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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on resident and staff interviews and record review, the facility failed to ensure three (#231, #31, #49) out of five residents of 37 sample residents, were provided the opportunity to participate in the development and implementation of his or her person-centered plan of care. Specifically, the facility failed to invite residents to their care plan meetings which occurred quarterly, annually and upon a resident's change of condition for Resident #231, #31, and #49. Findings include: I. Facility policy and procedure The Care Planning and Interdisciplinary Care Plan Meeting policy, written 2001 and revised September 2013, was provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:55 p.m. The policy revealed in pertinent part: Our facility's Care Planning/ Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. -The resident, resident's family and/ or the resident's legal representative/ guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. -Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family. II. Resident #231 A. Resident status Resident #231, under age 70, was admitted on [DATE] and readmitted on [DATE]. According to the September 2021 computerized physician orders (CPO), the diagnoses included a transient ischemic attack (TIA, mini stroke), vertigo, muscle weakness, type 2 diabetes mellitus, obesity, and long term insulin use. The 8/21/21 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. He required supervision with bed mobility and transfers. The resident was independent with walking in his room, corridors, dressing, eating, toilet use, and personal hygiene. B. Resident interview Resident #231 was interviewed on 10/11/21 at 12:00 p.m. He said he did not get invited to care conferences to discuss his personal care with staff. He said he would like to be involved with care conferences in the facility. C Record review (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/17/2020 Resident #231 was invited to attend his care conference at 2:00 p.m. in the social services office. That was the last documentation of an invitation to his care conference. II. Resident #31 A. Resident status Resident #31, under age 70, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included lymphedema (fluid build up from the lymphatic system), muscle weakness, unsteadiness on feet, and bipolar disorder. The 8/21/21 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. The resident was independent with bed mobility, transfers, dressing, eating, toilet use, bathing and eating. B. Resident interview Resident #31 was interviewed on 10/11/21 at 3:00 p.m. She said she was not invited to her care conferences. She said she did not receive anything about the care conferences in writing so that she could remember the date and time. C. Record review On 10/14/21 at 12:30 p.m. a review of the resident's records did not reveal invitations were given to Resident 31 for her care conferences. II. Resident #49 A. Resident status Resident #49, under age 70, was admitted on [DATE]. According to the September 2021 computerized physician orders (CPO), the diagnoses included anemia, hypertension (high blood pressure), diabetes mellitus, and depression. The 9/6/21 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. The resident required supervision with bed mobility, transfers, dressing, eating and personal hygiene. The resident was independent with toilet use, walking in her room, and the corridors. B. Resident interview The resident was interviewed on 10/12/21 at 2:00 p.m. She said she did not know what a care conference was in the facility. She said she had never been invited to discuss her care in a meeting with the staff. She said she did not recall ever being told about care conferences. C. Record review (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/21 at 12:35 p.m. a review of the resident's records did not reveal any invitations given to Resident 49 for her care conferences. II. Staff interviews The social service director (SSD) was interviewed on 10/13/21 at 3:18 p.m. She said the social service department only in the past few weeks began to handle the care conferences in the facility. She said up until recently the minimum data set (MDS) coordinator did the invites and coordination of the meetings. She said the MDS coordinator who coordinated the care conferences was no longer at the facility. She said she did not know where care conference invites were kept or if they were mailed out to the residents and their families. She said she cannot speak to why there were no records of residents being invited to care conferences. She said going forward the social services department will be handling the care conferences. She said she would from now on quarterly and annually let the residents know of their care conferences. She said she would provide the residents with calendars so that their care conferences would be written in them. She said going forward she would also email the families and invite them to the care conference meetings. The interim nursing home administrator (INHA) was interviewed on 10/13/21 at 3:18 p.m. She said she could not speak to what had happened before with the residents not being invited to their care conferences. She said she could only speak to that moving forward the residents would be invited to their care conferences.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 45676 Based on observations, and interviews, the facility failed to honor preferences of five (#64, #77, #10, #73 and #49) of six residents reviewed for choices out of 38 sample residents. Specifically, the facility failed to: -Ensure breakfast choices were honored for Resident #64, #77, #10, #73 and #49. Findings include: 1. Resident interviews Resident #64 was interviewed on 11/30/21 at 11:40 a.m. Resident #64 said she did not get a choice of what she wanted to eat for breakfast. She said she did get her choice of lunch and dinner but not breakfast. She said she would have liked to choose her own breakfast. Resident #77 was interviewed on 11/30/21 at 2:00 p.m. Resident #77 said her lunch missed her onions and she had to ask four different people for them. She said she never get to choose her breakfast, she just got what they brought her. She said she did want to choose her breakfast. Resident #10 was interviewed on 11/30/21 at 2:15 p.m. Resident #10 said she never was able to choose her breakfast, she only got to choose lunch and dinner. She said she wanted to speak to administration about that and other things but the director of nursing (DON) had not come to see her. Resident #73 was interviewed on 12/1/21 at 11:30 a.m. Resident #73 said he never was able to choose his breakfast, he only got what they brought him. He said if he did not like the meal he was sent, he just did not eat. He said he did get a choice for lunch and dinner. Resident #49 was interviewed on 12/2/21 at 9:30 a.m. Resident #49 said she never got a choice for breakfast, said the staff would write main on the tray ticket. The resident said that meant she received what was on the menu. She said she only got a choice if she physically went to the kitchen and told them what she wanted. She said she did not get her choice of how she wanted her egg cooked. She said if she marked over easy, she did not get it, she only got the main egg on the menu. 2. Staff interviews The dietary manager (DM) was interviewed on 12/2/21 at 3:30 p.m. The DM said she was aware residents had complained that they did not have meal choices when it came to breakfast. The DM said the residents should always have choices for their meals. The DM said they had one main lunch and dinner and have alternates such as hamburgers, hotdogs, and quesadillas. She said they can make reasonable accommodations for each meal. She said there were other eggs available such as fried eggs or hard-boiled that residents can order. She said they did also have breakfast meats the resident could have chosen from. She said she reminded staff to ensure the residents were asked preferences on their meal. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #8 was interviewed on 12/2/21 at 3:45 p.m. The CNA said residents had choices for each meal. Day shift 6 a.m. to 6:00 p.m. obtained the lunch and dinner menus and night shift CNAs obtained the breakfast menu choices. CNA #9 was interviewed on 12/2/21 at 3:55 p.m. The CNA said residents had a choice of a main menu and meal preferences. Once the resident made their choice, the menu was sent to the kitchen. She said she also looked at what type of diet they were on, such as mechanical soft or pureed. Night shift was responsible for requesting the breakfast choices. CNA #10 was interviewed on 12/2/21 at 4:05 p.m. The CNA said tray tickets had the menu choices printed on it. we She then asked the residents what they wanted for their meals. She said she was responsible for lunch and dinner; night shift was responsible for breakfast. If the resident was unable to read the menu, she said she read it to them.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on interviews and record review, the facility failed to resolve resident grievances for two (#1, #31) and six (#39, #45, #31, #49, #40, #231) resident council members out of 37 sample residents. Specifically, the facility failed to: -Respond to residents regarding their grievances expressed in resident council meeting; and, -Reply to Resident #1 and #31 grievances after the grievance was submitted. Findings include: I. Facility policy The Grievances Complaints Filing policy, 2001 and revised April 2017, was provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:55 p.m. The policy documented in part: -Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. -The Administrator and staff will make prompt effort to resolve grievances to the satisfaction of the resident and/or representative. -The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and in writing) of the findings of the investigation and the actions that will be taken to correct any identified problems. II. Resident group interview A resident group interview was conducted on 10/ 12/21 at 2:00 p.m. with six (#39, #45, #31, #49, #40, #231) residents identified by the facility as interviewable. The residents made the following comments about the grievance system in the facility: -The facility does not respond to written grievances. We write them and the facility does not come back to us to explain how they will resolve a situation. -We have complained and written grievance forms but what is the use if they won't come back and respond? -We have even written on the forms please confirm you received this grievance but that does not get them to come back to us either. -It doesn't matter if you write it or tell them verbally, they may not get back to us either way. