STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42192 Based on observations, interviews and record review, the facility failed to promote and support the resident right of self-determination in one (#116) and six out of six residents from the group meeting of the 56 total sample residents. Specifically, the facility failed to: - Honor the resident's rights to leave the facility at will. - Ensure his rights were protected by not filing a missing persons police report when Resident #80 did not return to the facility after four hours of absence of leave pass. Findings include: I. Facility policy The policy Leave of Absence/Therapeutic Leave: Patient, revised 11/1/19, was provided by the nursing home administrator (NHA) on 12/16/19. It read in pertinent parts Patients must have a physician order for a Leave of Absence (LOA)/Therapeutic Leave. Therapeutic leave is described as absences for purposes other than required hospitalization . If the patient is leaving for a therapeutic leave that includes an overnight stay, the Center must provide to the patient and resident representative a written Bed Hold Policy Notice & Authorization form. Refer to Accounts Receivable Policies and Procedures, Bed Holds policy. Prior to leaving the Center, staff will review patient care and medication needs with the patient and/or the person accepting responsibility for the patient. A flyer posted around the facility was observed on 12/9/19 at 10:15 a.m., alerted residents to this policy. It read in pertinent parts Attention all residents: before leaving facility you MUST: -Have an order to go on pass. -Sign out with your nurse before leaving the facility to go out on pass (even if you have an order to do so). A. Resident group (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident group meeting was held on 12/12/19 at 11:31 a.m. with six alert and oriented residents selected by the facility to participate in the group. The residents revealed in the meeting that some residents were allowed to leave the facility with a pass, however, they had to tell the nurse before they left The president of the resident council said in order for residents to leave the building they had to have a physician's order and needed permission to leave the facility. Six of the six residents said this policy made them feel like they were treated as children and not respected as adults. B. Resident #116's status Resident #116, under age 65, was admitted [DATE]. According to the December 2019 computerized physician order (CPO), diagnosis included traumatic brain injury. The 11/1/19 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 of15. The resident required supervision with activities of daily living (ADLs) and ambulation around the facility and required no physical assistance. 1. Resident interview Resident #116 was interviewed on 12/9/19 at 12:35 p.m. He said he can not leave the facility. He said he had to have a physician note to leave the facility. He said the physician would not give him a reason why he could not have a pass to go out of the facility. He said he feels locked up in the facility. 2. Record review The December 2019 CPOs documented the resident may go out with the activities department to attend store outings. The care plan entry dated 8/25/19 documented Resident #116 goal as the resident would go on one store outing quarterly. The interventions documented included the importance of going outside when the weather was good and an interest in attending veteran events outside the facility. A care plan meeting note dated 5/22/19 revealed the resident was no longer allowed out of the facility, with orders, in the community due to bringing in items that were not allowed in the facility. 3. Staff interview The assistant nursing home administrator (ANHA) was interviewed on 12/18/19 at 3:37 p.m. The ANHA said a physician's order was necessary for the safety of the residents. She said they need to always be aware of where the residents were and when they would be back. She said a standing order could be written if the resident was cognitively in tack and safe to leave and return to the facility. She said a physician's order could be written quickly in the event a resident had a last-minute outing they wanted to attend or had just arrived at the facility. 42161 (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Resident #80's status Resident #80, age 41, was admitted on [DATE] and readmitted on [DATE]. According to the December 2019 computerized physician order (CPO), diagnoses include major depressive disorder, post-traumatic stress disorder, and attention-deficit hyperactivity disorder. The 10/16/19 minimum data set (MDS) assessment revealed the resident's cognitive status was intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was completely dependent on a wheelchair. 1. Resident observation and interview Resident #80 was interviewed on 12/18/19 at 6:00 p.m. He said on 4/19/19 he left with one of the other residents to go with his mother to a nearby hotel to attend an Easter party. After the party the three of them went to a restaurant for dinner. When he and the other resident returned to the facility he said the nurse was very upset and made him feel like he 'committed a crime.' He said the nurse called the police and reported him and the other resident as missing persons. He said she yelled at him that he needed to sign out when he leaves the facility even though he had a four hour pass to leave the facility. He said the DON and NHA 'went crazy' when he got back. 2. Record review The progress note dated 4/20/19 at 12:00 a.m. and signed by the licensed practical nurse (LPN) read in pertinent part Resident #80 returned to the facility and was educated on signing out before leaving the facility and being back to the facility before midnight. It read Resident #80 understood and received his medication. The progress note dated 4/20/19 at 12:34 a.m. and signed by LPN #7 read in pertinent part Resident #80 was out on pass with his mother and had forgotten to sign out before he left. It read he barely made it back before midnight. 3. Police contact The NHA provided the facility's missing person report on 12/18/19 at 3:00 p.m. The missing persons report read that he went out on leave with his mother on 4/19/19. 4. Staff interviews The director of nursing (DON) was interviewed on 12/18/19 at 1:43 p.m. She said residents needed a physician order to leave premises. She said it was because some of the residents made bad decisions so they needed to have a pass. The admission director (AD) was interviewed on 12/18/19 at 2:23 p.m. She said there was no facility incident report or police report. The NHA was interviewed on 12/18/19 at 3:00 p.m. She said any resident who was out of the facility past the four hour allotted pass time was considered a missing person and the police would be contacted.

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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 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 42192 Based on observations and interviews, the facility failed to ensure the required list of names, addresses (mail and email), and telephone numbers of all pertinent state regulatory and informational agencies, resident advocacy groups such as the state survey agency, and the state ombudsman was posted. Specifically, the facility failed to post accurate state contact information and the state ombudsman contact information. Findings include: Observations The resident rights board was observed in the main hallway on 12/9/19 at 11:00 a.m. The Colorado state agency number was listed with no accompanying email or mailing address for filing a complaint. The number was called on 12/9/19 and led to the Colorado Department of Public Health and Environment (CDPHE) general line. The automated message went through all the departments of CDPHE, not including the nursing home complaint line or contact information. - The state ombudsman information was not updated to reflect the current ombudsman and their contact information. Resident group interviews A resident group interview was held on 12/12/19 at 11:00 a.m. with six alert and oriented residents selected by the facility to participate. They said they knew where the posted contact phone number was but no one had tried to call it. They did not know they could file a complaint with the state online or by mail. The residents reported knowing how to contact the city ombudsman but had not tried contacting the state ombudsman. Staff interview The assistant nursing home administrator (ANHA) was interviewed on 12/18/19 at 3:37 p.m. She said she did not know how often to update the posted contact information. She said she did not know what contact number was posted for the state only that one was posted. She said no residents had asked her for the information to contact the state.

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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** 42192 Based on observations and interviews, the facility failed to ensure that clean linens were available for resident use. Specifically, the facility failed to ensure that staff provided clean washcloths, bath towels and hand towels were available. Findings include: I. Lack of towels A. Observations On 12/10/19 at 11:12 a.m., room [ROOM NUMBER] did not have any towels. On 12/10/19 at 12:50 p.m., room [ROOM NUMBER] had no towels. On 12/10/19 at 12:57 p.m., room [ROOM NUMBER] had a wash cloth but no hand towels. On 12/10/19 3:24 p.m., room [ROOM NUMBER] had no towels. The following resident rooms were observed begining on 12/12/19 at 12:15 p.m. -room [ROOM NUMBER] had two residents resided in the room. The room had one towel rack and one washcloth. -room [ROOM NUMBER] had two residents resided in the room. The room had one towel rack and one dirty washcloth. -room [ROOM NUMBER] had two residents resided in the room. The room had no towels. -room [ROOM NUMBER] had no towels. -room [ROOM NUMBER] had two residents resided in the room. The room had one towel rack and no towels. -room [ROOM NUMBER] had one rack and no towels. -room [ROOM NUMBER] had two residents resided in the room. The room did not have a towel rack. One dirty wash cloth hung on the support bar. -room [ROOM NUMBER] had two residents resided in the room. There was one towel rack with no towels. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-room [ROOM NUMBER] had two residents resided in the room. The room had two towel racks, however one was broken. There was one dirty wash cloth which was hung on the non broken rack. -room [ROOM NUMBER] had two residents resided in the room. The room had one towel rack with no hand towels and one bath towel sitting on the sink. -room [ROOM NUMBER] had one dirty washcloth. -room [ROOM NUMBER] had no towels. B. Resident group interview A resident group interview was held on 12/12/19 at 11:00 a.m. with six alert and oriented residents selected by the facility to participate in the group. They said they had to ask for towels. Six of the six residents said they did not have towels in their rooms. The president of resident council said they were told they had to request a towel for the rooms. They said towels were not passed out daily. They said sometimes the staff could not give showers because there were no towels in the shower rooms. C. Resident interviews Resident #35 was interviewed on 12/12/19 at approximately 12:30 p.m. The resident said he was independent in his showers and there were times, he could not take a shower because there were no towels. Resident #72 was interviewed on 12/12/19 at approximately 12:45 p.m. The residents said she did not have towels in her room. She said that if she does get a towel it was a wash cloth. Resident #130 was interviewed on 12/12/19 at approximately 12:45 p.m. The resident said she does not ever have towels. She said she has to ask for towels. D. Staff interviews The laundry aide and laundry facility manager (LFM) were interviewed on 12/12/19 at 2:30 p.m. The laundry aide said the facility had a lot of towels to wash. She said the laundry was responsible for delivering the towels. She said the towels large shower towels were placed in the shower rooms and the linen closets along with wash cloths. The facilities manager said the towels were delivered to the residents but was not sure when or how often. The LFM said the facility had no hand towels only wash clothes and bath towels. He said there was no shortage of towels in the facility. The nursing home administrator (NHA) was interviewed on 12/12/19 at approximately 2:45 p.m. The NHA said the facility did not provide towels in the rooms unless requested, as there was only one towel rack in the room and it became an infection control issue. She said the residents had paper towels in the rooms. She said if the resident requested towels in the room, then it was put on the care plan. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Certified nurse aide (CNA) #10 was interviewed on 12/12/19 at 3:00 p.m. She said showers before breakfast were dificult to complete, as there were not always have towels then. She said towels were stocked in the linen closet and shower rooms around 8:00 a.m. every morning by the laundry staff. She said some residents have towels included in their care plan for daily delivery, otherwise, they were delivered when requested. She said the facility had never had hand towels. She said all of the residents have paper towel dispensers at their sinks. She said some do prefer regular hand towels and provide their own. Registered nurse (RN) #5 was interviewed on 12/12/19 at 2:55 p.m. RN #5 she said the body towels were small so it could take a few to do a shower. She said some residents used a lot of towels for showers. She said some mornings there were not any towels stock so we run out them. She said the facility never had hand towels.

