of bleeding due to aspirin use. Use a lipped mattress and observe for decline in function and notify the nurse; refer to physical therapy and occupational restorative nursing as indicated. The health status note, dated 8/10/21 at 9:20 a.m. for Resident #56, read in pertinent part: The night certified nurse aide (CNA) reported to the nurse that while transferring (Resident #56) that morning from bed to wheelchair using the hoyer lift, it accidentally hit the resident on the right eyebrow. The eyebrow was assessed and the injured skin area measured 0.8 centimeters (cm) by 1.5 cm, it was not open and it was slightly bruised. The nurse will monitor and a message was left for the doctor and the family. A pain evaluation was completed on 8/10/21 for Resident #56 and revealed no pain. -There was no interdisciplinary team follow-up after the 8/10/21 incident or investigation completed (cross-reference F610 for investigation). The health status note, dated 8/24/21 at 6:38 a.m. for Resident #56, read in pertinent part: Resident #56 had a witnessed fall that morning from the hoyer lift sling and was supported by a staff member to the ground. The resident was non communicative and no physical injury occurred. The resident was assisted back to the wheelchair. Vital signs were normal and no apparent injury was noted. The family and doctor were notified. A fall risk assessment tool was completed on 8/25/21 for Resident #56. It indicated the resident was confused, there were no unsafe environmental factors and a mechanical lift was used. The risk note, dated 8/30/21 at 6:02 a.m. for Resident #56 which was a late entry for the 8/25/21 incident, read in pertinent part: Interdisciplinary team reviewed an investigation of an incident that occurred at the bedside on 8/24/21. According to staff (Resident #56) was lowered to the floor by staff while utilizing the hoyer lift. This was a witnessed fall with no injuries. Therapy will assess the need for training with line staff with regards to using the hoyer lift. Risk management follow up notes, dated 9/1/21 at 12:42 p.m. for Resident #56, read in pertinent part: Date of incident was 8/24/21. Type of incident was an assisted fall. Root cause read therapy will assess (Resident #56) for proper use of transfers. Treatment required was to have therapy assess the appropriateness of transfers. -Evidence of staff training on transfers was requested on 10/14/21 and no training was provided by the facility. The facility failed to educate staff on the use of the Hoyer lift after the injury on 8/10/21, and a fall involving a Hoyer lift transfer that occurred on 8/24/21 for Resident #56. IV. Staff interviews (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Certified nurse aide (CNA) #6 was interviewed on 10/14/21 at 10:30 a.m. She said she assisted Resident #56 to the floor after the resident slid from the Hoyer lift sling. She said CNA #8 did not put the sling on correctly prior to the transfer from bed to wheelchair. She said the resident had no injury and the nurse was notified. She said vitals were taken and the resident was assisted back to the wheelchair. She said she had no additional training on how to use the Hoyer lift. She said the Hoyer lift required two staff to use it and because they were short handed, it was used with one person at times (cross-reference F725 sufficient staffing). CNA #8 was interviewed on 10/14/21 at 1:30 p.m. She said she refused to answer any questions regarding the incident with Resident #56. CNA #2 was interviewed on 10/14/21 at 1:35 p.m. He said he used the Hoyer lift with residents but often he had a hard time finding help to transfer someone with the lift, so the residents ended up staying in bed (cross-reference F725). He said there were two staff people when he used the lift but he had seen some staff members transferring residents alone. Registered nurse (RN) #3 was interviewed on 10/14/21 at 10:00 a.m. He said when a resident had a fall an assessment was completed, the doctor was called and the family. He did recall Resident #56 had a fall on 8/24/21. He said he followed the facility policy. He had no additional training on Hoyer lifts. He said he helped the CNAs a lot with transfers because the facility was short staffed (cross-reference F725). The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said a fall assessment, a pain assessment and a risk management form was completed for any resident who had a fall or injury. She said the RN assessed the resident for any injury and performed first aid if needed. She said the doctor was notified and the family. She said she was informed of the fall in the 24 hour book and then discussion happened in the interdisciplinary team meeting for follow up. The care plan was updated with interventions and education given to the key personnel involved in the incident. She was unaware of the 8/10/21 and the 8/24/21 incident with Resident #56. She said unless the staff wrote the fall in the 24 hour report book or told someone in management, she was unaware. She said she started today (during survey) to train the nursing staff on Hoyer lifts. V. Facility follow-up The staff inservice sign in sheet on Hoyer lift transfers with no date (that was initiated during survey), was provided by the INHA on 10/14/21 at 11:45 a.m. It listed 11 staff signatures but did not indicate their disciplines.