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-They do not tell us why they don't follow up. It seems they just don't care. III. Resident #1 A. Resident Status Resident #1, age 62, was admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included Guillain-Barre Syndrome (the body's immune system attacks the nerves), paraplegia, quadriplegia, type 2 diabetes mellitus, sleep apnea, morbid obesity, and glaucoma. The 7/11/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. The resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident required total dependence with bathing. The resident was independent with eating. The resident did not walk in their room or corridors. The resident had upper and lower extremity impairment on both sides of their body. B. Resident #1 interview Resident #1 was interviewed on 10/12/21 st 9:33 a.m. He said he had written many grievance forms but the facility did not respond back to him. He said the facility did not come back in and go over how his grievance was resolved. He said no staff came from the facility to talk to him about his grievances and asked him to sign any forms as proof his problem was resolved. C. Record review of grievances for Resident #1 The social services director (SSD) provided copies of Resident #1's concern (grievance) forms on 10/14/21 at 12:55 p.m. The following dates revealed written concerns of Resident #1. The forms had the resident's complaints and the facility resolution, but did not have any signatures or initials that the resident was provided a resolution to his concern. On 6/8/21 at 8:15 a.m. the resident wanted more fresh fruit. The resident did not sign that the facility followed-up on the matter. On 7/13/21 at 3:00 p.m. the resident wanted a light to be fixed in his room. The resident did not sign that the facility followed-up on the matter. On 10/11/21 at about 11:00 a.m. the resident complained his personal visitor binder was missing and he was upset that therapy was not seeing him to provide therapy. The resident did not sign the concern form that anyone followed-up on these matters. IV. Resident #31 A. Resident status (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #31, under age 70, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), the diagnoses included lymphedema (fluid build up from the lymphatic system), muscle weakness, unsteadiness on feet, and bipolar disorder. The 8/21/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. The resident was independent with bed mobility, transfers, dressing, eating, toilet use, bathing and eating. B. Resident interview Resident #31 was interviewed on 10/11/21 at 3:00 p.m. She said when she wrote grievances to the facility the staff did not return to discuss the matter with her. She said she did not know if the grievances were ever resolved or not. C. Record review of grievances for Resident #31 The social services director (SSD) provided copies of Resident #31's concern (grievance) forms on 10/14/21 at 12:55 p.m. The following date revealed written concerns of Resident #1. The form had the resident's complaints and the facility resolution, but did not have any signatures or initials that the resident was provided a resolution to her concern. On 6/22/21 at 3:30p.m. the resident's concern was the floor was sticky in the bathroom and not cleaned. The resident complained that in order to get her bathroom cleaned she had to ask housekeeping to do it. A resolution was written by staff but it was never signed or initialed by the resident to indicate any follow-up to the situation. V. Staff interview The SSD and the interim nursing home administrator (INHA) were interviewed on 10/13/21 at 3:20 p.m. The SSD explained the process for complaints/grievances was a complaint box was placed outside the door by the social service department and activity department offices. The SSD said any time a resident could complain about a matter. She said the resident could write the complaint themselves or have a staff member write it out for them. She said the staff were well trained to put a complaint form in the complaint box. She picked up the complaints daily and assigned complaints to the appropriate department head to resolve the situation within 72 hours. She said on the grievance form it was expected that the department head would write a description of the action taken for a resolution. She said the facility would follow up with the resident and have the resident sign the grievance form as proof the matter was handled to the resident's satisfaction. She said if a resident was resistant to sign the resolution form or refused to sign the form, the staff member must write on the form that the resident refused to sign the follow-up that the facility would provide. She said if a resident was dissatisfied with how the grievance was handled the grievance would go back to the interdisciplinary team and they would keep going over it until the matter was resolved to the resident's satisfaction. She said when the resident was satisfied with the resolution then the resident would sign the grievance form. Both the SSD and the INHA said they were unaware some of the grievance forms were not signed or initialed by the residents that they had received the follow-up to their grievance.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interviews, the facility failed to ensure five (#4, #16, #47, #51 and #52) of six residents reviewed out of 37 sample residents were free from abuse. Specifically, the facility failed to: -Protect Resident #4 from physical abuse by a staff member; -Protect Residents #4 and #47 from physical abuse by Resident #16; and, -Protect Residents #52 and #51 from physical abuse. Findings include: I. Facility policy The Abuse Prevention policy, not dated, was provided by the director of nurses (DON) on 10/14/21 at 10:30 a.m. read in pertinent part; Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse by anyone, including but not limited to staff (including agency or contract vendors), residents, volunteers, consultants, family members, legal guardians, friends or other individuals. This policy was based on Federal regulations and Colorado Occurrence Reporting Guidelines section of The Elder Justice Act. II. Incident of Resident #4 abuse from staff member on 10/2/21 A. Facility investigative report (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The facility investigative report, dated 10/2//21, provided by the interim nursing home administrator (INHA) on 10/12/21 at 10:30 a.m., read in pertinent part; Upon notification of the alleged incident of abuse between Resident #4 and the registered nurse (RN) #4, immediate action was taken by the center to ensure thorough investigation was upheld. The security camera footage was reviewed and revealed at approximately 7:00 p. m. RN #4 was observed on surveillance to be walking down the hallway sector with the supervised smoking material for authorized smoke break. Resident #4 observed self ambulating down the hallway at approximately 7:04 p.m. and walked outside into the smoking area. The footage was unable to articulate or visually see anything outside the courtyard in the smoking area and it was dark. At 7:09 p.m. Resident #4 was seen back in the building and sat in his walker. His demeanor showed him to be yelling and pointing to the RN. Other residents who were alert and oriented witnessed the allegation of abuse between the resident and the RN. RN requested the smoking material for safety measures from Resident #4, however the resident refused. RN #4 seized the smoking materials making contact with the resident shirt in an attempt to grab the smoking material from the resident. Due to the inappropriate encounter with the resident, RN was removed from the schedule. Among the interviews conducted, 50% of the resident population interviewed who are alert and oriented reported to see Resident #4 on the ground with the RN attempting to take a smoking item away from him. The other 50% did not see the incident. In totality of what the evidence revealed through thorough investigation, staff interviews, resident interviews, surveillance footage and observation, the allegation of Resident #4 being pinned by RN, the facility was unable to be efficiently substantiated. A police report was filed, family notified and the physician The investigation further revealed: Resident #4 was interviewed by the facility on 10/4/21 and he said in pertinent part; He was outside during smoke break when RN asked him for his lighter. Resident then replied RN grabbed him and pulled him off of his wheelchair causing him to fall on his butt and left him there face down. Another resident interviewed said in pertinent part, Resident #4 and RN started yelling at each other and RN grabbed the resident and pulled him out of his wheelchair. Resident tried to swat him away and the resident fell from his chair. RN did assist him up to the wheelchair after a few minutes. Two other residents witnessed RN #4 to pull Resident #4 out of his wheelchair onto the ground. B. Resident status Resident #4, age 75, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), pertinent diagnoses included chronic obstructive pulmonary disease and major depression. The 7/18/21 minimum data set (MDS) assessment revealed the resident had a cognitive deficit with a brief interview for mental status (BIMS) of 12 out of 15. He required supervision of one person for bed mobility, transfers, toilet use and dressing, and limited assistance for personal hygiene. He had verbal behaviors. C. Resident interview Resident #4 was interviewed on 10/13/21 at 1:30 p.m. He said RN #4 tried to take the cigarette lighter from him and they got into a physical altercation which caused him to fall out of his wheelchair. He said the RN tackled him on the ground, went through his pockets and took the lighter from him. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	D. Record review The health status note dated 10/3/21 at 9:00 a.m. read in pertinent part; Late entry, no behavioral problems noted. The health status note dated 10/3/21 at 5:53 p.m. which showed a line crossed through it (struck out as incorrect documentation), read in pertinent part, Resident notified the nurse he was abused by one of the staff members yesterday evening and there were also other residents who witnessed the incident. Resident told the nurse he was sitting in his walker smoking in the smoking area and the staff member came and pushed him and he rolled to the ground. The staff member started checking his pockets if he was hiding cigarettes in his pocket. Resident stated he was abused by the staff member and he wanted to report the incident. Incident was reported to the abuse coordinator, the director of nurses (DON), the doctor and family member. A skin assessment was done, no injury noted at that time, will continue to be monitored. Social service notes dated 10/4/21 at 9:03 a.m. read in pertinent part, Late entry: Social services checked in with resident regarding residents well being. Resident reported he was doing well but wanted to meet with social services more, as he feels this helped him. The behavior care plan, dated 6/23/2020, read in pertinent part: Resident #4 experienced issues with mood and behavior exhibited by impatience, verbal aggression, yelling, physical aggression, intimidating others, and acting in a way that is physically threatening towards others related to his disorder. Interventions include when conflict arises, remove residents to a calm safe environment and allow him to vent and share feelings. Increase communication between resident/family/caregivers about care and living environment: Explain all procedures and treatments, medications, all changes, rules and options. Frequent visits with one on one social worker for behavior and coping. Assist, encourage and support to set realistic goals. Allow him time to answer questions and to verbalize feelings, perceptions and fears as needed. III. Altercation with Resident #16 toward Residents #4 and #47 A. Facility investigative report The facility investigative report dated 10/9//21, provided by the INHA on 10/12/21 at 10:30 a.m., read in pertinent part: It was reported that a male resident (#16) utilizing his wheelchair to locomote was wheeling past another male resident (#4) and a verbal exchange took place as both residents were attempting to navigate in the opposite direction around a bed that was located in the hallway. Per witnesses of both staff and other residents the alleged victim (#4) began yelling at the assailant (#16) who in turn escalated and grabbed the broom off the housekeeping cart to hit the resident (#4) in the shin. Upon hearing the exchange between the residents, Resident #47 attempted to intervene, grabbing the broom while seated in his wheelchair and the alleged victim made contact with him on his left lower extremity. Staff intervened and immediately separated the residents and began assessing for any injury. The investigation further revealed Resident #47 was interviewed on 10/9/21, and stated: He saw Resident #16 hitting Resident #4 and he quickly got involved to stop the hitting and Resident #16 hit him with the broomstick to his left lower extremity. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #16 was interviewed by the facility on 10/9/21, and refused to talk to them. Resident #4 was interviewed by the facility on 10/9/21, and stated Resident #16 hit him with a broomstick in the knee as he was trying to pass him in the hallway. Four other staff and residents were interviewed and witnessed Resident #16 hit Residents #4 and #47. B. Resident #4 interview See resident status above. Resident #4 was interviewed on 10/14/21 at 11:30 a.m. He said Resident #16 hit him with a broomstick after he told the resident to speak English. He said he was a crazy man and he hit him in the leg. He said his leg was tender to touch but otherwise it was ok. He said the resident went to the hospital so he was no longer there. B. Resident #47 1. Resident status Resident # 47, under the age of 65, was admitted on [DATE]. According to the October 2021 CPO, pertinent diagnoses included paralysis. The 9/3/21 minimum data set (MDS) assessment revealed the resident had a cognitive deficit with a brief interview for mental status (BIMS) of 15 out of 15. He required extensive assistance of two people for bed mobility, transfers and toilet use. He required supervision for dressing and personal hygiene. He had no behaviors. 2. Resident interview Resident #47 was interviewed on 10/14/21 at 11:40 a.m. He said he saw Resident #16 hitting Resident #4 with a broomstick so he tried to take the broomstick away from the resident and in the process of doing so he was hit in the leg. He had no pain and said his leg was fine. C. Resident #16 1. Resident status Resident #16, age 81, was admitted on [DATE] and discharged to hospital on 10/9/21 on an M1 hold (deemed to be in imminent danger of harming himself or others). According to the October 2021 CPO, pertinent diagnoses included dementia and hypertension. The 8/11/21 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) of three out of 15. He required limited assistance from one person for dressing. He had supervision with bed mobility, transfers, toileting, dressing and personal hygiene. He had no behaviors. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	2. Record review for Resident #16 The health status note dated 10/9/21 at 1:24 p.m. for Resident #16 read in pertinent part, The nurse was called by the housekeeper to the hallway and said resident was seen hitting others, upon arrival she saw resident (#16) holding a broom stick and swinging at another resident (#4) hitting him in the lower extremity. The health status note dated 10/9/21 at 3:43 p.m. read in pertinent part, Resident #16 was sent to the hospital as ordered by the doctor for further evaluation. The risk management follow up for the incident on 10/9/21 for Resident #16 read in pertinent part: Type of incident: behavior, the root cause: resident to resident altercation. Treatment required, the resident was sent to the hospital. New interventions, the residents were immediately separated from each other, an incident was reported to the state and an investigation started. The physical altercation care plan for Resident #16 dated 9/8/21 read in pertinent part: Resident was involved in a physical altercation with another resident. The resident will not harm another resident or staff. Interventions put in place documented the physician was aware, medication was started and family were aware. State health department was aware, the police department was aware and social services will visit with the resident. One on one observation and staff will redirect the resident as needed based on presenting behavior. The social service care plan dated 8/14/21 read in pertinent part that Resident #16 had exhibited socially inappropriate behavior: instigating, name calling, and taunting. The resident will stop inappropriate behavior within five minutes of staff intervention. If behavior occurs, do not scold or embarrass residents, simply redirect residents, offer snacks to distract residents from behavior. Allow resident time to process the new environment, ensure safety and dignity and then monitor from a distance if necessary. Redirect residents to an activity in the facility. Notify social service and nursing if behaviors worsen. Notify the doctor if necessary. Psychiatric services if needed to evaluate and treat. D. Staff interview Licensed practical nurse (LPN) #2 was interviewed on 10/14/21 at 12:10 p.m. She said she was the nurse working the day of the incident between Residents #16, #4 and #47. She said she took the broomstick away from the resident gently, reported the incident to the director of nursing (DON), did the skin assessments and documentation to make sure the residents were safe. She said Resident #16 was sent to the hospital later that day and had not returned. IV. Administrative interview The INHA was interviewed on 10/14/21 at 5:55 p.m. She said regarding the incident between Resident #4 and RN #4, there were a lot of complaints about the nurse toward residents. She said they did a full investigation for the incident and since then the facility had fired the RN. She was not specific on the date, but said RN #4 had not returned to work since the day of the incident. She said the incident was unsubstantiated at first because the video footage did not have sufficient evidence but after the investigation they determined it was substantiated. She said they were in the process of reporting RN #4 to the department of regulatory agencies ([NAME]). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The incident between Resident #16, #4 and #47 was investigated and substantiated. She said Resident #16 had been sent out to the hospital after the incident and had not returned as of survey exit day 10/14/21. 39260 V. Altercation between Resident #51 and Resident #52 A. Facility investigation The facility investigation provided by the INHA was reviewed. It documented Residents #52 and #51 got into an argument over the television (TV) and ended up striking each other. The residents were immediately separated and monitored to prevent reccurrence. Both residents were coached on de-escalation and coping skills. Residents were currently safe and there has been no recurrence. The investigation further documented that Residents #51 and #52 were interviewed. Resident #51 reported that he hit Resident #52 in his face. It documented Resident #52 reported that Resident #51 hit him and then he hit Resident #51 back in his eye. Review of the nurse progress notes dated 9/20/21 (the day the incident was reported) revealed there was no documentation of the incident between Residents #51 and #52. Further review of the medical records for Residents #51 and #52 revealed there was no evidence that both residents were assessed for injury and pain. The interdisciplinary team (IDT) note for Resident #51 dated 9/21/21 documented an incident that was brought to staff attention on 9/20/21 and was investigated immediately. It documented Resident #51 was involved in a physical altercation with his roommate (Resident #52). The residents were separated immediately. Residents were immediately moved to separate rooms. It further documented that the police were notified and residents would remain separated. Staff would continue to monitor both residents for any behaviors. The IDT note for Resident #52 dated 9/21/21 documented an incident that was brought to staff attention on 9/20/21 and was investigated immediately. It documented per the resident's interview that Residents #51 and #52 were having a disagreement and it was reported that Resident #52 struck Resident #51 with a closed fist. It documented residents were separated immediately. B. Resident #51 Resident #51, age 65, was initially admitted [DATE] and was readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included post traumatic stress disorder and chronic obstructive pulmonary disease (COPD). The 9/7/21 minimum data set (MDS) assessment revealed the resident had moderately cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. He had no behaviors and rejection of care. He required limited assistance with bed mobility and supervision with transfers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The comprehensive care plan, initiated on 9/20/21 and revised on 9/21/21, identified the resident reported that he was hit by a fell ow resident. Interventions included: resident remains safe, physician made aware, no new orders, resident now resides in a room of his own and social service department will provide support and stress management as resident allows. Resident #51 was interviewed on 10/14/21 at 1:30 p.m. He was sitting in his room. He said he got into an argument with his roommate (Resident #52) about flushing the toilet. He said Resident #52 held his wheelchair and punched him in his face so he hit him back on his jaw. He said the staff separated them and he was in his own room now. He said he was not afraid of Resident #52. He said he was not assessed by the nurse. C. Resident #52 Resident #52, under age of 65, was admitted on [DATE]. According to the October 2021 CPO, diagnoses included end stage renal disorder and major depressive disorder. The 9/9/21 MDS assessment revealed the resident had moderately cognitive impairments with a BIMS score of 12 out of 15. He had no behaviors or rejection of care. He was independent with bed mobility and supervision with transfers. The care plan, initiated on 9/20/21 and revised on 9/21/21, identified it was reported by a fell ow resident that the resident had struck out at him making contact. Interventions included another room was offered to the resident, physician made aware, nursing assessment revealed no injuries. Resident #52 was interviewed on 10/13/21 at 10:45 a.m. He said he got into an argument with his roommate (Resident #51) and they both hit each other. He said he was moved to a different room. He said he was not afraid of Resident #51. D. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 10/12/21 at 1:39 p.m. She said she had worked at the facility for many years. She said Resident #51 sometimes got aggressive with other residents and sometimes would hit. She said she did not witness the altercation with his roommate (Resident #52) but heard he was involved in a physical altercation and both residents had been separated. The NHA was interviewed on 10/14/21 at 5:15 p.m. She said she had worked at the facility for two weeks. She said both residents were interviewed and they said they hit each other. She said Resident #52 was not accurate in reporting. She said after a reported altercation, the nurse should assess the residents for injury and pain. She acknowledged that there were no documented assessments for both residents regarding the incidents. She said education would be provided to the nurses on assessing residents after an altercation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interviews, the facility failed to investigate accident hazards thoroughly and timely to rule out abuse, and failed to prevent further injury affecting one (#56) of five residents reviewed out of 37 sample residents. Specifically, the facility failed to timely and thoroughly investigate an injury involving the Hoyer (mechanical) lift for Resident #56 on 8/10/21. Findings include: I. Facility Policy The Accidents and Incidents Investigating policy, revised July 2017, provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:50 p.m., read in pertinent part: All accidents or incidents involving residents, employees, visitors, vendors, etc., occuring on our premises shall be investigated and reported to the administrator. The nurse supervisor, charge or department director shall promptly initiate and document the investigation of the accident or incident. 