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F 0600 Level of Harm - Minimal harm or potential for 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** 41034 Based on observations, record review and interviews, the facility failed to protect from and prevent abuse for one (#43) of eight residents reviewed of 56 total sample residents. Specifically, the facility failed to identify, monitor, investigate, and put person-centered interventions and effectiveness to protect residents from sexual abuse from Resident #43. Cross reference F 610 (Investigate/prevent abuse) Findings include: I. Facility Policy The Abuse Prohibition policy, revised 4/4/17 read in pertinent parts, (name of facility) will prohibit abuse, mistreatment, neglect for all residents . The policy defined abuse as the willful infliction of injury, unreasonable confinement, resulting in physical harm, injury and mental anguish. The policy further reveals it included verbal abuse, sexual abuse, physical abuse, and mental abuse, willful, as used in the definition of abuse, means the individual must have acted deliberately, not the individual must have attended to inflict injury or harm. II. Resident #43 A. Resident status Resident #43, age 84, was readmitted on [DATE]. According to the December 2019 computerized physician orders (CPO), diagnoses included unspecific dementia with behavioral disturbance and unspecified symptoms and signs involving cognitive functioning and awareness. The 9/23/19 minimum data set (MDS) assessment revealed the resident's cognitive status was severely impaired with a brief interview for mental status (BIMS) score of 0 out of 15. The resident walked independently. The resident required a one person assist with all activities of daily living including personal hygiene and dressing. The resident resided in the memory unit. The December 2019 CPO showed an order for Risperdal .5mg (11/15/19) with the associated diagnosis of dementia with sexual behaviors. B. Observations (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/19 at 11:19 a.m., Resident #43 was observed quickly pushing Resident #91, who utilized a wheelchair and was cognitively impaired and was unable to speak or stop Resident #43 from pushing her. Resident #43 pushed Resident #91 down a long hall to the last room on the hall that was unoccupied at the time. The certified nursing aides (CNA) #1 and #2 were in a room assisting another resident. When the CNA #1 came out of a resident room and saw Resident #43 pushing Resident #91 into a room. The CNA #1 was observed to run down the hall and stopped Resident #43 from shutting the door. The CNA #1 told Resident #43, you need to leave her (Resident #91) alone and go back to your room. The CNA #1 pushed Resident #91 down the main sitting area. Resident #43 walked after the CNA #1 to the main room. On 12/9/19 at 11:23 a.m., Resident #43 left the memory unit and was wandering down the connecting hallway. Resident #43 went into a female resident's room and was stopped by CNA#3. The CNA #3 was observed to tell Resident #43, you are not supposed to leave your unit and should not be in her room, the CNA #3 then prompted Resident #43 to return to the memory unit. On 12/9/19 at 11:25 a.m., CNA #3 walked Resident #43 back to his room. The Resident #43 left the room and walked behind the CNA. The CNA #3 told the registered nurse (RN) #1 that Resident #43 was out of the unit again. On 12/9/19 at 11:26 a.m. RN #1 stated, although the memory unit was not secure, the residents who resided in the memory unit were not to leave the unit and the staff were to guard the doors. RN #1 stated there were not enough staff, thus the residents would take advantage of moments when staff were busy preforming cares that required two staff members, and the residents would leave during these moments. RN #1 stated Resident #43 has left the memory unit at least three times that day, however, the other units knew to assist him back to the memory unit. On 12/9/19 at 11:28 a.m. Resident #43 was observed standing near the nursing station shaking Resident #75's wheelchair. The nursing station was located next to Resident #75 room. Resident #75 tried to push herself away from Resident #43's grip. The surveyor was standing next to the RN #1 as Resident #43 grabbed the surveyors breast. The Resident #43 said I want to make love to you and then tried to grab the surveyor again. The Resident #43 said I know you like it. RN #1 observed the behavior and responded, that he did this to everyone. RN #1 said she also been touched inappropriately by Resident #43. On 12/9/19 at 11:32 a.m. CNA #1 was bending over to adjust a wheelchair bag by the wheel. Resident #43 was observed with his hand extended reaching for CNA #1 as she bent forward. RN #1 ran to the resident and intervened and told the resident to not touch the CNA. On 12/9/19 at 12:35 p.m. Resident #43 was observed trying to enter into Resident #75 room. Resident #75, who spoke Korean, began yelling as Resident #43 tried to get past her into the room. Resident #75 who utilized a wheelchair, continued to yell and began to hit Resident #43 across the chest with the back of her hand. Resident #43 was redirected from the area by staff. Resident #75 continued to yell and point at Resident #43. Resident #75 tried to communicate with the staff about what had happened in Korean however, staff were not able to understand. Resident #75 was agitated and continued to yell while gesturing for a 5 minute time period. Staff walked away and began to work with other residents. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 was interviewed on 12/9/19 at 12:36 p.m. RN #1 said Resident #43 was fast, and that he touched other residents inappropriately on the buttocks and the breasts. RN #1 stated they did not track when the resident touched other on the buttocks or breasts as it did not fit the criteria of tracking for sexual inappropriateness. On 12/9/19 at 12:39 p.m., Resident #43 was observed to wander into a crowded area in the living room and approached Resident #73 with his hand extended, Resident #43 was observed to pat the buttocks of Resident #73. Resident #73 was startled and began to speak in Spanish at Resident #43 and began to shoo him away with hand gestures. Resident #43 was redirected from the area. C. Record review The 12/9/19 care plan identified, Resident #43 had a history of exhibiting verbal, physical, and inappropriate sexual behaviors related to, cognitive loss/dementia. The care plan further documented, Resident #43 has had episodes of agitation toward other residents and exhibiting sexually inappropriate behavior towards staff and other residents with difficulty being redirected. The interventions on the care plan documented, the nature and circumstances (i.e. triggers) of the physical behavior with resident examples which included being provoked, becoming defensive, purposeful, during specific activities, involvement of others, and patterned would be evaluated. The care plan documented, the behaviors would be discussed amongst the interdisciplinary team and adjust care delivery appropriately. The care plan also called for removing the resident from the area if necessary. The physician's progress note dated 11/18/19 documented, the resident was seen for an increase in physical and verbal sexual behaviors. The behaviors increased after a decrease in Risperidone, typically in the afternoon when he was most active. D. Known history of the inappropriate touching The nurse's note dated 10/11/18, documented, Resident #43 was continually inappropriately touching the CNAs buttocks and Resident #43 would say I bet you like that. The nurse's note dated 10/25/18 documented, Resident #43 Resident #43 wandered into another resident's room. The other resident began to scream and yell loudly at him. The note proceeded to document, Resident #43 then hit the other resident. The nurse's note dated 11/9/18 documented Resident #43 kept approaching another resident, even after reminders and redirections. The physician order dated 12/11/19 showed the residents Risperdal was discontinued and the resident was started on Paxil and Zyprexa. The nurse's note dated, 1/1/19 revealed Resident #43 attempted to enter another resident's room during the night. The resident saw him at the doorway and yelled at him to stop. Resident #43 then pushed the other resident down into their wheel chair. A CNA saw the altercation and helped Resident #43 back to his room and assisted him to bed. , The nurse's note dated, 1/31/19 documented, Resident #43 was observed to grab another resident's wrist tightly, not wanting to let her go. The CNA's had to separate the two. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated, 2/12/19, the note reveled an increase in wandering with difficulty redirecting and sexual behaviors towards other residents. The nurse's note dated 5/28/2019, documented Resident #43 continued to wander into other resident's rooms and had the potential to become agitated at times. The nurse's note dated, 5/31/19, documented, Resident #43 came out of room a few times during the night, not fully dressed. The CNA tried to assist Resident #43, however, he was aggressive and behavioral. After, several attempts of coaching and redirection he followed staff to put clothes on and assisted him to bed. The nurse's note dated, 11/14/19 documented, Resident #43 was observed touching other residents in a sexual manner. The note documented the resident had to be redirected with little success. The note further documented, Resident #43 continuously entered other residents rooms. On 11/18/19 in interdisciplinary team note revealed the resident had no noted behavioral non-pharmacological interventions in the last 30 days. On 11/19/19 in a progress it reveals Resident #43 was repeatedly wandering the halls and making sexual gestures towards other residents and staff members. The nurse's note dated, 12/9/19 the progress note documented the Resident #43 inappropriately patted another resident on the buttocks. On 12/9/19 the progress note revealed a clarification that the resident was tapping various bodies on the unit as he ambulated past, redirection usually effective. On 12/9/19 nursing documentation note reveals the Resident #43 displayed an inappropriateness a few shifts ago. The note further documents the Resident had a 1:1. On 12/10/19 nursing documentation note reveals the Resident #43 touched the sitter's breast and buttocks The facility documents they are going to put a male sitter in place. On 12/15/19 in a progress note it was documented the resident was given a shower by a female CNA and requested sex. E. Behavior tracking The physician's order dated, 3/30/18 the resident's interventions to be used were to be tracked for November and December 2019 for inappropriate sexual behavior. Although, the behavior tracking was completed on the following days, it did not track all the incidents which occurred throughout the two months. The tracking was as follows: -11/14/19 the resident had 12 incidents of inappropriate sexual behaviors. The intervention used was other. The tracking does not describe the incidents, or the interventions. The interventions were not tracked for effectiveness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11/27/19 the resident had eight incidents of inappropriate sexual behaviors. The interventions used were redirection, 1:1 staffing, return to room, and activity. The tracking did not describe the incident. The interventions were not tracked for effectiveness. -12/1/19 the resident had five incidents of inappropriate sexual behaviors. The interventions used were activity, return to his room, and using the toilet. The tracking did not describe the incidents. The interventions were not tracked for effectiveness. -12/3/19 the resident had one incident of inappropriate sexual behaviors. The interventions used were redirection. The tracking did not describe the incident and if the intervention was effective. -12/6/19 the resident had ten incidents of inappropriate sexual behaviors. The interventions used were to adjust the room temperature. The tracking did not describe the incident(s) and if the interventions were effective. -12/16/19 the resident had two incidents of inappropriate sexual behaviors. The interventions were to redirect. The tracking did not describe the incidents and failed to document if the interventions were effective. F. The resident was at risk for abuse Resident #43 was at risk for abuse as documented in the nurse's note dated,12/9/19 showed, Resident #43 was hit by Resident #75 when he tried to enter her room. G. Interviews RN #1 was interviewed on 12/09/19 at 12:35 p.m. RN #1 said Resident #43 required a lot of redirection and observation, as he would approach other residents and touch them on their bottom or other parts of their body inappropriately. She described the behavior as, pawing, petting and talking very crude. She said several residents would get angry at him and would attempt to hit Resident #43. RN #1said Resident #43 needed more activities and it would help him to keep busy. RN #1 said these were conversations she had, had with her unit manager and the director of nursing. RN #1 said she was unable to take breaks or her lunch, as she was worried about the CNAs being alone and not able to redirect the resident. CNA #2 was interviewed on 12/9/19 at 12:47 p.m. The CNA said stated they typically take Resident #43 with them from room to room as they perform cares on other residents and ask him to wait outside. CNA #2 said Resident #43's behavior was typical dementia behavior and she did not consider it to be sexual; including the use foul language, crude remarks, and touching others on their bottoms. CNA #2 said they would redirect him. CNA #2 said she had been touched by Resident #43 and it made her feel very uncomfortable. CNA #2 said she felt that added activities and walks could help Resident #43. CNA #2 said the sexual inappropriate touching happened about three times a week. CNA #2 said when behaviors occur, the CNAs were not responsible to track and document, they were trained to inform the licensed nurse. CNA #2 further revealed the resident's who resided on the memory unit were not capable to make safe daily decisions due to their cognitive status. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) was interviewed on 12/9/19 at 1:57 p.m. The NHA reviewed her files and said there were not any investigations for sexual abuse for the last three months for Resident #43. The NHA said she was the abuse coordinator. The director of nursing (DON) was interviewed on 12/9/19 at 2:38 p.m. The DON stated the memory unit where Resident #43 resided was not a secured unit. She said the residents were able to leave the unit if they wished, however, most of the residents wore a wander guard bracelet for safety. The DON stated the residents would stay in the unit or the staff would follow as they were at risk for elopement. The DON stated that Resident #43 wore a wander guard as he was at risk for elopement. She said she was aware Resident #43 would touch other residents and staff members on the bottom and breast. The DON stated he would also wander into other resident's rooms. The staff would redirect, however, most of the time he was easy to redirect. The DON said that Resident #43 touching breasts and buttocks of others was not included in the medication administration record (MAR) for sexual behavior monitoring. The DON stated patting buttocks or female resident breasts was not considered sexual abuse and therefore not tracked on the behavior monitoring. The only behavior they track would be Resident #43 pulling down his pants and showing his penis. The DON stated when Resident #43 touched breasts and bottoms it was care planed, but not investigated or tracked. The DON said there were different levels of sexual inappropriateness. CNA was interviewed on 12/10/19 at 10:50 a.m. The CNA who was assigned as a one on one with Resident #43 said the resident was fast, and would continually attempt to grab at her breasts and buttocks. She said she had been touched inappropriately by the resident on several times during her work day. The CNA said she told the unit manager that she would not stay in the room with him alone. The CNA said the resident would use offensive terminology when describing sex. She said she suggested to the unit manger only males work with the resident. The CNA said she was concerned for any female being alone with him.