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 41968 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide an adequate number of nursing staff to address the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents. As a result of inadequate staffing, the facility failed to: -Provide care and services in a dignified, respectful manner and environment (cross-reference F550); -Provide necessary care and services to ensure residents' activities of daily living (ADL) needs were met (cross-reference F676); -Provide necessary care and services to prevent pressure injuries (cross-reference F686); -Provide necessary care and services to maintain residents' restorative care and prevent functional decline (cross-reference F688); and -Provide necessary care and services to residents to prevent accident hazards and accidents with injuries (cross-reference F689). These failures contributed to residents going without baths/showers and not feeling clean, residents experiencing accidents with injuries, residents developing pressure injuries, and residents going without restorative and range of motion services. Findings include: I. Resident census and conditions According to the 10/11/21 Resident Census and Conditions of Residents report, the resident census was 80. The following care needs were identified: -44 residents were in a chair most of the time; -Three residents had contractures; -62 residents needed assistance from one or two staff members for transfers and nine were dependent; -17 residents needed a mechanical lift (Hoyer or other lift) for transfers, (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	-64 needed preventive skin care, -Two residents had pressure ulcers, -14 residents needed rehabilitative services, -24 residents were dependant for bathing, -47 residents needed one or two person assistance with bathing, -57 residents needed one or two person assistance with toilet use, and -12 residents were dependent for toilet use. II. Facility policy The Staffing policy, revised October 2017, provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:50 p.m., read in pertinent part: The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. III. Staffing expectations The INHA) was interviewed on 10/14/21 at 5:50 p.m. and provided the staff requirements for each unit in the facility based on the current census and resident needs. For all of the units in the facility, the licensed nurses worked 12 hour shifts from 6:00 a.m. to 6:00 p.m. The next shift worked 6:00 p.m. to 6:00 a.m. The certified nurse aides (CNAs) worked 12 hour shifts from 6:00 a.m. to 6:00 p.m. for day shift and 6:00 p. m. to 6:00 a.m. for the evening / night shift. Some CNAs worked eight hour shifts, 6:00 a.m. to 2:00 p.m for the day shift and 2:00 p.m. to 10:00 p.m. for the evening shift. Review of the daily staffing schedules revealed they were confusing and difficult to follow. The numbers of nursing staff who worked on each unit or called off for their shifts were not well documented. Comparison/determination of staffing expectations versus staff who reported for duty was impossible to decipher. IV. Resident #71 observation/interview On 10/12/21 at 9:10 a.m., Resident #71's call light was on. The resident was lying in bed. She said she turned her call light on about five minutes ago. She said she was waiting on staff to get her out of bed. She said she needed two person assistance. She said one of the CNAs came into her room and said she was going to get help to get her up. She said it happened frequently, they were always short staffed and she has to wait for a long time. At 9:42 a.m. (32 minutes later), CNA #4 came to answer the resident's call light. She said they were helping another resident who needed two person assistance. She said they did not have enough staff. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	V. Effects of working schedule on facility residents A. Cross-reference F550 The facility failed to provide dignified, respectful care to Resident #68, who was observed on two occasions struggling to eat his meals while suffering violent tremors. Although the resident called for help repeatedly, he did not receive timely assistance, causing him distress and psychosocial harm. B. Cross-reference F676 The facility failed to provide assistance with ADLs to ensure the highest practicable quality of life and care, for Residents #51, #58, #63, #64 and #77. The facility failed to provide regular showers to Residents #51, #58, #63, #64 and #77 who needed assistance with ADLs; and failed to provide nail care for Residents #51 and #58. Residents said during interviews that they requested baths and nail care and did not receive the assistance they needed. Residents #51, #58 and #63 said they could smell themselves, because it had been so long since they bathed. Resident #64 said she did not want to put on clean clothes because she felt dirty. Resident #77 said she wore a cap because she did not want anyone to see her stringy, greasy hair. C. Cross-reference F686 The facility failed to turn and reposition Resident #29 at least every two hours to prevent