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 lift for transfers. III. Record review 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. 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. Resident was assisted back to the wheelchair. Vital signs were normal and no apparent injury was noted. The family and doctor were notified. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. -The facility failed to initiate a thorough investigation into the injury with the Hoyer lift when they became aware of the first injury on 8/10/21 for Resident #56. There were no additional residents or staff interviewed and staff had not been properly trained or re-educated on the use of the Hoyer lift, which may have prevented recurrence on 8/24/21. (Cross-reference F689 for accident hazards) IV. Interviews Certified nurse aide (CNA) #6 was interviewed on 10/14/21 at 11:00 a.m. She said she assisted Resident #56 to the floor safely during a Hoyer lift transfer. She said CNA #8 did not put the Hoyer lift sling on the resident properly and the resident slid out of the sling during the transfer. She said she had not been trained on how to use the Hoyer lift in over a year. 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. The director of nurses (DON) was interviewed on 10/14/21 at 5:50 p.m. She said an investigation happened with education provided to staff members to prevent further injuries from occurring. She started Hoyer lift training today (after being being identified during survey) for nurses and aides that worked directly with residents.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on observations, interviews and record review, the facility failed to ensure one (#74) of two residents reviewed out of 37 sample residents received an ongoing person-centered program of activities designed to meet the needs and interests, and promote physical, mental and psychosocial well-being. Specifically, the facility failed to provide ongoing activities for one resident and failed to turn on the television or play music in his room which he could not do on his own. Findings include: I. Facility policy The Activity Programs policy, dated 2001 and updated November 2010 was provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:55 p.m. It revealed in pertinent part: Activity programs designed to meet the needs of each resident are available on a daily basis. 1. Our activity programs are designed to encourage maximum individual participation and are geared to the individuals needs. 3. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident and include, as a minimum: Activities that stimulate the cardiovascular system and assist with range of motion, such as exercise, movement to music, wheelchair basketball/volleyball, etc., are offered five to seven times per week. Intellectual activities that are mentally stimulating, such as current events, trivia, word games, book reviews, educational movies, etc., are provided five to seven times per week. -Weather permitting, outdoor activities are held on a regular basis. -Spiritual programming is scheduled to meet the religious needs of the residents. II. Resident #74 status Resident #74, under age 70, was admitted on [DATE]. According to the September 2021 computerized physician orders (CPO), diagnoses included traumatic hemorrhage of the right cerebrum (brain), traumatic brain injury (TBI), aphasia (loss of ability to understand or express speech), and an enteral feeding tube (a device inserted through the stomach to supply nutrition). (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/5/21 minimum data set (MDS) assessment revealed the resident was unable to complete a brief interview for mental status (BIMS). He had an altered level of consciousness which fluctuated in and out. He required extensive assistance with bed mobility, eating, toileting and personal hygiene. He was dependent for transfers, dressing and bathing. It was somewhat important that he listen to music, have religious activities and keep up with the news. It was very important he visited with pets, and went outside when the weather was nice. III. Observations On 10/11/13 at 9:00 a.m. until 1:00 p.m. the resident was in his bed, awake, in a hospital gown. He had the television on. Staff did not offer him any activities. On 10/12/13 at 9:00 a.m. until 1:30 p.m. the resident was in bed, awake, in a hospital gown. He had the television on. Staff did not offer him any activities. On 10/13/21 from 10:00 a.m. until 12:30 p.m. and from 2:00 p.m. until 3:15 p.m. the resident was in his bed, awake, wearing a hospital gown. The television was not on. He did not have any music on from a radio. His eyes were open and he stared at the blank screen on his television. -At 5:16 p.m. the resident was in his bed, awake, wearing a hospital gown. The television was not on. He did not have any music on from a radio. His eyes were open and he stared at the blank screen on his television. On 10/14/21 from 10:45 a.m. until 12:15 p.m. the resident was in his bed, awake, wearing a hospital gown. The television was not on. He did not have any music on from a radio. His eyes were open and he stared at the blank screen on the television. IV. Resident interview Resident #74 was interviewed on 10/13/21 at 12:00 p.m. When asked if he would like the television on to watch something he nodded his head up and down yes. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 10/13/21 at 5:25 p.m. She said Resident #74 received almost nothing from activities. She said activities rarely visited him and often no one even helped turn on his television. She said he was just left in bed all day long with no activities. She said someone could get him a special wheelchair and help him get up. She said she thought he would like to go outside but he has not gone outside in the nice weather. She said she felt it was really sad to leave him in bed with only his television. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service director (SSD) was interviewed on 10/13/21 at 4:30 p.m. She said, Our activity director quit recently. She said she was providing activities for now. She said she had an exposure of how to do activities when she worked in the child welfare department. She said someone was hired today for activities. She said they would get the new person trained and also provide them with a consultant. She said by looking at the activity records they provided Resident #74 with activities one time per week. She said the resident could not get up on his own and needed help to turn on the television. She said the facility could not change the past with Resident #74 not being provided independent activities. She said, Going forward he will receive one-to-ones at least three times a week. She said she would look in the activity director's room for any extra notes on providing the resident with more visits. She said if she found notes that Resident #74 had received activities she would provide them. No notes were provided after the interview. The INHA was interviewed on 10/13/21 at 4:45 p.m. She said the facility had just today hired an activity director. She said the new activity director would be trained by their activity consultant. She said Resident #74 would be a focus as well as others who were in need of one-to-ones. VI. Record review The activities and social service progress notes were provided by the interim nursing home administrator (INHA) on 10/14/21 at 12:55 p.m. The notes revealed: Resident #74 received eight one-to-one (1:1) visits on the following dates in September 2021: -9/1/21, 9/4/21, 9/5/21, 9/9/21, 9/17/21, 9/24/21, 9/25/21, and 9/30/21. Resident #74 received three 1:1 visits on the following dates in October 2021: -10/6/21, 10/7/21 and 10/13/21. The 9/1/21 care plan revealed the resident's daughter said her dad enjoyed listening to classic rock music and keeping up with local and national sports and weather reports. The goal was for the resident to have two to three 1:1 visits as tolerated through the next review date. -No specifics were written for the 2-3 visits to be provided weekly or monthly. Interventions were: Activities staff will provide one to one visits as tolerated, activities will provide classic rock music and turn resident's television on to local news and weather stations. Provide activities from religious activities, bingo, meditation, music, trivia and many other things. During state survey the activity section of Resident #74's care plan was revised on 10/11/21. It revealed the resident grew up working on cars and was a handyman. He enjoyed listening to classic rock music. He liked to keep up with local and national sports and weather reports. He preferred not to interact with peers and had no favorite activities. He was a Christian but did not practice his faith. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The goal was to maintain cognitive stimulation, provide two to three 1:1 visits with care partners (nothing was written to indicate two to three visits would be provided weekly or monthly), and social activities as desired and tolerated. Interventions were: Activities staff will provide 1:1 visits as tolerated, activities will provide classic rock music and turn resident's television on to local news and weather stations. Staff will ask yes or no questions for communication. Certified nurse aide (CNA) to assist the resident to attend groups if interested. The facility failed to identify and provide meaningful person-centered activities for Resident #74.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on observations, record review, and staff interviews, the facility failed to ensure one (#29) of three out of 37 sample residents received the care and services necessary to prevent the development of pressure injuries and to promote healing of pressure injuries. 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. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, from http://www.npuap.org (10/18/21): Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). The National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers reads that steps to prevent the emergence of pressure ulcers in individuals identified as being at high risk include scheduled repositioning to avoid individuals being in a position that places pressure on a vulnerable area for a long period of time. The following steps should be taken to prevent the worsening of existing pressure ulcers and promote healing: -Positioning that places pressure on the pressure ulcer should be avoided. -The pressure ulcer should be assessed upon development and reassessed at least weekly. The results of assessments should be documented. -The ulcer should be observed with each dressing change for signs of infection, improvement, deterioration, or other complications. -Signs of deterioration in the wound should be addressed immediately. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The assessment should include: location, category/stage, size, tissue type, color, peri-wound (skin around the wound) condition, wound edges, exudate, undermining/tunneling, order. II. Resident status Resident #29, age 86, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included adult failure to thrive and protein calorie maturation. The 8/20/21 minimum data set (MDS) assessment revealed the resident's cognition was not assessed. According to the admission progress note dated 8/14/21, the resident was alert and oriented to person, place and situation. The MDS documented she required extensive assistance from staff to perform bed mobility and transfers. The resident did not have any pressure injuries at the time of assessment but was at risk of developing pressure injuries. III. Observations and interview The resident was observed on 10/12/21 from 10:15 a.m. to 12:30 p.m. She was lying on her back in her bed. She was on a pressure relieving mattress, not an alternating air mattress. Multiple staff were observed to walk the hall and did not offer to turn or reposition the resident. During an interview with the resident at 12:35 p.m., she said no staff came to turn her. IV. Wound care observation The resident's wound was observed on 10/13/21 at 10:35 a.m. during wound care. There was no dressing on the wound. The nurse said the hospice certified nurse aide (CNA) visited with the resident and gave her a bed bath. She said she believed that was when the dressing fell off. The wound was red in color with some slough. There was no odor or drainage. There were no signs of infection. The nurse cleaned the wound and applied the dressing. The nurse said the wound was unstageable. V. Record review The comprehensive care plan, initiated on 10/11/21 (14 days after wound was identified) and revised on 10/13/21 (during survey), identified the resident had a pressure ulcer to her coccyx and it was unstageable. Interventions included to administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, if the resident refuses treatment, confer with the resident, hospice and interdisciplinary team (IDT). The care plan, initiated on 10/13/21 (during survey) and revised on 10/13/21, identified the resident had a history of refusing care and repositioning which could worsen the wound. Intervention included: if the resident refused care, talk to the resident about her concerns and go back at a time agreed on, inform hospice if the resident continues to refuse and respect the resident's wishes. -The care plan failed to include that the resident was at risk for skin breakdown, and appropriate interventions to prevent skin breakdown, such as turning and repositioning every two hours. -There was no evidence that the resident refused to be repositioned. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The admission skin assessment, dated 8/14/21 documented, bilateral lower extremities dry skin and discoloration. It documented the resident's skin was intact. A Braden Scale for Predicting Pressure Ulcer Risk assessment was completed on 8/14/21. The resident's score was 18, mild risk for developing pressure injuries. The assessment identified a potential problem: Rarely eats a complete meal and generally eats only about half of food offered. Protein intake includes only three servings of meat or dairy products per day. Occasionally will take a dietary supplement. Weekly skin assessments dated 9/2/21, 9/4/21, 9/11/21, 9/18/21, 9/25/21 and 10/2/21 revealed no skin issues. A shower sheet dated 9/28/21 was reviewed. It was identified by the director of nursing (DON) that the resident had an open area on her coccyx and edema to bilateral feet. -There were no descriptions and measurements of the wound. -There was no evidence the physician was notified, treatment orders requested/implemented, or the care plan updated (see above). A timeline of the wound was provided by the regional nurse consultant/infection preventionist (RNC/IP) on 10/13/21 at 11:00 a.m. It documented the following: -9/15/21 - the physician noted on a visit that the resident's skin was fragile and at high risk for skin breakdown. Resident is on a pressure relieving mattress (the care plan was not updated). -9/20/21 - the hospice nurse noted upon her visit that the resident's skin was intact. -9/25/21 - the facility registered nurse (RN) noted on a skin assessment that the resident's skin was intact. -9/28/21 - during a full facility skin sweep, the director of nursing (DON) noted an open area to the resident's coccyx. The physician was made aware and the hospice nurse in the facility was made aware. -10/5/21 -Wound doctor noted that the ulcer was healing. A physician order entered on 9/30/21 (two days after the wound was identified) ordered to clean the wound with normal saline and apply border dressing. A physician order entered on 10/5/21 ordered to cleanse the area with wound cleanser, pat dry with gauze, apply layer of santyl to wound bed and cover with foam dressing every day and as needed. The wound tracker form dated 9/30/21 documented the resident had an unstageable pressure injury to her coccyx and it measured 4.5 x 6 centimeters (cm) x utd (undetermined depth). The wound tracker form dated 10/5/21 was reviewed. It documented the resident had an unstageable pressure injury to her coccyx and it measured 2 x 4.5 cm x utd. It revealed the wound was healing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of point of care documentation (where CNAs document) from 8/14/21 to 10/14/21 revealed there was no task/intervention for the CNA to reposition or turn the resident. VI. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 10/12/21 at 2:00 p.m. She said the resident was in hospice and was unable to reposition herself. She said she believed the resident developed the wound because she laid on her back most of the time. She said sometimes she would be so busy and did not have time to reposition the resident. (Cross-reference F725, sufficient nursing staffing.) The director of nursing (DON) and the regional nurse consultant/infection preventionist (RNC/IP) were interviewed on 10/14/21 at 2:45 p.m. The DON said she had been in her position for two weeks. She said according to the weekly skin assessments, the resident had no skin issues. She said the staff should be turning and repositioning the residents who were unable to turn themselves, to prevent skin breakdown. She said she did a house wide sweep to assess all residents' skin to identify any skin breakdown. She said on 9/28/21 during the skin assessments, she identified an open area on Resident #29's coccyx. She said she notified the doctor but did not assess and measure the open area. She said she did not measure the wound because she did not want to measure inaccurately. She said she was not sure how the wound developed but she believed probably because of poor nutrition intake and immobility. The RNC/IP said when a wound was first identified, it should be assessed and measured. She said the nurse should notify the physician to obtain orders for treatments. She said not treating the wound in a timely manner could cause the wound to get worse. She said the DON should have measured the wound and ensured treatment orders were in place. The RNC/IP said the resident was seen by the wound doctor and the wound was healing. VII. Facility follow-up The interim nursing home administrator (INHA) provided a physician progress notes via email dated 10/14/21 (the day survey ended) for Resident #29. It documented in pertinent part, The resident developed an unavoidable skin breakdown on her buttocks that may never heal due to poor nutritional status, immobility, poor hydration, and terminal cancer. She is on a pressure relieving mattress and a wound care team is in place. -However, findings revealed the resident's pressure injury was not unavoidable or impossible to heal. According to the 10/5/21 wound tracker form, the wound had decreased in size and showed signs of improvements. It documented that the wound doctor noted that the wound was improving.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on observations, record review and interviews, the facility failed to ensure two (#56 and #1) of three residents reviewed received appropriate services and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrated as unavoidable, out of 37 sample residents. Specifically, the facility failed to provide Resident #56 and #1 with a restorative range of motion program to promote independence in accordance with the care plan. Finding include: I. Facility policy The Restorative Nursing Services Policy, revised July 2017, provided by the nursing home administration interim (NHAI) on 10/14/21 at 12:50 p.m., read in pertinent part: Residents will receive restorative nursing care as needed to help promote optimal safety and independence. Residents may be started on a restorative nursing program upon admission, during the course of study or when discharged from rehabilitative care. Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting residents in: -Adjusting or adapting to changing abilities; -Developing, maininting or strengthening his or her physiological and psychological resources; -Maintaining his or her dignity, independence and self-esteem; and -Participating in the development and implementation of his or her plan of care. II. Resident #56 A. Resident 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). She required extensive assistance with two people for transfers, bed mobility, toileting, hygiene and dressing. She required extensive assistance from one person for eating. She used a Hoyer lift for transfers. B. Observations (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56 was observed on 10/11/21 at 11:30 a.m. in the dining room. She sat in a wheelchair, and had a pillow wedged under her right side because she leaned that way. Her left hand was contracted and she wore no brace or splint. On 10/12/21 at 12:45 a.m. Resident #56 sat in her wheelchair in her room. She leaned to the right and had no brace or splint on her left hand. On 10/13/21 at 6:43 a.m. Resident #56 sat in her wheelchair in the day room. She wore a splint brace on her left hand and there was a pillow propped under her right side to help sit her up straight. C. Record review The contracture care plan for Resident #56, revised on 12/1/21, read in pertinent part; Resident has a contracture to her left side. Document education to the resident regarding the benefits of wearing the splints recommended by therapy and document when she declines the splints. Encouragement to increase tolerance of splints, for better outcomes. Place splints per recommendation and remove the splints when the resident makes non-verbal requests, by grimacing or pulling at equipment, or showing signs of discomfort. Give pain medications as ordered. Monitor for effectiveness and side effects. Have physical therapy and occupational therapy screen and evaluate and treat as needed for possible therapy interventions as ordered by the doctor. Monitor skin integrity every shift. The restorative care plan for Resident #56, revised on 9/17/20, read in pertinent part; Resident is on a restorative program to improve and maintain range of motion and to prevent further contractures. The goal was to not develop any new contractures to the left hand through the next review date. Interventions were to do passive range of motion to the left wrist and digits to flex the extension for 10-15 repetitions within a pain free range, and hold for 10 seconds. The restorative note for Resident #56, dated 7/14/21, provided by the nursing home administration interim (NHAI) on 10/14/21 at 12:50 p.m., read in pertinent part: Resident participates in restorative passive range of motion (PROM) to left upper extremity wrist flexion extension 10-15 repetitions (reps) and hold for 10 seconds. PROM left upper extremity digits flexion extension 10-15 reps and hold for 10 seconds. Palm protector was placed, assisted with meals and transferred for 30 minutes. The restorative note for Resident #56, dated 8/5/21, provided by the NHAI on 10/14/21 at 12:50 p.m., read in pertinent part: Residents participated in restorative active range of motion of all joints, all planes, with group balloon toss for 30 minutes. The restorative note for Resident #56, dated 8/10/21, provided by the NHAI on 10/14/21 at 12:50 p.m., read in pertinent part: Resident participated in restorative active range of motion of all joints, all planes (positions) for 15 minutes. The restorative notes for Resident #56 dated 8/12//21, 8/13/21, 8/21/21 and 8/23/21, provided by the NHAI on 10/14/21 at 12:50 p.m., all read in pertinent part: Resident participated in restorative active range of motion of all joints, all planes for 15 minutes. The restorative notes for Resident #56 dated 8/31/21, provided by the NHAI on 10/14/21 at 12:50 p.m., read in pertinent part: Resident participated in restorative active range of motion of all joints, all planes for 15 minutes. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The restorative notes for Resident #56 dated 9/2/21 and 9/4/21, provided by the NHAI on 10/14/21 at 12:50 p. m., all read in pertinent part: Resident participated in restorative active range of motion of all joints, all planes for 15 minutes. The restorative note for Resident #56 dated 9/15/21, provided by the NHAI on 10/14/21 at 12:50 p.m., read in pertinent part: Resident participated in restorative active range of motion of all joints, all planes except for left upper arm, assisted in dining room with meals up to 30 minutes. No other restorative notes were provided for any other dates past 9/15/21. D. Staff interviews Restorative aide (RA) #1 was interviewed on 10/12/21 at 8:30 a.m. She said Resident #56 was on restorative services but she had not worked with her because the facility pulled her to the floor to work so the restorative program was not being completed. She said she worked with residents last about three weeks ago and it was sporadic then as well. She said splints were put on Resident #56's left hand when she did work with her and she did passive range of motion to her extremities. Certified nurse aide (CNA) #6 was interviewed on 10/14/21 at 10:25 a.m. He said restorative program worked with Resident #56 to put her splint on every day. He said he did not know how to apply it. He said someone was there every day. He said her splint was in the laundry so she did not have it on today. CNA #2 was interviewed on 10/14/21 at 10:30 a.m. She said the restorative aide worked on the floor a lot. She said Resident #56 was supposed to wear a splint on her hand but it was not always put on there. She said the facility was short staffed so all the care was hard to get accomplished. Cross-reference F725, sufficient nursing staffing The regional nurse consultant was interviewed on 10/14/21 at 5:30 p.m. She said she assisted with the restorative program. She said residents were assessed monthly to see how the residents were progressing. She said the restorative aides (RAs) worked with residents seven days a week. RAs put the splints on Resident #56 and documented the progress. She said the restorative aides were pulled to the floor to work and the facility had to juggle the program to care for all residents. She said they were aware of some residents having a decline with lack of a restorative program. The director of nursing (DON) was interviewed on 10/14/21 at 5:50 p.m. She said she just started overseeing the restorative program. She said residents had not been seen consistently as the facility was short staffed, so the restorative aides were pulled to work the floor. Her plan was to meet with the restorative team monthly to continue the participation with residents and their needs. 43135 III. Resident #1 A. Resident status (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1, under age 70, was admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Guillain-Barre Syndrome (the body's immune system attacks the nerves), paraplegia, quadriplegia, type 2 diabetes mellitus, sleep apnea, morbid obesity, and glaucoma. The 7/11/21 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. The resident required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. The resident required total dependence with bathing. The resident was independent with eating. The resident did not walk in his room or corridors. The resident had upper and lower extremity impairment on both sides of his body. Resident #1 had received no restorative services for the previous seven day look-back period. B. Resident interview Resident #1 was interviewed on 10/12/21 at 9:33 a.m. He said he had not had restorative nursing care for about a month. He said he was to get restorative six days a week. He said he liked the restorative certified nurse aides (CNAs) who did work with him. He said they often did not have time to work with him. He said the CNAs told him they could not do restorative sometimes because they were needed to fill positions as floor staff instead. (See director of nursing interview below.) He said due to his excessive weight he rarely got out of his bed. He said he needed exercises to be done with him in his bed. C. Record review Record review revealed no care plan to address the resident's limited range of motion (ROM) with a restorative program. The 6/3/21 restorative program resident caseload documentation was provided by the interim nursing home administrator (INHA) on 10/12/21 at 2:20 p.m. It revealed Resident #1 was to have restorative six days a week as tolerated. Resident #1 had his program for active range of motion (AROM) in all planes (upper and lower extremities). The restorative nursing progress notes were provided by the interim nursing home administrator (INHA) on 10/13/21 at 4:20 p.m. Resident #1's documented restorative notes revealed: -On 9/2/21, Resident participates with restorative all joints, all planes, support hose placed to both feet. -On 9/7/21, Resident participates in restorative AROM (active range of motion) all joints, all planes, support hose placed, boots and sock placed for 15 minutes. -On 9/8/21, Resident participates in restorative AROM (active range of motion) all joints, all planes, support hose placed, boots and sock placed for 15 minutes. -On 9/10/21, Resident participates in restorative AROM (active range of motion) all joints, all planes, support hose placed, boots and sock placed for 15 minutes. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no restorative progress notes from 9/11/21 through 10/13/21. There was no evidence of refusals. D. Staff interviews The director of nursing (DON) was interviewed on 10/14/21 at 5:50 p.m. She said she was in charge of restorative and the regional nurse consultant (RNC) oversaw the restorative program. The restorative program members met monthly. She said if a person refused to do the restorative program when it was offered to them the facility tried to figure out why and how to solve it in their monthly meeting. She said the restorative certified nurse aides (RCNAs) worked seven days a week. She said seven days per week for restorative was the expectation of the facility. She said the RNAs had had to go to the floor to be CNAs when the facility was short staffed. She said it had happened several times. She said that could be the reason why Resident #1 had not had his restorative program for about a month. She said they were actively working on hiring more RCNAs and CNAs. She said she did not have any documentation that Resident #1 refused any restorative care in the last month. The RNC was interviewed on 10/14/21 at 5:55 p.m. She said the facility was actively trying to hire more staff. She said that would help the restorative program when more staff were hired. She said she did not have any refusal documentation of restorative care for Resident #1 in the past month.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on record review and interviews, the facility failed to ensure one resident (#52) of one out of 37 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to: -Have a complete dialysis communication form between the facility and dialysis center for continuity of care for Resident #52; and, -Obtain a physician order to check for bruit (swishing sound) and thrill (vibration/pulse) to Resident #52 dialysis site for possible complications. Findings include: I. Facility policy The Dialysis Care policy, revised June 2020, was provided by the regional nurse consultant (RNC) on 10/14/21 at 3:00 p.m. It read in pertinent part,the facility will be responsible for care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing for all non dialysis needs of the resident including during the time period when the resident is receiving dialysis. Inspect shunt sites for color, warmth, redness, tenderness, pain, edema, drainage and briut once per shift. The facility will arrange transportation to and from the dialysis provider, as well as for meals (if necessary), medication administration, and a method of communication between the dialysis provider and the facility. II. Resident status Resident #52, age 56, was admitted on [DATE] According to the October 2021 computerized physician orders (CPO), diagnosis included end-stage renal disorder. The 9/9/21 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 12 out of 15. He was independent with bed mobility and supervision with transfers. He was coded for dialysis. III. Resident interview The resident was interviewed on 10/13/21 at 11:00 a.m. He said he went to dialysis three days a week. He said when he gets back from dialysis, the nurse would not assess his site. He said he did not remember the nurse checking for bruit and thrill at his dialysis site. IV. Record review (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan revised on 9/5/21 revealed the resident had hemodialysis related to renal failure. Intervention included to check and change dressing daily at the access site, encouraging resident to go for the scheduled dialysis appointment, monitor vitals, monitor for redness, swelling, warmth or drainage to site. And monitor intake and output. Review of October 2021 CPO, documented to check bruits and thrills on left arm each shift. -The order was dated 10/13/21 during survey after the facility was made aware. Review of the resident's medical record, there was no documentation that the nursing staff checked and monitored for bruit and thrill at the dialysis site for possible complications. Review of October 2021 treatment administration record (TAR) documented to check bruit and thrill on left arm each shift, which dated 10/13/21 after the facility was made aware. Review of the resident's dialysis communication forms dated 9/28/21, 9/30/21, 10/2/21, 10/2/21, 10/5/21, 10/7/21, 10/9/21 and 10/12/21, documented vitals taken at the facility prior to resident leaving for dialysis. -The dialysis communication form failed to include a documentation section from the dialysis center and post-dialysis assessment when the resident returned from dialysis. V. Staff Interviews Licensed practical nurse (LPN) #3 was interviewed on 10/12/21 at 3:00 p.m. She said she was taking care of the resident. She said the resident went for dialysis three days a week. She said the nurse would do pre and post dialysis assessments on the day the resident went to dialysis. She said before the resident left for dialysis, the nurse would take his vital signs and when the resident returned to the facility, a post assessment should be completed by the nurse which include checking the resident's vitals, assess the site and check for bruit and thrill. She said there should be a physician order to check for bruit and thrill. She said she was not aware that there was no order to monitor the bruit and thrill. The director of nursing (DON) was interviewed on 10/14/21 at 3:00 p.m. in the presence of the regional nurse consultant (RNC). She said when a resident was on dialysis, there should be a communication form between the facility and the dialysis center for continuity of care. She said before the resident left for dialysis, the nurse should assess the resident and document the assessment on the communication form sent with the resident to the dialysis center. She said when the resident returned from dialysis, she expected the nurse to do a post dialysis assessment which included assessing the site for bleeding and any signs and symptoms of infection. She said the nurse should check for bruit and thrill. She said she was not aware that there was no physician order to check for bruit and thrill for Resident #52. She said there should be an order to check for bruit and thrill to ensure there were no complications to the site. She said she would provide education to the nurses to check for bruit and thrill and she would obtain an order from the physician. VI. Facility follow-up (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A new dialysis communication form was created and provided by the DON on 10/14/21. It revealed a section for facility staff to document the resident assessment prior to leaving for dialysis and a section for the dialysis center to document their assessments.