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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** 42192 Based on interview and record review, the facility failed to have evidence that allegations of potential abuse involving one (#388) of four sampled residents were thoroughly investigated and failed to take steps to protect residents from further potential abuse. Findings include: I. Resident #388 A. Resident status Resident #388, age 75, was admitted to the facility on [DATE]. According to the computerized physician orders (CPOs), the diagnosis included Parkinson ' s disease. The 12/6/19 social services note revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The 12/1/19 nursing note revealed the resident required limited assistance with activities of daily living and was independent with locomotion around the facility in a wheelchair. B. Resident interview Resident #388 was interviewed on 12/09/19 at 2:21 p.m. She said one day the speech therapist was to sit with her in the dining room. She asked the resident to meet her there. She said a group of female residents joined her at the table. She said they told her she needed to move to another table because she was in someone else's spot. She said this upset her and she cried. She said the assistant nursing home administrator (ANHA) assisted her to another table and comforted her. She said a couple of days later she was in the library. She said a different group of female residents came into the library. She said she greeted them and continued to look through the books. She said the female residents walked in rudely and told her they were going to have a meeting in the library and she needed to leave. She said she left the library upset. She said as she left the library there was a man sitting in his wheelchair who was making fun of her Parkinson's movements. She said this made her more upset and she cried when she got to her room. She said licensed practical nurse (LPN) #5 comforted her in her room after this incident. She said as a result of these incidents she keeps to herself, eats in her room and focuses on her rehabilitation therapy so she can prepare for discharge. C. Record review A review of the progress notes on 12/15/19 revealed no progress notes about either incident experienced by the resident. D. Staff interview (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #5 was interviewed on 12/16/19 at 1:44 p.m. LPN #5 said she recalled the incident. She said she did console Resident #388 after her encounter in the library. She said the resident was in her room and looked upset. She said she asked her why she was upset and the resident told her what had happened in the library. She said she went to the library after the resident told her story. She said when she entered the library, there were no residents there so she could not verify her story. She said if she could have verified the event she would have done a progress note about the incident. She said she was not overly upset, however, she could not provide any additional information. LPN #5 said she did not report the incident to the abuse coordinator. The nursing home administrator (NHA) was interviewed on 12/16/19 at 2:00 p.m. The NHA said she had no abuse allegations reported by staff from Resident #388, therefore she had no investigations completed. The ANHA and NHA were interviewed on 12/16/19 at 5:50 p.m. The ANHA said she was the staff who comforted the resident in the dining room. She said the resident did not seem distressed or upset about being asked to move tables. She said she helped the resident to another table and left to help other residents. The NHA said she talked to the resident and LPN #5. She said the resident reported not being afraid or wary of going to areas of the facility. She said the resident was comfortable in the facility. She said the LPN #5 reported comforting the resident, and then went to the library to investigate and did not find anyone. She said since the nurse did not find anyone in the library to interview she did not write a note or tell anyone. She said the nurse comforted her and did not think any more of it. She said she felt it did not meet the regulation for verbal abuse because the male resident who was laughing was not making physical gestures towards her while laughing.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42193 Based on observations,interviews and record review, the facility failed to ensure that one (#22) of three reviewed for assistance with activities of daily living (ADL) received appropriate treatment and service to maintain or improve his or her abilities out of 56 sample residents. Specifically, the facility failed to provide proper nail care for Resident # 22; and meal assistance for Resident # 22. Findings include: I. Meal assistance A. Resident #22 Resident #22, age 94, was admitted on [DATE]. According to the December 2019 computerized physician orders (CPO), the diagnoses included advanced dysphagia (difficulty swallowing) and dementia. The 2019 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a mental status score of 3 out of 15 for the brief interview of cognitive status. She required extensive assistance with activities of daily living (ADL) including eating assistance and grooming care. B. Observations 12/11/19 noon meal --At 11:34 a.m., Resident #22 was observed sitting in the dining room awaiting her meal. --At 11:36 a.m., Resident #22 received a180 cc cup of milk. --At 12:03 p.m., the resident received her meal which was a philly steak sandwich and tater tots. In addition there was chicken noodle soup. --At 12:04 p.m., the resident tried to pick up her sandwich, however she could not get a good grip on it because it was not cut up. --At 12:07 p.m., the resident dropped her food before it reached her mouth. She had not received assistance or encouragement with eating. --At 12:10 p.m., certified nurse aide (CNA) #15 watched the resident struggle to get tater tots on her fork, but offered no assistance. --At 12:15 p.m,, the resident took a few bites of her tater tots using her fingers. The resident ate 15% of her food. She had not received assistance or encouragement with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--At 12:21 p.m., CNA #15 gave the resident one bite of food. --At 12:22 p.m., the resident was struggling to get a drink from a regular cup and she did not receive any assistance. --At 5:15 p.m., Resident #22 was sitting at her table awaiting her evening meal. --At 5:20 p.m., the resident received her meal. The meal included chicken, mashed potatoes and zucchini. --At 5:22 p.m., The resident was sitting alone at her table and did not eat any of her food. She received no eating assistance. --At 5:26 p.m., An unidentified CNA sat down with Resident #22 and helped her with eating her dinner. The CNA assisted the resident for the next 15 minutes. The resident had eaten 20% of her food.The CNA left the table.The resident took some drinks of her milk but did not eat any more food. --At 5:32 p.m.,the CNA returned to the table and assisted the resident out of the dining room. The resident was not encouraged to eat her meal, and was not offered any alternatives. 12/17/19 noon meal --At 12:17 p.m., Resident #22 was observed in the dining room after she received her meal. Resident was not using her lidded cup. Her regular cup was sitting on her plate of food. The meal was grilled cheese sandwich and a bowl of tomato soup. She was observed to drink approximately 135 cc of her coffee. The resident did not receive assistance with eating. --At 12:22 p.m., Resident #22 placed the soup bowl on her plate of food and drank from the soup bowl. --At 12:26 p.m., Resident #22 looked around the dining room and was not eating. She was not offered any eating assistance. --At 12:29 p.m., Resident #22 continued to not eat, and she was not offered any assistance. --At 12:31 p.m., CNA#15 served the resident a cup of cocoa. CNA #15 pushed the resident's lunch plate away from her. The CNA did not offer the resident an alternative meal replacement. --At 12:37 p.m., the resident took a sip from her cocoa cup. --At 12:39 p.m., CNA #15 sat down at the table with the resident and offered no assistance with eating. The CNA talked to the other resident at the table. She did not talk to resident #22. --At 12:40 p.m., the CNA assisted the resident out of the dining room. She had eaten 30% of her lunch. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. The care plan last updated on 10/8/19 identified the resident required assistance in the dining room with cueing and assistance at meals. The resident required assistance with her ADLs (Activities Of daily living) due to cognitive loss and dementia. The Kardex report dated 12/18/19 included that Resident #22 needed supervision and extensive assistance with eating.The kardex revealed that the resident required extensive assistance with grooming tasks at bed and sink level. The diet order and communication form dated 10/11/19 documented the resident needed assistance with dining and eating. Interviews CNA #13 was interviewed on 12/17/19 at 4:49 p.m. The CNA stated the resident was able to feed herself however, she required encouragment and cueing. II. Nail care A. Observations On 12/12/19 at 2:00 p.m., the resident was observed to have long fingernails approximately half an inch over her nail beds.There was a dark substance under her nails. On 12/16/19 at 4:42 p.m., Residents #22's fingernails remained long in length with a dark substance under her nails. Registered nurse(RN) # 5 observed the resident's nails. The RN confirmed the resident's nails needed to be cleaned and trimmed. The RN assisted the resident to her room to perform nail care. RN#5 soaked the resident's hands in warm water and then cleaned under the resident's nails. When she was finished, she trimmed the resident's nails and filed them.The resident was observed to be cooperative with nail care. B. Record review The care plan last updated on 10/8/19 identified the resident required assistance with her ADLs (Activities Of daily living) due to cognitive loss and dementia. C. Staff Interviews RN#5 was interviewed on 12/16/19 at 4:45 p.m. She said Resident # 22's nails should be cleaned during her showers and as needed. CNA #13 was interviewed on 12/17/19 at 4:49 p.m. The CNA said the resident needed assistance with all activities of daily living. The resident required extensive assistance with dressing, showers and eating assistance. The CNA said the resident was cooperative with care.

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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 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** 42192 Based on observations, interviews and record review the facility failed to provide person-centered activities for one (#46) of 11 of the 56 sampled residents. Specifically, the facility failed to provide person-centered activities for Resident #46. Findings include: Resident #46's status Resident #46, age 79, was admitted [DATE] and readmitted [DATE]. The December 2019 computerized physician order (CPO) diagnosis included legal blindness and colitis. The 9/24/19 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision and setup assistance with most activities of daily living (ADLs). The resident enjoyed listening to her books, television, and movies, spending time around animals, keeping up with the news, family visits and spending time outside during nice weather. Resident interview Resident #46 was interviewed on 12/9/19 at 11:03 a.m. She said the facility provided no activities for the blind. She said the facility did not offer her large print materials or read things to her that she had to sign. She said she went to the crossword group activity once. She said the facility staff read the crossword clue and the number of boxes for the answer. She said they did not give her enough time to answer. She said she got frustrated and stopped going. She said she only had her audiobooks for engagement. She said she missed doing crossword puzzles and watching television since her eyesight continued to deteriorate. She said she used to be able to read the daily newsletter with her magnifying glass but could not read it that way anymore. She said no one would take the time to read it to her when she asked. She said it felt like she had little input in the activities that interested her. Family interview The resident's family member was interviewed on 12/16/19 at 3:06 p.m. She said she felt her family member was not being provided enough activities to meet her needs. She said the facility told her she could not bring in outside services for her family members' blindness. She said any services brought into the facility had to be contracted with the facility. She said the facility did not offer the services and did not make efforts to obtain the services for her loved one. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan revised on 7/22/19 revealed the resident would engage in daily routines that were meaningful relative to her preferences. The goal included the resident would plan and choose to engage in preferred activities, television, audiobooks, and accept pet visits monthly through the next review date. Interventions included activities to assist the resident with her audiobooks and offer pet visits. The resident enjoyed listening to her books, television, and movies, spending time around animals, keeping up with the news, family visits and spending time outside during nice weather. The activity participation records for September, October and November 2019 were provided by the activities director (AD) on 12/17/19. The records revealed independent engagement in listening to audiobooks, relaxing, pet visits, socializing and phone calls. The records did not document activity staff offering the resident to engage in current events group, going outside, community outings or group games or specific accommodations made for the resident's visual deficit. Staff interview The AD was interviewed on 12/17/19 at 1:03 p.m. She said that the activities offered were for sensory stimulation and accommodated visually impaired residents. She said the activity staff read out loud the crossword puzzle and had staff to assist with bingo. She said Resident #46 primarily relied on her talking books. She said even when the resident was invited to activities she refused. She said the resident refused groups saying she was blind and she would not be able to participate in them anyway. She said the resident did receive pet visits and family visits. She said the resident had not mentioned wanting the chronicle (newsletter) read to her in the morning. She said the only time the resident asked for assistance with reading materials was when she got a personal card in the mail. She said the activity staff made accommodations for visually impaired residents. She said the facility obtained bigger whiteboards and projectors for the crosswords to make them bigger. She said the only sensory activity done with the residents outside the memory unit was the fingernail group and flower arranging. She said there were residents who received one-to-one room visits. She said activities staff would go talk with residents bringing reading materials and other things the residents were interested in.