the development of a pressure injury, accurately assess the resident's skin and identify the pressure injury once it developed, and implement timely treatment interventions to treat the pressure injury after it was first identified. The facility failures contributed to the resident developing an unstageable pressure injury to the coccyx. The resident said during interview that staff did not reposition her, and staff stated during interview that they were too busy to turn/reposition residents as frequently as needed to prevent skin breakdown. D. Cross-reference F688 The facility failed to ensure Resident #56 was provided the goods and services necessary to maintain her physical well-being with restorative care. Interviews regarding restorative care revealed the following. Certified nurse aide (CNA) #3 was interviewed on 10/12/21 at 2:00 p.m. She said the facility was short staffed and all the residents' care cannot be completed. She said the schedule changed every day. She said the schedule had five and six CNAs listed but she said the staff listed had not worked. She said there were no restorative aides because they work on the floor now. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	Restorative certified nurse aide (RCNA) was interviewed on 10/13/21 at 8:30 a.m. She said there were about 20 residents who were on the restorative program. She said she was pulled to the floor to work often so the residents did not receive restorative care on those days. She said Resident #56 was on a restorative program for range of motion and to apply a splint to her hand. She said she had not worked with her in over three weeks. CNA #6 was interviewed on 10/13/21 at 4:10 p.m. She said Resident #56 was supposed to wear the splint daily and the restorative aides had not worked with the resident. She said the staff was short and the restorative aide had to work on the floor to help out. Record review for Resident #56 also revealed documentation for restorative care showed nothing after 9/16/21. The RCNA said it had been a struggle at the facility to keep staff. E. Cross-reference F689 The facility failed to ensure Resident #56's safety with transfers via Hoyer lift, with which the resident was injured twice Interviews regarding hoyer lifts and falls revealed the following. CNA #2 was interviewed on 10/13/21 at 4:00 p.m. He said there was not enough staff to help with hoyer lift transfers. He said residents had to stay in bed when they cannot find another staff person to help with the transfer. CNA #6 was interviewed on 10/13/21 at 4:10 p.m. She said the facility did not have enough staff to help with the care of residents. She said she assisted with hoyer transfers with two people but she said some CNA moved residents without getting help. VI. Individual resident and staff interviews regarding staffing Additional resident and staff interviews confirmed the facility failed to have an adequate number of staff to meet the residents' needs. Interviews with residents who, per facility assessment were cognitively intact and interviewable, and with staff, revealed the following. Resident #57 was interviewed on 10/13/21 at 4:40 p.m. He said he had to have a Hoyer lift for transfers in and out of bed. He said he had to stay in bed often because there was not enough staff to help with the transfers. He said when a transfer occurred with one CNA it worried him that he would fall. Resident #59 was interviewed on 10/13/21 at 4:45 p.m. He said he used a Hoyer lift for transfers and he had to wait long periods of time for staff members to find help. He said they always used two people with the lift. Agency certified nurse aide (ACNA) #1 was interviewed on 10/13/21 at 9:00 a.m. She said the facility was short staffed and she had a hard time getting help to transfer residents with Hoyer lifts. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Some	The staffing coordinator (SC) was interviewed on 10/13/21 at 4:05 p.m. She said she scheduled nursing staff based on the day's census. She said there were 10 to 12 residents assigned to one CNA. She said the facility was aware they were short staffed and they were using agency and temporary staff, and many current staff were working overtime. She said they offered sign on bonuses with full time employment. She said they pulled as many staff as they could from restorative and non-nursing duties to help with answering lights, bathing, passing food trays, and providing help with resident care. The director of nursing (DON) was interviewed on 10/14/21 at 5:50 p.m. She said the facility was short staffed and they pulled the restorative aide to work on the floor a few times a week. She said they tried to juggle the needs of the residents to help maximize the cares. The INHA was interviewed on 10/14/21 at 5:50 p.m. She said they were trying to hire staff. They were in between staff coordinators so they all worked together to make up the daily schedule. Some CNAs worked 16 hours to help with the overlap of cares. She said they had ads out and they were recruiting daily. They were pulling friends and family members to help recruit and calling prior employees. She said they had new contracts with agencies and they had increased wages. 39260