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on observation, record review and interviews, the facility failed to ensure it was free of a medication error rate of five percent (%) or less on one of two units. Specifically, the medication administration observation error rate was 8.11%, or three errors out of 37 opportunities for error for Resident #42. Ocean spray, advair disk and fluticasone medications were not administered during medication observation times. Findings include: I.Facility policy The Administering Medication policy, revised December 2021, provided by the nursing home administrator interim (NHAI) 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. For residents not in their room or otherwise unavailable to receive medication on the pass, the medical administration record (MAR) may be ' flagged. ' After completing the medication pass, the nurse will return to the missed resident to administer the medication. II.Resident #42 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. III. Observation and interview Resident #42 was interviewed at 8:10 a.m. She said she had not had her medication nor refused her medications (as charted below in the medication administration record). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was observed on 10/13/21 at 8:16 a.m. to pass medication. She said at the beginning of the medication pass Resident #42 refused her medications on some days. The medication administration (MAR) record showed the ocean spray, advair disc and fluticasone medications were due at 9:00 a.m. LPN did not offer Resident #42 the medication at that time. During the survey observation, a visual of the medications was requested to see if the medication was available. LPN showed the ocean spray, advair disc and fluticasone were not in the medication cart. LPN went to the storage room to try and find the medication and none were available. She looked in the medication cart again and found the advair disc and the fluticasone medications. The ocean spray was not found in the cart. Advair disc was not offered to the resident and was a missed medication. The fluticasone was offered to the resident and said she would take the medication in her room. LPN went to the residents room but the resident was not in the room. LPN did not try to find the resident and the medication was not given. LPN said she documented any missed or refused medications in the residents' chart. She went to the next residents' MAR to give medications. IV. Record review The October 2021 computerized physician orders (CPO) for Resident #42 revealed the following orders: -Ocean nasal spray, two sprays in both nostrils four times a day. Order start date ws 4/29/21. -Advair disk aerosol 100-50 milli (mcg) one inhalation orally two times a day. Order start date 9/24/21. -Fluticasone propionate suspension 50 mcg, one spray in both nostrils two times a day. Order start date 2/23/21. The October 2021 medication administration record (MAR), for Resident #42 revealed: -Ocean spray medication was documented on 10/13/21 at 9:00 a.m. as refused, -Advair disk aerosol medication was documented on 10/13/21 at 9:00 a.m. as refused, and, -Fluticasone propionate suspension medication was documented on 10/13/21 at 9:00 a.m. to see nurse note. The health status note for Resident #42 on 10/13/21 at 10:44 a.m. read in pertinent part: Doctor was notified and reported the ocean spray medication was not available and received a new order for nasal spray over the counter on hand medication. No other documentation was available. V. Staff interviews LPN #3 was interviewed on 10/13/21 at 4:30 p.m. She said when a resident refused medications or a medication was late or missed, the physician was notified and a nurse note was written. She said she tried to give the medication at a later time when refused. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 refuses medication, a nurse note was written and the doctor was notified each time. She said she started the re-education on medication administration to the nurses 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 for any changes.

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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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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.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on observations, interviews and record review, the facility failed to provide special eating equipment and utensils for eating meals for one (#68) of one resident reviewed out of 37 sample residents. Specifically, the facility failed to provide physician ordered adaptive devices, a plate guard and weighted silverware, for Resident #68. The resident, after calling for assistance and not receiving it, had to eat his spaghetti with his hands. Cross-reference F550, dignity/respect. Finding include: I. Facility policy The Adaptive Equipment - Feeding Device policy, revised December 2020, was provided by the minimum data set (MDS) coordinator on 10/14/21 at 4:56 p.m. It revealed in pertinent part: Adaptive feeding equipment is used by residents who need to improve their ability to feed themselves and in order to enable residents with physically disabling conditions to improve their eating functions. -Upon request, verbal or written, from the nutrition or nursing departments, an occupational therapist, when possible, will assess residents for any potential problems related to feeding themselves. -Adaptive equipment will be provided by the occupational therapist to the nutrition services department to be included with meal service for the resident daily. -The facility will provide residents appropriate assistance to ensure that the resident can use the assistive device when consuming meals and snacks. -An updated list of adaptive equipment will be obtained by the nutrition services department from the rehabilitation department at least once a month to ensure accuracy. -Types of adaptive equipment are not limited to: A. Built-up silverware. B. Built-up dish with inner lip. C. Special cups. D. Special cups and glass holders. E. Plate guards. -Assessment findings will be communicated to the attending physician for an order before providing adaptive equipment. II. 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). (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 with 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). III. 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. 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 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 spaghetti with his left hand. The resident swayed continuously on his bed back and forth with his shoulders from the right to the left. -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 director of nursing (DON) entered the resident's room after her assistance was requested by the surveyor. She said the resident should not have been given food without silverware of any kind, 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 ago. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Record review The 9/19/21 certified physician order revealed the resident had a diet order to have a regular diet with a mechanical soft texture, large portions with adaptive equipment and an adaptive cup. The 10/8/21 dietary progress note revealed that the resident needed a plate guard and weighted utensils to promote self-feeding. Will order adaptive equipment and continue to monitor. 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. The October 2021 medication administration and treatment record (MARs and TARs) documented at 5:30 p. m. the resident had adaptive equipment but during a meal observation (above) he did not. The nursing progress note written by the interim nursing home administrator on (INHA) on 10/13/21 at 8:10 p. m. documented: 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. V. 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 nursing and dietary staff would be trained concerning adaptive equipment. She said the resident should have been given a plate guard and adaptive silverware to eat with. She said the resident needed the adaptive equipment to eat with because he had tremors. She said last night the DON came to her and they took care of the situation with the resident immediately. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The registered dietician (RD) was interviewed on 10/14/21 p.m. at 4:30 p.m. She said she had heard about Resident #68 not having silverware or adaptive devices last night to eat his spaghetti. She said she heard he ate the spaghetti with his hands. She said she did not understand how staff did not notice he did not have silverware to eat with. She said she did not have an answer as to why the resident did not receive his adaptive devices to eat spaghetti. She said she had provided an in-service today to the dietary staff to help the resident and everyone who needed a plate guard, adaptive devices, and weighted silverware. She said Resident #68 should have been given special devices to eat with, including a plate guard and weighted silverware. VI. Facility follow up A copy of the dietary staff in-service was provided by the RD on 10/14/21 at 4:30 p.m. The training documentation, dated 10/14/21, revealed: -Six dietary staff signed a participation sheet for the in-service provided by the RD. -The dietary staff were taught how to identify adaptive equipment and why adaptive equipment should be used. -Where to identify on a meal ticket what adaptive equipment was needed for a resident. -How to identify residents who needed adaptive equipment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41172 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life, quality of care and infection control. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program policy, dated July 2016, was received from the nursing home administrator (NHA) on 12/8/21 at 12:44 pm. The policy read in pertinent parts, The Administrator shall delegate the necessary authority for the QAPI Committee to establish, maintain and oversee the QAPI program. The QAPI committee advised the administrator and owner and/or governing body. The committee had the full authority to oversee the implementation of the QAPI program, including, but not limited to the following: -Establishing performance and outcome indicators for quality of care and services delivers in the facility; -Choosing and implementing tools that best capture and measure data about the chosen indicators; -Appropriately interpreting data within the context of standards of care, benchmarks, targets, and the strengths and challenges of the facility; and -Communicating the information gathered and their interpretation to the owner/governing board (body). II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct F600 Prevention of Abuse and Neglect During a recertification survey on 10/14/21, abuse was cited at an E level. During the revisit survey on 12/8/21, the facility was cited at an increase of scope and severity for abuse at a G (harm) level. F610 Investigation of Abuse and Neglect (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a recertification survey on 10/14/21, investigation of abuse was cited at a D level. During the revisit survey on 12/8/21, the facility was again cited at a D level. F676 Care and Services to prevent a decrease in activities of daily Living (ADLs). During a recertification survey on 10/14/21, care and services to prevent a decrease in ADLs was cited at a E level. During the revisit survey on 12/8/21, the facility was again cited at an E level. F679 Activities meet interest and needs of residents During a recertification survey on 10/14/21, activities to meet the interests and needs of residents were cited at an E level. During the revisit survey on 12/8/21, the facility was again cited at an E level. F686 Prevention of Pressure Ulcers During a recertification survey on 10/14/21, prevention of pressure ulcers was cited at a G (harm) level. During the revisit survey on 12/8/21, the facility was cited again for prevention of pressure ulcers at a G (harm) level. F880 Infection control During a recertification survey on 10/14/21, infection control was cited at an E level. During the revisit survey on 12/8/21, the facility was cited at an increase in scope in severity at an F level. III. Cross-referenced citations Cross-reference F600: The facility failed to protect residents after allegations of abuse. Cross-reference F610: The facility failed to thoroughly investigate allegations of resident verbal abuse. Cross-reference F676: The facility failed to provide care and services to prevent a decrease in activities of daily living. Cross-reference F679: The facility failed to provide activities to meet the interest and needs of residents. Cross reference F686: The facility failed to prevent the development of pressure ulcers. Cross-reference F880: The facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent infections, including the development and transmission of COVID-19. IV. Interviews (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA was interviewed with the clinical nurse consultant (CNC) on 12/8/21 at 12:46 p.m. The NHA said the director of nursing (DON), NHA, minimum data set (MDS) coordinator, therapy, social services, activites, maintenance and consultants attended the QAPI meetings. The wound care nurse did not attend the meetings and no frontline staff attended the meetings. She said the committee met monthly. The NHA said the QAPI committee worked off an agenda, each department brings a report, for example, falls, infection control, skin and wound concerns are brought to the meeting by the DON. The NHA said the committee knew when an issue arose based on the department head reports. The CNC said she cited the facility herself for not understanding how to write and follow a performance improvement plan (PIP). She said she was educating the facility on writing a PIP . The CNC said she was working with the facility on how to track and look at things to see if what they are doing is working, the ability to identify trends, and look at root cause analysis. She said not just the number of falls for example, but looking at the root cause of falls. The CNC said there was currently no formal method for staff to report quality concerns, but she would be working on developing that. She said we need to work on training direct care staff on what QAPI is, and how to submit a concern or be part of the committee. The NHA said regarding abuse, the facility had written a PIP on 11/12/21, regarding lack of follow up on abuse. She said swe identified things on our grievance forms that should have had an investigation. She said the CNA had done education with the leadership team of the state occurrence reporting guidelines, and specifically abuse. However, the resident to resident abuse occured after this training. The NHA said she should have investigated the allegation of staff to resident abuse more by asking more questions and inquiring about what the resident meant by the staff person being rough. The NHA said regarding the multiple missed showers for residents, we knew it wasn't perfect, our audit wasn't effective. She said it was hard to keep everything straight and hard to keep track of who was leading what tasks. The NHA said the facility failed to complete skin assessments timely, and this caused the failure in preventing pressure ulcers. The CNC said there was a real lack of understanding in how to write and review audits. She said the facility was focused on getting staff in the building, and as a result training of staff did not get done as it should have. She said there was miscommunication to the staff about resident preferences. The MDS coordinator had done a shower audit of preferences of residents for showers, and then did not share any of that information with the staff. The NHA said we tried to fix it, but we haven't yet. The CNC said, activities to meet the interests and needs of the residents is a concern, we agree. We thought we hired the right people, but they have since left. We need to focus on meaningful activities. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said, we have talked about activities, but have no plan yet. The CNC said regarding concerns with staff not wearing personal protective equipment equipment, and lack of staff and resident hand washing, we have had a lot of new staff and were not diligent in getting in front of the education and return demonstration, of infection control practices. She said, education took a back seat to getting people hired.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on observations and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections in one out of six units. Specifically, the facility failed to: -Ensure appropriate personal protective equipment (PPE) was worn prior to entering an isolation room; and, -Hand hygiene performed when gloves were removed during wound care. Findings include: I. Facility policy and procedure The Infection Control Guidelines for All Nursing Procedure policy, revised August 2012, was provided by the interim nursing home administrator (INHA) on 10/11/21 at 10:00 a.m. It read in pertinent part, standard precaution will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precaution applies to blood, body fluids, secretions and excretions regardless of whether or not they contain visible blood, non-intact skin, and /or mucous membranes. Employees must wash their hands for 10 to 15 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: after contact with blood, body fluids, secretions, mucous membrane or non-intact skin, after removing gloves, before handling clean or soiled dressings, gauze pads etc. Wear PPE as necessary to prevent exposure to spells or splashes of blood or body fluids or other infectious materials. II. PPE observations and interview On 10/11/21 at 2:07p.m., an isolation cart was observed in front of resident room [ROOM NUMBER]. On the door was signage which indicated the resident was in contact isolation for clostridium difficile(C-diff) infection and that hand hygiene should be performed appropriate PPE needed to be worn prior to entering the room. The medical doctor (MD) was observed to enter the resident's room. She did not perform hand hygiene and did not wear PPE prior to entering the room. She proceeded to the resident while she was lying in bed. She removed the cover from over the resident and touched the resident's hand with her bare hands (no gloves). She exited the room and did not perform hand hygiene. She proceeded to the nurses station. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:13 p.m., the MD entered the resident's room for the second time. She did not perform hand hygiene and did not wear PPE prior to entering the room. She was observed to touch the resident's hand with her bare hands (no gloves). At 2:16 P.M., the MD was observed to wear a pair of gloves while in the resident's room after touching the resident who was in contact isolation precaution with her bare hands. At 2:18 p.m., the MD exited the room with the gloves on. After she was half way down the hall, she went back into the resident's room to remove the gloves. She removed the gloves and performed hygiene. The MD was interviewed at 2:19 p.m. She said she was not sure if the resident was on isolation but she would find out from the nurse. - However, there was an isolation cart by the door and signage on the down indicating the resident was in isolation. She said if an isolation cart was in front of a resident's door and had signage on the door, the staff should check with the nurse prior to entering the room. She said it was an emergency situation with the resident that was why she entered the room and did not follow infection control protocol. She said the emergency response team was called to start an intravenous (IV) for the resident. -However, the IV was not started. At 2:20 p.m., registered nurse(RN) # 2 entered the resident's room. She did not perform hand hygiene and did not wear the PPE prior to entering the room with the isolation cart and signage on the door. RN #2 was interviewed at 3:00 p.m. She said she was aware the resident was on contact isolation. She said prior to entering the room she should have performed hand hygiene and donned PPE. She said it was an emergency. -However, the emergency team was called to insert an IV, the IV was not inserted. III. Wound care observation and interview On 10/12/21 at 3:06 p.m., licensed practical nurse (LPN) #3 was observed to provide wound care. She placed a white towel on the floor under the resident's feet. She gathered all materials to change the dressing and placed them on the resident's bed with no barrier. She wore a pair of gloves. She did not perform hand hygiene prior to donning the gloves. She used the scissors to cut the old dressing from the resident's right leg. The old dressing was saturated with dark red blood. She removed the old dressing and placed it on the towel. She cleaned the wound with normal saline(NS). After she was done cleaning the wound, she did not remove her contaminated gloves and perform hand hygiene. She picked up the clean dressing with her contaminated gloves and applied the clean dressing. After she applied the clean dressing, she removed her gloves and donned clean gloves. She did not perform hand hygiene. She proceeded to the left leg wound. She removed the old dressing and the same procedure as above was repeated. After she applied the clean dressing, she removed her gloves and performed hand hygiene and she exited the room. (continued on next page)

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