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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** 20287 Based on observations, record review and interviews, the facility failed to ensure one (#19) of four residents who entered the facility with limited mobility and range of motion 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 56 sample residents. Specifically, the facility failed to ensure: -Resident #19 received restorative services to prevent potential worsening of contractures. -Resident #19 received passive range of motion (PROM). Findings include: I. Facility policy and procedures The facility policy titled Restorative Nursing Care Delivery Process revised August 2016, Model B Integrated Restorative Nursing Program read restorative care is integrated into daily care assignments and all CNAs can carry out restorative interventions with specific training/instructions regarding the patient's program. The policy also read, patients should be evaluated for a restorative program including those who have been identified as having a decline in ADLs, decline in range of motion (ROM), recent falls, contractures, and bedfast patients. A. Resident #19's status Resident #19, age 61, was admitted on [DATE]. According to the December 2019 computerized physician orders (CPO) diagnoses included persistent vegetative state, contracture, quadriplegia, and type II diabetes mellitus. The most recent minimum data set (MDS) assessment dated [DATE] revealed that a Brief Interview for Mental Status (BIMS) was not conducted, nor was a staff assessment for mental status conducted. The resident was coded as total dependence with all activities of daily living. The resident was coded as having impairment for upper and lower extremity ROM on both sides with no range of motion services. 1. Observation The resident was observed on 12/9/19 at approximately 3:00 p.m. The resident was lying on his back. The resident was unresponsive when spoken too. 2. Record review (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan last revised on 12/4/19 identified the resident was at risk for alterations in functional mobility related to contractures, muscle spasms, and a diagnosis of persistent vegetative state. Pertinent interventions included bilateral palm protectors to be worn at all times with the exception of hand hygiene and bathing; provide positioning and support of affected limb; reposition frequently and PRN (as needed). The care plan for resident #19 did not specifically address the resident's diagnosis of contractures The activities of daily (ADL) living care plan for resident #19, revised on 12/18/18 did not include a goal or interventions for restorative services or PROM. The December 2019 CPO for resident #19 did not show any orders for PROM or restorative services. One progress note for resident #19 dated 12/12/19 read external device removed and site inspected. Removable hand protectors in place. Skin intact underneath. Hands contracture bilaterally . The December 2019 MAR documented, the palm protectors were in his hands. However, it did not show evidence PROM was completed on his bilateral hands. The medical record failed to show the resident was on a restorative program and that PROM was completed on his upper and lower extremities. 3. Interviews Registered nurse (RN) #6 was interviewed on 12/17/19 at approximately 2:00 p.m. The RN said the resident was unable to move on his own. She said that he wore the palm protectors in his hands to keep his hands safe from injury. She said his hands were cleaned daily. She said the range of motion was to be completed by the certified nurse aides, but no specific program. She said he would benefit from a restorative program. The director of nursing (DON) was interviewed on 12/18/19 at 3:10 p.m. The DON said at one point in time he was on a restorative program, however, no longer. She said he was bed bound and he was unable to move any of his body on his own. She revised the medical record and confirmed there was no documentation that PROM was completed. She said the restorative program got discontinued for Resident #19 on 3/24/19. She said he would benefit from a restorative program. The DON said the restorative program which was used was the model B, where the certified nurse aides completed the range of motion. The DON said the limited range of motion should be on the care plan.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 29594 Based on observations, record review and interviews the facility failed to ensure the resident environment remained as free of accident hazards as possible, and that each resident received adequate supervision and assistive devices to prevent accidents. This failure affected one (#33) of 56 total sample residents. Specifically: Falls -The facility failed to protect Resident #33 from numerous falls which resulted in major injuries. Equipment -The facility failed to ensure space heaters were not used in resident areas. -The facility failed to ensure medical devices were not plugged into non-medical grade power strips. Findings include: I. Falls A. Immediate jeopardy 1. Situation of Immediate Jeopardy Resident #33, age 57, was admitted on [DATE] with a readmitted [DATE]. According to the December 2019 computerized physician orders (CPO) the diagnoses included, essential (primary) hypertension, type 1 diabetes mellitus with hyperglycemia, traumatic subdural hemorrhage with loss of consciousness of specified duration, muscle weakness, unspecified lack of coordination, cognitive communication deficit, fracture of unspecified part of the body left mandible, subsequent encounter fracture with routine healing, fracture of unspecified part of the body right mandible, subsequent encounter fracture with routine healing. The 9/18/19 minimum data set (MDS) assessment revealed the BIMS interview could not be conducted because the resident was rarely to never understood. He required extensive assistance from one person for bed mobility, dressing, toilet use, and personal hygiene, extensive assistance from two people for transfers, was totally dependent with eating, and was not walking (used a wheelchair). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/17/19 at 11:46 a.m., the nursing home administrator (NHA) was notified Resident #33 sustained 26 falls within five months with major injury, which included, numerous major injuries which included, head trauma, bone fractures, lacerations, and black eyes. Resulting in a significant cognitive and mobility decline with a recent diagnosis of traumatic brain injury (TBI). These failures created a situation of immediate jeopardy. The facilities response was as follows: Resident (#33) was placed on 1:1 for monitoring of intervention effectiveness on 12/17/19 at 11:50 a.m. 1:1 to use call light and or ask floor staff for coverage when a break is needed. These interventions were implemented on December 17, 2019. - Physician order for Hospice Consult 12/17/2019 -Restorative Nursing Plan ordered/implemented, stand pivot transfer assist to promote upright functional mobility. Assist with ambulation as tolerated using walke-6 times/week for 15 min. Restorative Nursing Program to be completed by CNA (certified nurse aide) and monitored by DON (director of nurses). -Vitamin D B-12 Level (Drawn 12/17/2019 WNL (within normal limits) -Motion Lights placed in room to improve lighting and behaviors due to impulsivity on 12/17/2019 -Binder with the following information has been presented to staff with education. The binder is kept in the residents room. Behavior Modification Techniques Likes/Dislikes pulled from care plan: -Likes: Reading the newspaper, walking, lavender oil, hip hop on his phone, going outside, watching TV, snacks, enjoys comedies and National Geographic -Dislikes: close supervision, group activities, helmet -New staff will be educated during orientation to the floor. Education initiated by the DON on 12/17/19 to include but not limited to floor staff. Training to include residents fall mitigation efforts to reduce injury. Continue to participate in Pet visits as scheduled and resident allows, at least weekly. -Knee pads, elbow pads and a variety of helmets for the resident to choose from offered and accepted. Residents requests items to be removed and they are removed when requested. Offer to resident every shift. CNA will document in POC refusal or acceptance under the Task tab. -Use a soft approach soft tone of voice, talk slowly in short simple sentences re-approach later -Monitor and track hours of sleep -Room de-cluttered, padding added to the sink and bed board. Excess furniture removed and TV hung on the wall to attempt to reduce major injury with fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Monitor and report changes in alertness, attention, sleep patterns, behavior, or mood to physician, DON and CED (center executive director/ nursing home administrator). -Basil plant given to resident with scheduled watering times. Interviews initiated by DON or designee with staff on the resident's unit. Questions targeted to assess the effectiveness of interventions, gain information related to residents needs for direct care staff and to implement appropriate newly suggested interventions. 1. What interventions do you feel are working to prevent falls? 2. What fall interventions are not working. 3. What suggestions do you have to prevent falls. 4. Have you received enough education related to fall interventions. -Physicians will continue to evaluate the need for additional interventions to assist in preventing falls with major injury. -On December 17, 2019 the team held an Immediate QAPI meeting to identify any root cause or trends for resident falls. Incidents reviewed to include activity during fall, staff interviews, time of day and number of falls and effectiveness of current interventions. Trend identified for two times frame, scheduled timed toileting was added at 1400, 2200, 0600. Scheduled water times for plan on Tuesday/Friday at 1600. CNA Fall Care communication tool was developed 12/17/2019. -Nurses will monitor completion of documentation, intervention appropriateness/effectiveness each shift, to be reviewed by the IDT (interdisciplinary team) . 2. Based on review of the facility's removal plan, observations and record review, the NHA was informed the Immediate Jeopardy situation was removed on 12/18/19 at 11:00 a.m. However, deficient practice remained at a G level. The NHA said the abatement plan interventions had been implemented as of 12/17/19 after the immediate jeopardy was called. B. Facility Policy The fall policy dated 3/15/16 documented in pertinent parts, .Patients will be assessed for fall risks as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Patients experiencing a fall will receive appropriate care and investigation of the cause Communicate patients fall risk status to caregivers, Develop individualized plan of care, Review and revise care plans regularly Conduct Interdisciplinary team meeting with 72 hours of falls The Center Executive Director (NHA) and Center Nurse Executive (director of nurses) will conduct a post fall review . II. Resident #33's- multiple falls with major injury The nurse's notes, interdisciplinary team (IDT notes) event summaries and care plan were reviewed. The medical record documented the resident had fallen at least 25 times between 7/11/19 and 12/15/19. The facility failed to protect the resident from multiple falls, and two falls resulted in major injuries, and ten with minor injuries and 13 falls with no injuries. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Although an event summary report was completed on the falls, the facility failed assess and implement effective fall interventions and re-evaluate the fall interventions after a fall for effectiveness. The facility failed to investigate to identify root cause of falls to determine trends then modify the fall interventions and failed to provide adequate supervision to prevent further falls and/or further injury from frequent falls. As a result the resident sustained numerous major injuries which included, head trauma, bone fractures, lacerations, and black eyes. Resulting in a significant cognitive and mobility decline with a recent diagnosis of traumatic brain injury (TBI). Although, the 25 (no event summary completed for 8/20/19) event summary reports were completed, and had a root cause conclusion, the reports documented the events of the falls and poor safety awareness and did not have a root cause. On 9/4/2019 at 4:39 p.m. the physician progress note documented in pertinent part: . the resident was alert, with no acute distress, his jaw wired shut, and he was unable to verbalize and has a bruise over the left eye. (Traumatic brain injury) TBI without LOC of unspecified duration sequelae. Given the patient's fall history over the past year, I think he has sustained enough head trauma and accumulated enough injury to be consistent with traumatic brain injury. His personality and decision-making capacity certainly is impaired compared to 6-12 months ago. I discussed this with the NP as well as nursing and the patient's mother. I think the patient has sustained significant brain trauma that has led to at least a mild cognitive deficit . Prior to the falls with major injuries which occurred on 8/20/19 the resident experienced two falls with minor injuries, and three falls with no injury. The resident experienced six falls with minor injuries and five falls prior to the second fall with major injury on 9/19/19. The falls with major injuries were as follows: 1. Major injury fall #1 -On 8/20/19 the IDT progress note documented, social services director (SSD) received call from a nearby medical office that Resident #33 stopped in the medical office and did not feel well. The medical office said called the facility to report that Resident #33 had fainted face first to the floor, and as a result suffered a laceration to the front and back of his head and appeared to have broken teeth. The resident was sent to the emergency room . -On 8/24/19 the progress note documented the resident was readmitted to the facility after a stay in the hospital for post/trauma/accident. The resident had a fracture of mandible fracture and a subdural hematoma. His jaw was wired shut. The medical record failed to show an event summary report was completed in relation to this fall in order to identify root cause, and to evaluate interventions. 