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interview, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of two (#68 and #182) out of 37 sample residents. Specifically, the facility failed to: -Ensure physician-ordered Apokyn Solution medication (for Parkinson's/tremors) was available for Resident #68; and -Ensure Buprenorphine Hydrochloride (analgesic) medication was available for Resident #182. Cross-reference F760, significant medication errors. Findings include: I. Facility policy The Provider Pharmacy Requirements policy dated 2007, provided by the interim nursing home administrator (NHAI) on 10/14/21 at 10:50 a.m., read in pertinent part: Regular and reliable pharmaceutical service are available to provide residents with prescription and non-prescription medications, services, and related equipment and supplies. Assisting the nursing care center, as necessary, in determining the appropriate acquisition, receipt, dispensing and administration of all medications and biologicals to meet the medication needs of the residents and the nursing care center. II. Resident #68 A. Resident status Resident #68, age 78, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnoses included Parkinson's, depression, renal disease and coronary artery disease. The 9/20/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. He required extensive assistance with two people for transfers, bed mobility, toileting, dressing and hygiene. He was not assessed for eating. He had no behaviors and he had no rejection of cares. B. Record review The October 2021 CPOs for Resident #68 revealed the following orders: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Apokyn Solution 10 milligrams per milliliters (mg/ml), inject 0.2ml subcutaneously every six hours as needed for severe tremors related to Parkinson's disease four times daily. Check blood pressure before and after administration, hold if blood pressure less than 120/80, recheck 30 minutes after administration. The order start date was 10/23/18. The August 2021 medical administration record (MAR) revealed Resident #68 was administered Apokyn medication one time and it was effective. The September and October 2021 MARs, revealed Resident #68 had no doses of Apokyn administered. The health status note dated 10/12/21 at 8:33 a.m. for Resident #68 read in pertinent part: The nurse contacted the pharmacy to refill the medication Apokyn injection. The pharmacy person stated the medication was a specialty med and can only be refilled by a specialty pharmacy. The nurse called the provider to get an updated prescription, and the provider told the nurse another pharmacy will refill the medication and send it to the facility when it was approved. Record review revealed no other doctor contacts for medication refills for Resident #68 and no follow up. The medication was not administered or available on 10/12/21 when needed. D. Staff interview Licensed practical nurse (LPN) #1 was interviewed on 10/13/21 at 9:30 a.m. She said she wanted to give Resident #68 the medication Apokyn for his tremors but there was no medication available to administer. She said she called the pharmacy for a reorder and was told the medication was a specialty medication and needed it refilled at another pharmacy. She called the physician to get a refill order and to call the other pharmacy. III. Resident #182 Resident status Resident #182, age 52, was readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnosis of cerebral vascular disease, renal disease, heart failure and anxiety. The 8/18/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required extensive assistance with two people for bed mobility, transfers, toileting, hygiene and dressing. He had supervision of one for meals. He had no behaviors and no refusals of care. He took scheduled and as needed pain medications. Resident Observation and Interview Resident #182 was observed and interviewed on 10/12/21 at 11:30 a.m. He sat in a recliner chair in his room and was eating cookies talking to his family. He said he did not have any pain. He said when he missed his medication (Buprenorphine) he had a hard time sleeping and he felt more restless when he did not get the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review The October 2021 CPOs for Resident #182 revealed the following orders: -Buprenorphine Hydrochloride (HCl) tablet, give sublingually two milligrams (mg) or one film three times a day for chronic pain. Order date was 8/19/21. The August 2021 medication administration record (MAR) revealed Resident #182 was administered zero doses of Buprenorphine. There were 19 check marks that were documented see nurse notes. The health status note dated 8/12/21 at 2:52 p.m. read in pertinent part: Resident #182 medications were verified by the physician. New medication order for tylenol as needed and a discontinued order for naloxone were updated. All other orders remained the same. Electronic medication administration record (EMAR) note dated 8/13/21 at 8:05 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting on pharmacy for delivery. -At 12:55 p.m. waiting for delivery, and -At 4:35 p.m. still waiting in the pharmacy. EMAR note dated 8/14/21 at 10:05 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy delivery. -At 2:16 p.m. waiting for the pharmacy to deliver, and -At 6;27 p.m. waiting for the pharmacy to deliver. EMAR note dated 8/15/21 at 9:49 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy to deliver. -At 11:15 a.m. waiting for pharmacy to deliver, and -At 4:51 p.m. waiting for the pharmacy to deliver. EMAR note dated 8/16/21 at 9:15 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy to deliver. -At 11:43 a.m. waiting pharmacy to deliver, and -At 4:10 p.m. waiting for the pharmacy to deliver. EMAR note dated 8/17/21 at 8:42 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, unable to fill due to only prescribed by an additional specialist. -At 1:45 p.m. the medication was on hold due to additional specialist may need to prescribe, -At 6:23 p.m. the doctor changed the medication order. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	EMAR note dated 8/18/21 at 8:29 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, doctor to change medication order. -At 12:45 p.m. see nurses note, and -At 4:25 p.m. the pharmacy was called and said they were still waiting for the signed prescription from the medical director. EMAR note dated 8/19/21 at 8:43 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, message left at the doctor's office for possible medication replacement. The September 2021 MAR revealed Resident #182 did not receive three doses of Buprenorphine. There were three check marks that were documented see nurse notes. EMAR note dated 9/12/12 at 4:51 p.m. read in pertinent part: Buprenoorphine tablet sublingual one mg, not given. EMAR note dated 9/13/12 at 4:00 p.m. read in pertinent part: Buprenoorphine tablet sublingual one mg, not given. The health status note dated 9/16/21 at 9:03 a.m. read in pertinent part; Resident #182 went to the follow up appointment on Thursday 9/16/21 for the medication Buprenorphine. The health status note dated 9/16/21 at 11:40 a.m. read in pertinent part: Resident #182 went to the follow up appointment for Buprenorphine and the resident told them he had severe chest pain and needed to go to the hospital. He was sent to the hospital from his appointment. IV. Staff interviews The pharmacist was interviewed on 10/14/21 at 3:15 p.m she said all medication orders get faxed to the pharmacy and filled the same day. The pharmacy had up to three deliveries a day so no resident would be without the medication. She said the medication Apokyn Solution was used for uncontrolled body movements or tremors related to Parkinson's disease. Resident #68 had the medication ordered and the pharmacy was able to deliver the medication shortly after it was called in for a refill anytime it was needed. The medication benefited the resident if it was used correctly for his quality of life. She said the medication Buprenorphine for Resident #182 needed a physician's signature to dispense to the facility. The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said medications were to be given as ordered. When the medication was not available the nurse called the pharmacy to follow up on the medication and called the physician if needed for any changes. She was aware of the medication Buprenorphine for Resident #182 was not available and a plan was put in place to reeducate the admissions department about special medications. She said the facility going forward put provisions in place for Resident #182 with the clinic specializing in the medication Buprenorphine. She said appointments were made in advance for the resident to make sure he had the medication refilled. She said she was unaware of Resident #68's tremors and unavailable medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician was interviewed 10/14/21 at 3:00 p.m. She said she had been aware just in the last few days the medication Apokyn was unavailable for Resident #68's tremors. She said the resident had this medication prescribed by the neurologist. She knew the resident had a decline in the past six months but the medication did not change the trajectory of the resident's status. She said the pharmacy called her for any refills and she had not been notified of any until three days ago. She said the Buprenorphine medication was a specialty medication and she could not sign for it. She started Resident #182 on tramadol to help with his pain levels until the medication Buprenorphine was available.