2. Major injury fall #2 On 9/19/19 at 9:26 p.m., the resident experienced a fall with the one to one sitter. The progress note documented the resident was agitated. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/19/19 at 7:05 p.m., the event summary report documented, the agency CNA stated that she stood up to call a facility aide to relieve her, and the resident stood up to follow her and fell forward onto the floor. The resident injured his knees and elbows bilaterally. The report documented the interventions which were in place prior to the fall were as follows: - Medications reviewed by NP and dose adjustments were made to his insulin and B/P medications. -Monitor vital signs, including orthostatic B/P as needed and report to MD as indicated. -NP reviewed medications and made adjustments with his insulin and B/P medications. -Offer/assist resident with urinal/commode as requested/needed. -Staff continue to remind him to ask for assistance. -Utilize night light in the room/bathroom. -Medication evaluation as needed. -Place call light within reach when in bed or close proximity to bed. -Resident had one on one supervision. After the fall an x-ray was ordered, as the resident was complaining of pain. The report documented, the resident refused all the imagining to be completed and he was sent to the emergency room for evaluation. 3. A summary of the falls with minor injuries were as follows: --On 7/11/19 at 1:30 p.m., the event summary report documented, the resident was in the lobby, he stated he was sitting for about 15 minutes, stood up and started walking. He got dizzy and fell to his knees. The resident's blood glucose (BG) level was 358. He was assisted back to his room. The neurological check (neuro checks) and assessment were completed. The report documented the preventative measures which were in place prior to the fall were call light and personal items were within reach, and room was clutter free. The resident experienced an abrasion to bilateral knees. The corrective action was the resident had a history of dizziness, and had been instructed not to ambulate (walk) self or go outside. The resident was impulsive. The progress note at 3:07 p.m. read in pertinent part, Orders obtained include: assist resident to his room and encourage him to use call light for assistance . -On 7/26/19 (no time indicated), the event summary report documented, the resident was noted to be walking outside the facility this shift. Resident traveled to Target shopping center where two employees discovered the resident. Resident returned to the facility via employee transportation. Resident #33 stated the scraps and cuts on his right knee and right palm of hand, came from a fall in the parking lot. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 7/26/19 at 1:35 a.m., the event summary report documented, the resident was observed on the floor next to bed. The resident received a 3 cm laceration to the back of the resident's head and abrasion on his left elbow. Resident had regular socks on at the time of the fall. The resident was educated to use the call light when trying to go to the bathroom. Non-slip socks were placed on the resident. Preventative measures were put into place prior to the fall included, call light and personal items within resident's reach and clutter free environment. - On 9/2/19 at 1:00 p.m., the event summary report documented, the resident was found on the floor face down. The resident was assisted into a chair then assessed by the licensed nurse. The resident had hit the back of his head (soft bump noted). The report documented a meeting was to be scheduled with the family to discuss his multiple falls. -On 9/5/19 at 2:15 p.m., the event summary report documented, the primary nurse reported that the resident had a fall in his room and sustained lacerations on his forehead. The nurse practitioner ordered STAT x-ray of the c-spine and skull. Resident #33 said he was trying to pick up the TV remote and he fell . --On 9/5/19 at 4:25 p.m., the event summary report documented, NP had just finished speaking to the resident regarding increased recent falls and she was standing at nurse's cart when NP and RN heard a loud crash from the resident's room. When they entered his room they found him lying face up on the floor, unresponsive. Resident had a heartbeat with agonal breathing. Staff assisted the resident with breathing via ambu bag and called 911. Resident was responsive, breathing independently and able to answer questions when emergency medical services (EMS) arrived. Resident transported to ER for further evaluation. -On 9/11/19 at 12:28 a.m., the event summary report documented, the resident was wheeling himself around the unit, he stood up, resulting in a fall and landed on his right elbow. Resident reported pain in his elbow and it was red. He was able to move all extremities. A STAT x-ray of elbow was ordered due to pain. Resident continued to try and stand even when educated that he was too weak. The license nurse and certified nurse aide (CNA) were taking turns with 1:1 attention for the resident. -On 9/18/19 at 1:30 a.m., the event summary report documented, the resident was found on the floor of his room. He had bleeding to his upper eye from the previous fall. The resident had fallen the previous day on 9/17/19 at 9:15 a.m., by rolling out of bed. He said he wanted to get into his wheelchair. -On 9/19/19 at 6:30 p.m., the event summary report documented, the resident was transferring from his wheelchair to bed, and threw himself backwards onto the bed, striking his head on the door handle of the door. The incident was witnessed and he had a bump on the upper back of his head. -On 12/10/19 at 5:00 a.m., the event summary report documented, the resident was noted to be on the floor in his room. Resident said he hit the back of his head. The report documented, the care plan was followed. The interventions put into place was to attempt to assist the resident out of bed as early as possible when he awakes. IV. Resident fall history after 9/13/19 Abbreviated survey (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 9/13/19 during an abbreviated survey, the facility was cited for F 689 at a harm level; upon exit (9/13/19) until compliance (10/7/19) Resident #33 also sustained two falls (see above). After the facility was back in compliance the resident sustained: - On 10/19/19 at 2:00 p.m., the event summary report documented, the resident was sitting in his geri-chair when he told the sitter he had to go to the bathroom. The sitter was positioned in front of the chair, she turned slightly to unplug the tube feeding (TF), he then stood and slid to the floor. He did not hit his head. - On 10/28/19 at 7:15 p.m., the event summary report documented, the sitter informed the nurse while the resident attempted to ambulate independently after sitting up in bed; the resident was unsteady and fell back onto the bed. - On 11/28/19 at 4:00 p.m., the event summary report documented, the resident had an unwitnessed fall and was found on the floor in the library room. The report documented no injury. - On 12/6/19 at 4:00 p.m., the event summary report documented, the emergency bathroom light came on in the residents room. The resident was found in the bathroom between the toilet and the wheelchair (w/c). The w/c brakes were locked. The resident was sitting on the floor facing the wall with his pull-ups and pants just above his knees. He was not able to tell the nurse what had happened. He had rapid respirations and was wide eyes as if very frightened. The resident experienced a second fall on 12/6/19 at 8:15 p.m., the resident fell while trying to stand up in the dining room. Resident #33 became agitated with staff when attempting to redirect. - On 12/10/19 at 10:50 a.m., (second fall for the day) the event summary report documented, the resident was in the hallway, and was seen holding onto the rails with buttocks on the floor, w/c behind him. A CT-Scan was ordered for his head. -On 12/15/19 at 8:40 p.m. the event summary report documented, the resident self propelled in w/c, closely monitored by nursing staff. During the end of shift reported the resident rolled around the corner to another hallway away from nurses. Residents in the atrium hollered to get the nurses attention that the resident was on the floor. Resident noted on the floor with mild twitching lasting approximately 30 seconds. Once eyes opened, they were slow to respond. Pupils sluggish and unchanged. V. The facility failed to implement effective fall interventions and re-evaluate the fall interventions after a fall for effectiveness. The director of nurses (DON) was interviewed on 12/17/19 at 9:45 a.m. The DON said that after each fall the care plan was updated. She said the care plan was updated to include, how and when the resident fell , then the interventions were listed. She said the resident had experienced so many falls, that the program had a difficult time with keeping all of the information. The care plan last updated, on 12/10/19 identified the resident was at risk for falls related to experiencing dizziness, diabetes mellitus (DM) with uncontrolled blood sugars (BS). The resident was ambulatory with poor safety awareness and impulsiveness. The care plan was updated with dates and interventions after each fall included: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Utilize night light in the room/bathroom. 7/29/19 -Medication evaluation as needed. 7/29/19 -Place call light within reach, anticipate resident's needs as he may not use the call light related to the decline in cognitive status. 7/29/19 -Maintain a clutter-free environment in the resident's room and consistent furniture arrangement. 7/29/19 -When the resident is in bed, place all necessary items within reach. 7/29/19 -Monitor for and assist with toileting needs. 7/29/19 -Encourage resident to attend all activities that maximize their full potential while meeting their need for socialization. 7/29/19 -Monitor vital signs including orthostatic blood pressure as needed and report to MD. 7/29/19 -Offer/assist the resident with the urinal/commode as requested/needed. 7/29/19 -Assess for changes in medical status, pain status, mental status and report to MD.7/29/19. -NP reviewed medications and made adjustments to his insulin and B/P medications. 8/12/19 -Medications reviewed by nurse practitioner (NP), dose adjustments made to insulin and blood pressure (B/P) medications. 8/18/19 -Resident has a history of dizziness and falling, staff continue to remind the resident to ask for assistance. The resident is impulsive and continues to transfer on his own. 9/6/19 -Resident was placed in a recliner in the atrium for closer supervision. 9/10/19 -Resident has refused therapy, will try again and see if he will participate. 10/19/19 -Soft helmet related to recent fall and impulsiveness. Therapy to address fall. 10/29/19 -The wheel chair cushion was re-evaluated with the second fall.12/10/19 The facility failed to show that the interventions were evaluated for effectiveness, and were timely. The interventions in the event summary report, had listed, he was reminded to use the call light and to wait for assistance, however, this intervention proved to not be effective as he continued to fall 23 more times since the intervention was put into place. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The intervention of encourage resident to attend all activities, was added to the care plan however, according to the interview with the nursing home administer on 12/17/19 at 3:45 p.m., the resident did not like to attend group activities. Review of the activity participation records for November and December 2019 showed he did not attend activities that he preferred in room activities. The regional nurse consultant said on 12/17/19 at 3:45 p.m., he was being evaluated for pet therapy as he liked dogs. The resident was observed on 12/10/19 at 3:21 p.m. in his room with a 1:1 CNA. They were sitting in the room, not engaged in any interactions, i.e talking or other activities. The resident began moving his feet back and forth, the CNA got up and took him to the bathroom. Afterwards, they returned to where they were sitting previously. They remained in the room until 4:06 p.m. The CNA took the resident out of his room and walked around the unit. The intervention of resident refused therapy was added on 10/19/19 and that they would attempt again if he would participate. However, the facility was aware he was not wanting to participate in therapy according to the interview with the NHA on 12/17/19 at 3:45 p.m. The NHA said the resident was referred to therapy 13 times and he refused nine times and worked with therapy five times. The intervention with soft helmet was added on 10/29/19, however, he had 20 falls prior to the soft helmet addition on the interventions. The summary event reports showed he had eight unwitnessed falls, and eight falls which resulted in a head injury or report that he hit his head. The remaining four falls were witnessed and staff reported he did not hit his head. The NP was interviewed on 12/17/19 at 12:50 p.m. The NP said the resident did not like to wear the soft helmet and he would throw it across the room. The event summary reports were reviewed and none of them reported the soft helmet was on when the resident sustained falls and injuries. The NHA was interviewed on 12/17/19 at 3:45 p.m. The NHA said the resident was always walking, and enjoyed going outside to walk. She said he was difficult to keep sitting, as he always enjoyed walking. The facility failed to include the resident in a restorative walking program. The medical record showed no evidence the resident was on a restorative program which would have allowed the resident to safely engage in an activity he enjoyed. The care plan failed to include, from the event summary report on 12/10/19 showed the interventions put into place after the fall was to attempt to assist the resident out of bed as early as possible when he awakes. VI. The facility failed to ensure the certified nurse aides and the licensed nurses were aware of the plan of care Observations On 12/16/19 at 9:45 a.m., the registered nurse (RN) #3 was observed to keep the resident near the nurses cart. She was observed to pass medications to other residents. When she would leave the cart to go to another resident room, she would push the resident to the room and have him sit outside the room while she cared for the other resident. On 12/16/19 at approximately 4:00 p.m., the certified nurse aide was sitting with the resident. The CNA said he was on a one to one sitter with Resident #33. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	VII. Interviews RN #3 was interviewed on 12/16/19 at 9:43 a.m. she stated she was pretty much 1:1 with him. She said she wasn't sure if there was an order or not but he would get up and fall. RN #3 said she tried to keep him close. She said she had him sit at the cart while she went into other rooms so he could be close to her The director of nurses (DON) was interviewed on 12/17/19 at 9:45 a.m. The DON confirmed the resident had fallen 26 times since July 2019. She said an event summary and fall investigation should be completed after each fall. She said interventions should be implemented and added to the care plan after each fall. She said when the IDT reviews the falls then the IDT team will add more interventions as needed. She said she keeps a log of all falls, however, she does not have any information from July 2019 to September 2019. She said a unit manager was keeping the log and she could not find the information. She said she took over monitoring the falls in September 2019. She said a fall investigation should have been completed when he fell outside of the facility. The DON said Resident #33 had a sitter since September 2019, however, she said it was discontinued in early November 2019 as the criteria to use a one on one sitter was to prevent falls, however, he had three falls with the one on one sitter, and the IDT reviewed the falls and determined to remove the one on one sitter, and just keep an eye on him. She said the NP reviewed the medication on 8/14/19. She said the soft helmet was added to the care plan 10/29/19. The DON said in July 2019, he was alert and oriented, and he has now had a significant change in his cognitive status. She said it was a combination of falls and diabetes. The DON said the NP said that he had a traumatic brain injury. The DON said the logs were used to track and trend, however, she confirmed she only had the logs since September. She said most of his falls were in his room, but she was not sure of the times he fell . The medical director was interviewed on 12/17/19 at 12:50 p.m. The MD said earlier in the resident's stay at the facility he had been the primary physician. He said he was aware the resident had sustained numerous injuries, which included bone fractures and head trauma. He said Resident #33 had been discussed at the quality assurance performance improvement (QAPI) meeting and the falls were unresolvable until his condition worsened. He said the sitter was unsuccessful as the resident became angry. He said the resident had lost all muscle tone and when he stood up he fell . He said there was nothing more they could do to keep him from falling. He said if there was anything that could prevent him from falling, it would of been added a year ago. The MD said the facility could not be held accountable for keeping people safe when they made poor decisions. The primary physician (PP) was interviewed on 12/17/19 at 12:50 p.m. The primary physician heard the medical director's reasons for the falls and then replied the resident had type one diabetes and he also had a condition that his blood pressure dropped when he stood. The tachycardia could contribute to passing out. He said the resident was extremely brittle diabetic. His blood sugar was difficult to regulate. The primary physician confirmed the resident had sustained subdural hematomas as a result of hitting his head. He said the resident had poor judgement. The primary physician said the resident had fallen when he resided at an assisted living prior to moving to the facility. The PP said short of chemically restraining the resident he was not sure what else could be done. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The NHA was interviewed on 12/17/19 at 3:45 p.m. The NHA said while he had the sitter, he would become agitated and did not like the sitter. She said the resident was not on a one to one sitter prior to the immediate jeopardy at 11:50 a.m. She said the staff take it upon themselves to keep him on a one to one, because they know he has had multiple falls. He liked to go outside and he wears a wander guard as he did not sign out like he should. She said the only resort they had to keep him safe was restrain him. She said the family was pleased with the care and had no suggestions. 20287 IX. Space heaters A. Observations On 12/9/19 at 12:00 p.m., residents were observed in the main dining room awaiting their meal. The dining room had three space heaters which were spread across the dining room. The space heaters were currently being used. On 12/9/19 at 2:00 p.m., room [ROOM NUMBER] had a space heater. The resident was in her room lying in bed. B. Interviews The MTD was interviewed on 12/9/19 at 4:50 p.m. The MTD said that the space heaters had been in the building since the day after Thanksgiving. He said the circle pump on the was being replaced as it was not pumping hot water through the furnace. He said the parts had been ordered, but the space heaters four in the dining room were being used and one in 801 and one in 1202. He said that the main dining room was cold and therefore the space heaters were requested to assist in warming the dining room. The MTD said the space heaters did not have breakers on them, so the nurses were responsible to turn them off and on. He said he knew the facility was prohibited from using space heaters. The nursing home administrator (NHA) was interviewed on 12/9/19 at 5:07 p.m. The NHA said she knew she could not use space heaters in the facility, however, she would rather use the space heaters, then have the resident ' s be cold or to infringe on their rights to move. She said she would rather take a citation then let the residents be cold. The NHA said she would not have the space heaters removed. C. Follow-up On 12/9/19 at approximately 7:00 p.m., theNHA had the four space heaters in the dining room and three space heaters removed from resident rooms, including room [ROOM NUMBER]. 42161 X. Failed to ensure medical devices were not plugged into non-medical grade power strips. A. Environmental tour and staff interviews (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/12/19 at 9:00 a.m. and on 12/16/19 at 2:30 p.m. the following observations were made of medical equipment being plugged into non-medical grade power strips: - Rooms #1105, #1208, #1204 and #1510 the oxygen concentrators were plugged into power strips. - room [ROOM NUMBER] the continuous positive airway pressure (CPAP) machine was plugged into a power strip. - room [ROOM NUMBER] the bed and oxygen concentrator were plugged into a power strip. - room [ROOM NUMBER] the gastric tube feeding dispensing machine was plugged into a power strip. The environmental tour was conducted with the maintenance director (MTD), his assistant the maintenance worker (MW) and the housekeeping manager (HM) on 12/16/19 at 2:30 p.m. The MTD said medical equipment could not be plugged into power strips and only plugged into the wall. He said some of the rooms needed more power outlets installed and since there were not enough outlets some of the families and residents were plugging the medical equipment in the power strips. The MTD, MW and HM were observed unplugging the medical equipment and plugging it into the walls in rooms #1105, #1208, #1204, #1402, #1509 and #1510 as they were being shown the concerns during the tour. In room [ROOM NUMBER] the MTD said he wanted to communicate with the floor nurse for a safe ti [TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observation, interviews and record review, the facility failed to manage pain in a manner consistent with professional standards of practice for two (#66, and #53) out of five sample residents out of 56 total sampled residents. Specifically the facility failed to complete a thorough pain assessment for Resident #53 and #66. Findings include: I. Facility policy and procedure The pain policy and procedure was revised on 11/1/19. It documented that patients were evaluated as part of the nursing assessment process for the presence of pain upon admission/readmission, quarterly, with change in condition in pain status, and as required by the state thereafter. The facility used pain management that was consistent with professional standards of practice,the comprehensive person-centered care plan,and the patient ' s goals and preferences was provided to patients who required such services. II. Resident #53 Resident #53, age 90, was admitted on [DATE]. According to the December 2019 computerized physician orders (CPO) diagnoses included, hypertension, major depression and osteoarthritis. The minimum data set (MDS) assessment dated [DATE] showed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15.The resident required supervision with mobility and transfers.He was independent with locomotion, dressing and eating. The MDS coded the resident as having experienced pain in the past five days.The pain had affected his day to day activity.The pain was coded as being frequent. A. Resident interview The resident was interviewed on 12/10/19 at 10:56 a.m. The resident said he had pain in his knees and that the pain level was at 7 the majority of the time. He said he needed a knee replacement, but because of his age, it was not going to occur. The resident said that he received Tylenol, but that was not good enough. He said no non-pharmaceutical was tried. He said he wakes up at 2:00 a.m., and then he lays in bed awake. The resident was interviewed a second time on 12/17/19 at approximately 4:00 p.m. The resident said his pain tolerance level was 4 out of 10. He said that he was often at a 7 out of ten.He said he would really appreciate some non medication approaches, as he did not want to increase her narcotic usage. B. Pain management plan (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CPO included an order for the resident's pain to be evaluated every shift starting on 12/11/17 using a pain scale of 0-10, and to document on the medication administration record (MAR). The resident's December 2019 CPO and recent physician telephone orders revealed current orders for pain control include: -Gabapentin Capsule 100 mg give 200 mg by mouth three times a day for osteoarthritis and neuropathy -Hydrocodone-Acetaminophen tablet 5-325 mg every eight hours as needed for pain -Tylenol 500 mg give 1000 mg three times a day for pain The medical record failed to show any non-pharmaceutical interventions were prescribed or used for the resident. C. Pain assessment The most recent pain assessment was completed 9/4/18 over a year ago and it failed to completely and accurately assess the resident's pain level. The pain assessment documented the resident was able to indicate the location and characteristics of his pain. However, the assessment did not show that the location, or the characteristics of the pain were assessed.The acceptable level of pain on the assessment was seven. However, the MAR documented the resident as having a level of four without any indication as to when the resident was assessed or reassessed after any interventions if any were given. The assessment documented the pain was in his knees, lower extremities and his back. The assessment did not document any non-pharmaceutical interventions.The medical record showed no evidence the non medication interventions were provided. The assessment concluded the resident was dissatisfied with the drug regimen and wished to have a stronger pain medication from the provider. The care plan last revised on 4/22/19 identified the resident exhibited or was at risk for alterations in comfort related to acute pain with a diagnosis of neuropathy. The care plan documented current acceptable pain level of 7/10 however it varied due to resident pain tolerance. The goal was for the resint to achieve an acceptable level of pain control. Pertinent interventions were to utilize pain scale, medicate for pain as ordered, complete pain assessment per protocol. -The care plan failed to document any interventions which were non-pharmaceutical. The physician's note dated 11/14/19 documented, the resident had generalized osteoarthritis in his back, hands, knees and shoulders. The note documented the resident received gabapentin 200 mg three times a day, hydrocodone was available as needed, and scheduled Tylenol three times a day. The progress note documented the resident felt it was not really benefiting him much but wanted to continue it for now. Pain was from both his knees and he was not a candidate for surgery. The note further documented the pain awakened him at times. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews The director of nurses (DON) was interviewed on 12/18/19 2:31 p.m.The DON said a complete pain assessment was to be completed on admission, quarterly and on a change of condition. She said a full assessment needed to be completed even if the resident was on a pain regimen. She said the pain scale was to ask every shift. She said it needed to be documented on the MAR. She confirmed the latest pain full assessment was done over a year ago on 9/10/18 and the resident ' s pain tolerance was marked as a 7. The licensed practical nurse (LPN) #6 was interviewed on 12/18/19 at 10:08 a.m. The LPN said the resident complained of pain in his knees and also pain from his arthritis. She said that there were no non-pharmaceutical interventions used. She said the resident ' s pain tolerance was 4 out of 10. She said he did not take the PRN hydrocodone as he did not like how it made him too sleepy. Follow up The facility submitted via email on 12/20/19 a response that the resident was assessed for pain quarterly through the MDS assessment. However, the MDS assessments completed on 9/27/19, 7/31/19, 5/6/19 and 2/11/19. However, the MDS assessments failed to assess the resident for the characteristics of the pain, additional symptoms associated with the pain, current medical condition, and the resident ' s goal for pain management. 42193 III. Resident # 66 Resident #66, age 66, was admitted on [DATE]. According to the December 2019 computerized physician orders (CPO), the diagnoses included type 2- diabetes mellitus with hyperglycemia and hypertension. The 10/18/19 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15.She required no assistance with bathing,dressing,eating or mobility. The MDS indicated pain assessment interview and it determined that the resident had a frequent pain level of 7.The MDS coded the resident as not having any non-medication interventions. A. Resident Interview Resident # 66 was interviewed on 12/10/19 9:41 a.m.The resident stated that the facility lowered her medication dose right after she moved into the facility. She said that a tolerable pain level was between two and three on the pain scale.The resident said her pain level could get as high as a six or seven on the pain scale.She said she had not been to a pain clinic and had not tried any non-pharmacological methods of pain relief. She preferred to take medications to relieve her pain.The resident said that her pain issues were caused by a gastric bypass surgery that she had in 2003. She said that her pain is localized in her stomach area. B. Pain Management Plan (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The CPO included an order for the resident's pain to be evaluated every shift starting on 1/10/18 using a pain scale of 0-10, and to document on the medication administration record (MAR). The resident's December 2019 CPO and recent physician orders revealed current orders for pain control included: -Norco Tablet: 5/325 mg give one tablet by mouth every eight hours as needed for chronic pain. -Lyrica 200mg tab. one tablet three times a day for pain. -Tylenol 325 mg Give 650 mg three times a day as needed for pain. -Biofreeze 4% Menthol topical analgesic. Apply topically every six hours as needed for shoulder pain. The medical record failed to show no non-medication interventions were used. C. Pain assessment 10/22/19 Pain numeric intensity rating had a value from 7 to 10 as indicated by the Numeric Rating Scale.The resident stated that the worst pain she had over the last five days was rated a seven and at a rate of frequently. The assessment did not document any non-pharmaceutical interventions. The medical record showed no evidence the non medication interventions were provided. The numeric rating scale had not indicated where the resident was experiencing pain. D. Staff interviews RN # 5 was interviewed on 12/18/19 at 2:20 p.m.The RN said that Resident # 66 ' s pain issues were challenging to the nurses. Resident came to the facility taking 10 mg Norco and the nurse practitioner (NP) changed the order to 5 mg Norco. Resident was upset that the dose of the medications had been changed. The resident ' s pain level was usually at a 6 out of 10. RN #5 said that some of the non-pharmacological interventions for the resident were rest, therapy, and an increase in activity. The RN stated that the resident did not appear to be in pain most of the time. The RN stated that she was sure that the resident had pain but she did not feel that her pain was that bad.

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F 0725 Level of Harm - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42192 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 adequate nursing staff which considered 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 had delayed call light response, failed to provide assistance with activities of daily living (ADLs), prevent avoidable accidents, prevent delayed toileting assistance and insufficient amount of staff to provide meal assistance. Cross-reference F677 failure to provide assistance with activities of daily living; F688 failure to provide range of motion and positioning assistance; F689 failure to ensure resident safety and prevent falls and accidents. Findings include: I. Resident census and conditions According to the 12/9/19 Resident Census and Conditions of Residents report, the resident census was 138 and the following care needs were identified: -90 residents needed assistance of one or two staff with bathing and 34 residents were dependent. No residents were independent. -73 residents needed assistance of one or two staff members for toilet use and one resident was dependent. Two residents were independent. -104 residents needed assistance of one or two staff members for dressing and two were dependent. Two residents were independent. -79 residents needed assistance of one or two staff members and zero were dependent for transfers. One resident was independent. -84 residents needed assistance of one or two staff members with eating and two were dependent. A. Staffing requirements for each station According to the desired staffing pattern documentation provided by the staffing coordinator on 12/11/19: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Staffing schedules dated for Saturday 11/16/19 for overnight shift showed the facility had staffed nine CNAs, two LPNs, and one RN. - Staffing schedules dated Saturday 12/7/19 for overnight shift showed the facility had staffed five CNAs, two LPNs and two RNs. B. Resident group interview A resident group interview was held on 12/12/19 at 11:00 a.m. with six alert and oriented residents selected by the facility to participate. They said the certified nurse aides (CNAs) care but they did not have enough help. They said sometimes they did not have enough staff to give showers. They said the CNAs were responsible for entire hallways and sometimes two if they were short-staffed during a shift. They said they had to wait up to two hours for a call light to be answered. They said the residents often overheard staff talking about how short-staffed they were. C. Resident interviews Resident #46 was interviewed on 12/9/19 at 12:00 p.m. She said the nursing staff were very bad about answering the call light. She said their answer time can be between 40-90 minutes. She said sometimes they will come in and turn the call light off saying they will be back and then do not come back. She said they have two CNAs for four halls. Resident #107 was interviewed on 12/9/19 at 12:40 p.m. She said the CNAs are overworked and have no help when they are busy. She said they have to help in the dining room during meals and then pass room trays. She said it can take up to two hours to get help some times of the day. Resident #388 was interviewed on 12/9/19 at 2:21 p.m. She said the facility was understaffed like something else. She said she had to wait for assistance for 45 minutes to get off the toilet. Resident #16 was interviewed on 12/19/19 at 2:46 p.m. She said it was impossible to get help from the nursing staff between 7:30 a.m. and 9:30 a.m. when they got the residents up and at breakfast, between 11:00 a.m. and 1:00 p.m. when they help with lunch and between 2:00 p.m. and 3:00 p.m. during shift change. Resident #135 was interviewed on 12/11/19 at 10:05 a.m. She said staffing could be scary around the facility sometimes, especially at night. She said she had to wait for toileting help for twenty minutes sometimes. Resident #36 was interviewed on 12/10/19 at 10:31 a.m He said that sometimes after he pushes the call light he waits a long time, could be waiting 30 minutes up to two hours. He said the evenings were the worst. D. Staff interviews Certified nurse aide (CNA) #7 was interviewed on 12/12/19 at 12:18 a.m. She said the facility was not sufficiently staffed at night. She said it was typical to have only two CNAs on the four [NAME] halls at night and one registered nurse (RN). She said on a busy night two CNAs were not enough. She stated they did not hire new staff quickly and were often short-staffed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29594 Based on observations, record review and interviews the facility failed to ensure it was free of a medication error rate of five percent (%) or greater. Two errors, involving two (#59, #86) of five residents out of 36 sample residents, were observed out of 25 opportunities for error, resulting in a medication error rate of 8%. Specifically, the facility failed to: - Ensure resident #59 ' s insulin was administered as ordered. - Ensure resident #86 did not receive medication without a physician ' s order. Findings include: Professional References [NAME], [NAME], Stockert, and Hall (2017) Fundamentals of Nursing (Ninth edition), pages 624-628. It read in pertinent part, To prevent medication errors, follow the six rights of medication administration consistently every time you administer medication. Many medication errors can be linked in some way to inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. Right time to administer medications safely, you need to know why a medication is ordered for certain times of the day and whether you are able to alter the time schedule. Give priority to time-critical medications that must act and therefore be given at certain times. You administer time-critical medications within 30 minutes before or after their scheduled time. For example, give insulin (a time-critical medication) at a precise interval before a meal. According to the manufacturer ' s prescribing information, Humulin 70/30 insulin should be administered subcutaneously (under the skin) approximately 30 to 45 minutes before a meal. Facility Policy The facility Medication Administration: General policy, revised 11/1/19, read in pertinent part, Accepted standards of practice will be followed. The purpose read that the facility was to provide a safe, effective medication administration process. Medication error observation and record review Licensed practical nurse (LPN) #3 was observed on 12/12/19 at 9:41 a.m. obtaining a finger stick blood glucose level on Resident #59 which was an hour and 41 minutes later than scheduled administration. The December 2019 medication administration record (MAR) read finger stick blood glucose. Notify medical doctor (MD) if blood sugar was less than 70 or greater than 400. Every morning at 7:00 a.m. and at bedtime for diabetes mellitus. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #3 prepared and administered the resident ' s insulin which was 41 minutes later than scheduled administration. The December 2019 MAR read Humulin 70/30 suspension 100 units/milliliter (ml) inject 13 units subcutaneously two times a day for diabetic management, scheduled at 8:00 a.m. LPN #3 was observed at 11:36 a.m. applying Ammonium Lactate Cream 12% to Resident #86 ' s right ear. The December 2019 MARs did not show an order for the use of the cream. Staff interviews LPN #3 was interviewed on 12/12/19 at 9:41 a.m. She stated that she took Resident #59 ' s blood sugar after she ate because she got anxious about the results. She stated that if the resident ' s blood sugar was too low then the resident would not take her insulin. LPN #3 was interviewed at 11:36 a.m. She said, after looking for the order for the cream and not finding it, that it must have been discontinued so she would remove it from the medication cart so others did not use it. The director of nursing (DON) was interviewed on 12/18/19 at 1:49 p.m. She stated that when nurses were administering medications they should check the medication administration record (MAR) and the label on the medication to confirm the order prior to administering the medication. She said that medications should only be given when there was an order. She said that if a medication was ordered at a specific time the nurses would have an hour before and an hour after where they can give the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 29594 Based on record review, observations and staff interviews, the facility failed to ensure that all drugs and biologicals were in locked compartments and only authorized personnel had access to them. Specifically, the facility failed to ensure medications were not left out on the cart or at the nurses ' station when a nurse was not present. Findings include: Observations On 12/9/19 at 10:32 a.m. the medication cart located on the 1500 hall was observed with a medication card lying on top of it. The medication card contained Seroquel 50 milligram (mg) tabs. There was no nurse in the hallway. - At 10:33 a.m. a staff member walked past the cart. - At 10:36 a.m. registered nurse #5 returned to the medication cart and picked up the medication card and went into the medication room. On 12/12/19 at 11:36 a.m licensed practical nurse (LPN) #3 was observed at the nurses station. She was sitting at the computer and had a plastic 30 milliliter (ml) medication cup full of a thick white liquid sitting on the desk next to her. The nurse got up and went to the medication room, she left the medication cup at the nurse station, unattended. While in the medication room a staff member and a resident passed by the nurses station where the medication was set. She returned to the nurses station, looked up an order on the computer, got up again and went to the locker room across the hall. She left the medication cup on the counter at the nurses station, unattended. Staff interviews Registered nurse (RN) #4 was interviewed on 12/9/19 at 10:45 a.m. She acknowledged that she had left the medication card of Seroquel on her cart. She said it had been discontinued and she was going to put it in the medication room to be destroyed but someone had come and and asked her to help with something so she left. She said that the nurses were not supposed to leave medications unattended on the medication carts. LPN #3 was interviewed on 12/12/19 at 11:40 a.m. She acknowledged that she had left the medication cup at the nurses station, unattended. She said that medications were not supposed to be left unattended by nurses. The director of nursing (DON) was interviewed on 12/18/19 at 1:49 p.m. She confirmed that medications should not be left unattended by the nurses.