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interviews, the facility failed to ensure two (#68 and #182) out of 37 sample residents were free of significant medication errors. The facility failed to: -Notify the physician and follow up timely when Apokyn Solution medication (for tremors related to Parkinson's disease) was not available and not given for Resident #68; and -Notify the physician and follow up timely when Buprenorphine Hydrochloride (analgesic) medication was not available and not given for Resident #182. These failures contributed to Resident #68 experiencing violent tremors and Resident #182 experiencing severe (7/10 on a scale of zero to 10) pain. Cross reference F550 dignity/respect, and F755 pharmacy services. Findings include: I. Facility policy The Administering Medications policy, revised December 2012, provided by the interim nursing home administrator (INHA) on 10/14/21 at 10:50 a.m., read in pertinent part: Medication shall be administered in a safe and timely manner, and as prescribed. Medications must be administered in accordance with the orders, including any required time frame. The individual administering the medications must check the label to verify the right resident, right medication, right dosage, right time and right route before administering the medication. When a resident uses an as needed medication the attending physician and interdisciplinary team with support from the pharmacist, shall evaluate the situation, examine the individual as needed, determine if there was a clinical reason for the as needed medication and consider whether a standing dose was clinically indicated. II. 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 (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	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 . III. Resident #68 A. Resident status Resident #68, age 78, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnoses included Parkinson's, depression, renal disease and coronary artery disease. The 9/20/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of nine out of 15. He required extensive assistance with two people for transfers, bed mobility, toileting, dressing and hygiene. He was not assessed for eating. He had no behaviors and he had no rejection of cares. B. Observations Resident #68 was observed on 10/11/21 at 11:50 a.m. eating lunch in the dining room. He had two sandwiches on a plate, no silverware and two cups of fluid. He tried to eat the sandwich but had continued, uncontrolled jerking movements to his extremities. The bread from the sandwich flung around the table because the resident could not control his jerking movements/tremors. He was sliding down in his wheelchair while trying to eat his lunch. Two staff members noticed he had a hard time holding his sandwich and he was sliding down in the wheelchair. The resident said please help me up and the staff members assisted him to sit up better in the chair. The sandwich was taken out of his hand and he was assisted out of the dining room. On 10/13/21 at 5:48 p.m. Resident #68 was in his room in his bed. He was attempting to eat his spaghetti and his hands and his arms shook uncontrollably. He called out help me, someone get me some silverware please, a fork, a spoon. He repeated this several times. He said, Please, please, please, give me a fork and a spoon please. He continued to use his left hand to stir the spaghetti while repeating please, please and he ate the plate of spaghetti with his hands only. (Cross-reference F550 dignity and F810 adaptive utensils.) The resident swayed continuously back and forth, flailing his arms and shoulders from the right to the left. C. Record review (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The Parkinson's care plan, dated 3/19/18 for Resident #68, read in pertinent part: Monitor, document and report to the medical director as needed any signs and symptoms of Parkinson's complications. Poor balance, constipation, poor coordination, insomnia, dysphagia, tremors, gait disturbance, incontinence, muscle cramps or rigidity, decline in range of motion, skin breakdown, mood changes, and decline in cognitive function. The psychosocial well-being care plan revised on 10/11/21 read in pertinent part: (Resident #68) will verbalize feelings related to emotional state related to his disease process. Administer medications per physician order. See medication record. Monitor for effectiveness and side effects. The October 2021 CPOs for Resident #68 revealed the following orders: -Apokyn Solution 10 milligrams per milliliters (mg/ml), inject 0.2ml subcutaneously every six hours as needed for severe tremors related to Parkinson's disease four times daily. Check blood pressure before and after administration, hold if blood pressure less than 120/80, recheck 30 minutes after administration. The order start date was 10/23/18. The August 2021 medication administration record (MAR) revealed Resident #68 was administered Apokyn medication one time and it was effective. The September and October 2021 MARs revealed Resident #68 had no doses of Apokyn administered. The health status note dated 10/12/21 (during the survey) at 8:33 a.m. for Resident #68 read in pertinent part: The nurse contacted the pharmacy to refill the medication Apokyn injection. The pharmacy person stated the medication was a specialty med (medication) and can only be refilled by a specialty pharmacy. The nurse called the provider to get an updated prescription, and the provider told the nurse another pharmacy will refill the medication and send it to the facility when it was approved. Record review revealed no other doctor contacts for medication refills for Resident #68 and no follow up. The medication was not administered or available on 10/12/21 when needed. There was no documentation in nurses notes since the medication was last administered regarding tremors, assessment and/or monitoring. D. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 10/14/21 at 10:30 a.m. She said Resident #68 needed a lot of assistance when he flailed his arms and body around. She said the flailing happened often. Licensed practical nurse (LPN) #1 was interviewed on 10/13/21 at 9:30 a.m. She said she wanted to give Resident #68 the medication Apokyn for his tremors but there was no medication available to administer. Registered nurse (RN) #1 was interviewed on 10/13/21 at 1:30 p.m. She said Resident #68 had a lot of tremors. She said the physician was aware of them. (continued on next page)

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	065001	A. Building B. Wing	10/14/2021

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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F 0760 Level of Harm - Actual harm Residents Affected - Few	The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said she was not aware of the Resident #68's tremors and the medication. She said when medication was not available the nurse called the pharmacy and the physician for follow up. III. Resident #182 A. Resident status Resident #182, under age 60, was readmitted on [DATE]. According to the October 2021 CPO, pertinent diagnosis included cerebral vascular disease, renal disease, heart failure and anxiety. The 8/18/21 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required extensive assistance with two people for bed mobility, transfers, toileting, hygiene and dressing. He had supervision of one for meals. He had no behaviors and no refusals of care. He took scheduled and as needed pain medications. B. Resident interview/observation Resident #182 was observed and interviewed on 10/12/21 at 11:30 a.m. He sat in a recliner chair in his room and was eating cookies, talking to his family. He said he did not have any pain. He said when he missed his medication (Buprenorphine) he had a hard time sleeping and he felt more restless when he did not get the medication. C. Record review Review of Resident #182's physician orders revealed in pertinent part: -Buprenorphine Hydrochloride (HCl) tablet, give sublingually two milligrams (mg) or one film three times a day for chronic pain. Order date was 8/19/21. The August 2021 MAR pain record for Resident #182, revealed on a 0-10 scale with 10 being the worst pain, he had a pain levels of: -zero, 10 times out of 24 assessments, -one, two times out of 24 assessments, -three, two times out of 24 assessments, -four, two times out of 24 assessments, and; -seven, three times out of 24 assessments. The August 2021 medication administration record (MAR) revealed Resident #182 was administered zero doses of Buprenorphine. There were 19 check marks that were documented see nurse notes. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The health status note dated 8/12/21 at 2:52 p.m. read in pertinent part: (Resident #182's) medications were verified by the physician. New medication order for tylenol as needed and a discontinued order for naloxone were updated. All other orders remained the same. An electronic medication administration record (EMAR) note dated 8/13/21 at 8:05 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting on pharmacy for delivery. -At 12:55 p.m. waiting for delivery, and -At 4:35 p.m. still waiting in the pharmacy. The pain assessment on 8/13/21 revealed Resident #182 had no pain, and did not receive any scheduled pain medication or as needed medication EMAR notes dated 8/14/21 at 10:05 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy delivery. -At 2:16 p.m. waiting for the pharmacy to deliver, and -At 6:27 p.m. waiting for the pharmacy to deliver. EMAR notes dated 8/15/21 at 9:49 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy to deliver. -At 11:15 a.m. waiting for pharmacy to deliver, and -At 4:51 p.m. waiting for the pharmacy to deliver. EMAR notes dated 8/16/21 at 9:15 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, waiting for pharmacy to deliver. -At 11:43 a.m. waiting pharmacy to deliver, and -At 4:10 p.m. waiting for the pharmacy to deliver. EMAR notes dated 8/17/21 at 8:42 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, unable to fill due to only prescribed by an additional specialist. -At 1:45 p.m. the medication was on hold due to additional specialist may need to prescribe, -At 6:23 p.m. the doctor changed the medication order. EMAR notes dated 8/18/21 at 8:29 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, doctor to change medication order. -At 12:45 p.m. see nurses note, and (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-At 4:25 p.m. the pharmacy was called and said they were still waiting for the signed prescription from the medical director. The EMAR note dated 8/19/21 at 8:43 a.m. read in pertinent part: Buprenorphine tablet sublingual two mg, message left at the doctor's office for possible medication replacement. The September 2021 MAR revealed Resident #182 did not receive three doses of Buprenorphine. There were three check marks that were documented see nurse notes. The September 2021 MAR pain record for Resident #182, revealed he had a pain level of: -zero, eight times out of 20 assessments, -five, one time out of 20 assessments, -six, five times out of 20 assessments, and; -seven, seven times out of 20 assessments. EMAR note dated 9/12/12 at 4:51 p.m. read in pertinent part: Buprenoorphine tablet sublingual one mg, not given. EMAR note dated 9/13/12 at 4:00 p.m. read in pertinent part: Buprenoorphine tablet sublingual one mg, not given. The health status note dated 9/16/21 at 9:03 a.m. read in pertinent part; Resident went to the follow up appointment on Thursday 9/16/21 for the medication Buprenorphine. The health status note dated 9/16/21 at 11:40 a.m. read in pertinent part: Resident went to the follow up appointment for Buprenorphine and the resident told them he had severe chest pain and needed to go to the hospital. He was sent to the hospital from his appointment. The pain care plan for Resident #182 revised on 10/12/21 (during the survey) read in pertinent part: Resident is at risk for pain. The resident will voice a level of comfort through the review date. Give pain medications as ordered and monitor for effectiveness. Monitor for side effects of pain medications, update medical director as needed. Monitor pain every shift. Resident #182 was in and out of the hospital during October 2021. He was admitted to the hospital on 9/16/21 (see above note) and returned to the facility on [DATE], returned to the hospital on 10/12/21 and returned to the facility on [DATE]. He received Buprenorphine per physician orders during October 2021. The facility failed to give Buprenorphine medications as ordered during August and September 2021. III. Staff interviews (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The pharmacist was interviewed on 10/14/21 at 3:15 p.m she said all medication orders were faxed to the pharmacy and filled the same day. The pharmacy had up to three deliveries a day so no resident would be without their medications. She said the medication Apokyn Solution was used for uncontrolled body movements or tremors related to Parkinson's disease. Resident #68 had the medication ordered and the pharmacy was able to deliver the medication shortly after it was called in for a refill anytime it was needed. She said the medication benefited the resident if it was used correctly for his quality of life. The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said medications were to be given as ordered. When a resident refused medication, a nurse note was written and the doctor was notified each time. She said she gave some education on medication administration a few days ago on resident refusals and missed doses. When the medication was not available the nurse called the pharmacy to follow up on the medication and called the physician if needed for any changes. She was aware of the medication Buprenoorphine for Resident #182 not being available and said a plan was put in place to reeducate the admissions department about special medications. She said the facility had put provisions in place for Resident #182 with the clinic specializing in the medication Buprenorphine. She said appointments were made in advance for the resident to make sure he had the medication refilled. Regarding Resident #68, the DON said she was unaware of his tremors and medication unavailability (see above). The physician was interviewed on 10/14/21 at 3:00 p.m. She said the medication Apokyn for Resident #68 was prescribed by the neurologist. She said when the tremors or shaking started for Resident #68 the medication was supposed to help alleviate them. She said the Buprenoorphine medication was a specialty medication and she could not sign for it. She started Resident #182 on tramadol to help with his pain levels until the medication Buprenorphine was available. The resident had been in and out of hospitals and the facility was told he had to come back to the facility. The facility realized they could not meet the residents needs with filling the medication for his pain. She said the resident had the medication prescribed to help with the withdrawal of a drug and since he had been in and out of the hospital he was no longer in withdrawal. She said the resident would be seen in the outpatient clinic for behavioral issues and to take him off the Buprenorphine medication. Every time he went to the outpatient clinic he complained of chest pain so the clinic sent him back to the hospital. She said his chest pain was not related to not having the medication but from anxiety from wanting the real drug instead of a synthetic one. -However, there was no care plan or progress notes in Resident #182's medical record regarding these behavioral symptoms, withdrawal issues and treatment, or evidence of a plan to discontinue the resident's Buprenorphine medication.