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42161 Based on interview, observations, and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures. Specifically, the facility failed to ensure that residents' food was papatable in taste, texture, appearance and temperature. Findings include: A. Food committee minutes Review of the food committee minutes from August 2019 to November 2019 revealed the following concerns about palatability of food: -Room trays can get cold -Pellet warmers were not working properly B. Resident interviews Resident #125 was interviewed on 12/9/19 at 2:46 p.m. He said the soup kitchen had better food most of the time. He said there were no options to the alternative menu. He said if he could not eat the scheduled menu item because of dietary restrictions, his only options were peanut butter and jelly. He said the food was always delivered to his room cold and did not taste good. He said he did not understand why the kitchen could not make a good tasting pizza. He said the food was not very good. Resident #9 was interviewed on 12/9/19 at 3:48 p.m. Resident #9 said he did not like the food. He said the kitchen could not make a good tasting pizza. He said the kitchen needed help. He said the food looked good but did not taste good He said by the time his food tray left the kitchen and was delivered to his bedside table it was usually cold and did not taste good. Resident #66 was interviewed on 12/10/19 9:15 a.m. The resident said the food was not palatable, she said it was served sloppy and had no flavor. She said there was no choice on alternatives. Resident #57 was interviewed on 12/10/19 at 10:08 a.m. He said he ate in the dining room and in his room. He said the food was always served cold both in the dining room and in his room. Resident #36 was interviewed 12/10/19 10:35 a.m. The resident said the food did not have enough seasoning and was very bland, no salt or pepper served with the meal, by the time they bring it is cold,. He further said there were not very many choices. Resident #388 was interviewed on 12/10/19 3:19 p.m. The resident said the meals were served lukewarm at best. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #46 was interviewed on 12/10/19 at 10:59 a.m. The resident said the food was not hot when served, she said it was frequently cold and needed to be reheated. She said there was limited snacks at night. Resident #53 was interviewed on 12/10/19 11:01 a.m. The resident said the food was not good. He said the was served cold and it did not get delivered very quickly to his room. Resident #50 was interviewed on 12/10/19 12:51 p.m. The resident said the food was not good. She said it did not have any season to it. Resident #35 was interviewed on 12/12/19 at approximately 12:45 p.m. The resident said the food was served cold and did not have much flavor. C. Resident group interview The resident group meeting was held on 12/12/19 at 11:31 a.m. with six alert and oriented residents selected by the facility to participate in the group. The residents revealed in the meeting the food was an issue. Six of the six residents agreed the food was often served cold, and that it was bland in taste. The residents said the meat was tough and difficult to chew. D. Observation -On 12/12/19 the lunch meal service was continuously observed from 11:45 a.m. to 1:00 p.m. -A breeze blowing from the dining area through the distribution window and across the ready to serve food line. -The temperature log dated 12/12/19 revealed the starting temperatures for the meal were within palatable serving parameters being 160 degrees F and above. Temperatures held throughout the serving process. Tray line observation for evening meal 12/16/19 -On 12/16/19 the dinner meal service was continuously observed from 4:20 p.m. to 6:05 p.m. The meal consisted of hot options of country smothered chicken, herbed orzo, sliced carrots, and pear crisp. -A breeze flowing from the dining area through the distribution window and across the ready to serve food line. -The temperature log dated 12/16/19 revealed the starting temperatures for the meal were within papatable serving parameters being 156 degrees F and above. -At 5:55 p.m. the last food tray was placed into the [NAME] food delivery cabinet and delivered by certified nurse aide CNA #1. CNA #1 parked the cabinet at the end of hallway next to the nurses station. He opened the cabinet door and left it open while he delivered the room trays. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 12/16/19 at 6:05 p.m. the regular textured diet test tray was evaluated after the last resident was served. Test tray On 12/16/19 at 6:05 p.m., the regular diet test tray was evaluated. The meal was served on a serving tray with a dome over the plate holding the chicken, carrots, and the orzo. There was no plate warmer under the plate. --The country smothered chicken was cool to the palate at 106.8 degrees F and dry to the taste with not much flavor. The gravy was lumpy and solidified. -The herbed orzo was cool to the palate at 118.9 degrees F and was over cooked and was bland in taste. -The sliced carrots were cool to the palate at 103.8 degrees F with no taste of butter. Staff interviews The dietary manager (DM) was interviewed on 12/16/19 at 5:30 p.m. He said the food would stay warmer if the facility would provide them with better cabinets to keep the food warm. He said if the pellet warmers were working, they would help keep the food warm as well. The dietary manager (DM) and the dietary supervisor (DS) were interviewed on 12/17/19 at 12:40 p.m. The DM said residents would say the kitchen could improve on the food taste and temperatures. He said keeping the temperatures at a palatable level has been a problem for the facility. He said the draft coming from the dining room caused the cold air to pass over the serving line and was cooling the food immediately when putting it on the plate. He said the CNAs that are serving the food should be moving the food cabinet from room to room opening the door, taking the residents tray out and shutting the door as they deliver the tray to the resident. The DS said he has the pellets for the food warmer but he is waiting for someone to come out and fix the warmers. He said someone came out to fix the plate warmer and said it was fixed. The DM said when he turned it on and tried to use it he noticed it was not fixed and only one compartment slightly worked. He said that none of the plates in the warmer were getting warm enough to maintain food temperatures.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. 20287 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 resident safety and safe environment, abuse prevention and investigation, restorative and range of motion services, sufficient nursing staffing, meaningful activities, pain management, and palatable food. The facility's failure to identify and address quality concerns at F689 resulted in Resident #33 experiencing repeated falls with injury and functional decline. Findings include: Cross reference F689: The facility failed to ensure residents had an environment that reduced the resident risk of accident or injury, and that injuries and planned safety interventions were considered and evaluated to keep residents safe. These failures resulted in a situation of immediate jeopardy. The facility was previously cited on and abbreviated survey 9/13/19 at a G (harm) level. Cross reference F 688: The facility failed to ensure residents who enter facility with limited mobility and range of motion received appropriate services and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility was demonstrated unavoidable. Cross reference F 725: The facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents receive the care and services they required as determined by resident assessments and individual plans of care. The facility was previously cited on and abbreviated survey 9/13/19 at an E level. Cross reference F 679: The facility failed to ensure an ongoing activity program based on comprehensive assessment and care plan and the preference for each resident. Cross reference F697: The facility failed to provide pain management services to ensure highest practicable resident well-being. Cross reference F 804: The facility failed to ensure residents were consistently served meals which was palatable. Interview (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nurses (DON) was interviewed on 12/18/19 at 3:16 p.m. The DON said she attended the QAPI meetings monthly. She said the restorative program had been brought up in QAPI in previous months. She said that she understands the restorative program had changed, to model B, and that there were no specific CNAs assigned to the program. She said the program did not have any specific system to document range of motion. The DON said she had just taken over the restorative program within a few months. The nursing home administrator (NHA) was interviewed on 12/18/19 at 6:28 p.m. The NHA said the quality assurance meeting was held monthly. The entire interdisciplinary team along with the medical director, and the pharmacist attended the meeting. The meeting had an agenda which was followed. The QAPI was identified by incidents, grievances filed, resident council meetings and family. She said an action plan was determined and assigned to the appropriate member of the IDT team. She said falls had been on the agenda for the past two years. She said she thought the falls had reduced with the new admission process, when a new resident was admitted , the resident was placed on every two hour checks, non-skid socks applied. The facility had monthly regional calls and interventions were reviewed. She said Resident #33 was reviewed in the QAPI meetings. She said she can not figure out where the system failed. The NHA said F 725 was cited in September 2019. She said the complaint cleared with the plan of correction. She said the facility staffed to accuity and the case mix. She said the highest accurety was the memory care. She said the staffing ratios were reviewed and staffing patterns were changed. She said she was unable to identify where the system failed.

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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** 42161 Based on observations and interviews the facility failed to ensure infection control practices were followed to prevent the spread of infection. Specifically, the facility failed to ensure: - Proper care and storage of oxygen equipment, nasal cannulas. - Cleaning of call light cords and bathroom environment and equipment. Findings include: Observations and staff interviews On 12/12/19 at 9:00 a.m. and on 12/16/19 at 2:30 p.m. during the environmental tour with the maintenance director (MTD), maintenance assistant (MA) #1, housekeeping manager (HSM), and regional clinical representative who was the interim infection preventionist, and the nursing home administrator (NHA). The following observations were made: - room [ROOM NUMBER] had black substance in the caulking on the floor around the toilet. - Rooms #503, #704, #801, #802, #803, #807, #1102, #1106, #1108, #1204, #1207, #1308, #1403, #1606, #1610, and #1701 all had brown substance on call light pull cords in the residents bathrooms. - Rooms #1204, #1509, #1510, had oxygen nasal cannula lying on the floor and not stored appropriately. - room [ROOM NUMBER] had a temporary support beam next to the toilet with duct taped padding that was not a cleanable surface wrapped around it and there were deep scrapes in the toilet seat. The MTD said the pull cords were cleaned on a monthly basis. He said the pull cords could not touch the floor or be too short. He said he did not think about cleaning the pull cords before. He said he was going to buy a roll of cord to replace all of the pull cords. The MTD said for room [ROOM NUMBER] he was going to send someone in to clean the floor around the toilet and if it could not be cleaned then he would replace the tiles. The HSM said he would send someone in #501 right away. He said he did not know the pull cords should be cleaned regularly. The regional clinical representative who was the interim infection preventionist said the nasal cannula should have been stored in the plastic medical bags hanging on the oxygen concentrator. She said that in rooms #1204, #1509, and #1510 she had a certified nurses assistant (CNA) replace the nasal cannulas and place them in the bags. She said she was going to perform a staff training on how to properly store the nasal cannulas and what to do if they were found not in the storage bags. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility follow-up The MTD was interviewed again on 12/17/19 at 9:35 a.m. He said the MA #1 and himself were working on replacing all of the pull cords in the facility. He said most of them were already replaced and finished. He said he replaced the support bar in room [ROOM NUMBER] in the restroom. He said the MA #1 was spending his day fixing the problems in the rooms and replacing bathroom call light pull cords. He said he had the HSM add bathroom call light cords to their daily cleaning log. He said the new call light pull cords had a plastic sleeve around them which made them a cleanable surface. He said he made one of them dirty then cleaned it to see if it came all the way clean with success.