STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065152	A. Building B. Wing	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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 - Few	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** 41032 Based on observations, record review and interviews, the facility failed to promote and facilitate the resident's right to make choices about aspects of their lives in the facility that were significant to them for one (#15) of three residents reviewed out of 16 sample residents. Specifically, the facility failed to ensure Resident #15 received bathing assistance according to their preference. Findings include: I. Facility policies and procedures The Exercise of Rights policy, revised December 2006, was provided by the nursing home administrator (NHA) on 2/21/22 at 4:17 p.m. The policy revealed the residents had the freedom of choice, as much as possible, regarding how they wished to live their everyday lives, to receive care, subject to the facility's rules/regulations affecting resident conduct and those regulations governing protection of resident health and safety. -The facility staff would encourage residents to participate in planning their daily care routine including activities of daily living. The Activities of Daily Living (ADL's) Support policy, revised March 2018, was provided by the NHA on 2/21/22 at 4:17 p.m. The policy read in pertinent part: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The Shower and Tub Bath policy, revised February 2018, was provided by the NHA on 2/21/22 at 4:17 p.m. The policy revealed its purpose was to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The policy also revealed the staff member assisting the resident with the shower/tub bath should document the following information: (continued on next page)

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

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The date and time of the shower/tub bath was performed. -The name and title of the individual who assisted the resident. -If the resident refused the shower, the reason or reasons why they refused and the interventions that were implemented. -The signature and title of the staff member recording the data. -The staff member was also to notify the supervisor when a resident refused a shower/tub bath. II. Resident #15 status Resident #15, under the age of 65, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), diagnoses included functional quadriplegia, multiple sclerosis and anxiety disorder and the need for personnel assistance with care. The 1/10/22 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 15 out of 15. The resident needed extensive assistance from staff for bed mobility, transfers, dressing, toileting and personal hygiene. The resident did not walk, was not able to move form a seated to standing position and had functional limitations in range of motion in both upper and lower extremities on both the left and right sides. The bathing self-performance revealed the resident ad total dependence on staff for bathing support. III. Resident interview Resident #15 was interviewed on 2/18/22 at 2:37 p.m. Resident #15 said she relied completely on staff to give her a bath and wash her hair. Resident #15 said she preferred staff give her a full bed bath twice a week and wash her hair once a week; and did not feel clean and just wanted a bath. Getting washed made her feel more comfortable. Staff were supposed to help her take a full bath twice a week but they had not helped her bathe in over a week and she had not had her hair washed in two weeks. Resident #15 said she asked for staff assistance but was told by staff they would help her tomorrow; tomorrow never came. Resident #15 said she had not refused staff assistance. IV. Record review The comprehensive care plan last reviewed 1/29/22 revealed the hospice certified nurse aide (CNA) was to offer to assist the resident with showers Monday, Wednesday and Friday. The care plan was not updated to identify details on the resident's daily and personal choices regarding how she wanted to live her everyday life for twice a week bed baths, not showers. An orders administration note dated 12/29/21 at 8:53 p.m. revealed, Resident prefers to shower two (2) times a week in the afternoon every Wednesday and Saturday - bed bath. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A request was made to the nursing home administrator and independent nurse consultant (INC) on 2/21/22 at 10:00 a.m., for all bathing documentation from 12/1/21 to 2/21/22 for acceptance and refusals of showers for this resident. The resident would have had approximately 24 showers (two showers per week) in that time period. The NHA and INC were interviewed on 2/22/22 at 3:33 p.m. The INC said the resident's treatment administration record which was completed by the nurse revealed the resident had received showers as ordered each Wednesday and Saturday except for 1/15/22 and 2/19/22 which was rescheduled to 2/21/22. They were able to locate only two bath sheets completed by the CNAs, for the requested time period, showing the resident received a shower on 1/7/22 and 2/21/22. The INC acknowledged the nurses did not give resident showers and she would not be able to confirm how the nurses were verifying the administration of the showers before signing off on the treatment administration record. The INC said they were not able to locate any other CNA documentation of showers. The NHA acknowledged they had identified concerns with completion of ADL assistance but expected nursing staff to honor resident requests for assistance and follow the resident's care plan and personal preferences. The NHA expected staff to report changes in the resident preferences and offer alternatives if a shower could not be given or the resident refused. The INC acknowledged documentation for resident showers needed to be revised. V. Other staff interviews CNA #7 was interviewed on 2/21/22 at 2:35 p.m. CNA #7 said the CNAs were to follow the posted shower schedule. The shower schedule was posted at the nurse's station. Once a shower was offered and completed they were to complete the shower sheet documenting that the shower was completed and document any skin concerns. The CNA was then to report the findings to the nurse. The nurse was to sign off review of the shower sheet and document the shower in the resident record. CNA #2 was interviewed on 2/22/22 at 12:15 p.m. CNA #2 said the CNAs were to complete a shower sheet for each resident shower given, document any skin issues and then notify the nurse. The nurse was to review and sign off on the shower sheet. This documentation showed proof that a shower was given. Licensed practical nurse (LPN) #1 was interviewed on 2/22/22 at 12:28 p.m. LPN #1 said the nurses did weekly skin assessments. The CNAs were to give resident showers per the care plan, which should match the posted shower schedule. Showers were to be given based on the resident's preference for day and time of day. Once a shower was given the CNA was to notify the nurse on duty of the shower and any changes in the resident condition and skin. The nurse documented the shower in the resident record, but should not sign off that a shower was given until the CNA notified and confirmed that they gave the resident a shower.

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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** 41032 Based on observations, and resident and staff interviews, the facility failed to maintain a clean, comfortable, homelike environment for residents on three of five hallways. Specifically, the facility failed to ensure: -Resident rooms were in good repair where window curtains were in place, not falling off walls and not in a broken condition; -Resident rooms were clean and free of heavy dust buildup, debris and trash being left on floors and soiled privacy curtains, furnishings, and wall-affixed cubbies holding hygiene products; -The walls in resident rooms were cleaned and free from food and other dried debris; and -Resident rooms were free from unsightly chipped paint and flooring tiles. Cross-referenced to F689 accident hazards for electrical and trip hazards in resident rooms. Findings include: I. Facility policy The Quality of Life - Homelike Environment policy, undated, provided by the nursing home administrator (NHA) on 2/21/22 at 4:17 p.m. read in pertinent part, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include clean, sanitary and orderly environment; .Clean bed and bath linens that are in good condition; . Supplemental attachments/procedures for the home like environment, read in pertinent part: Daily room cleaning to include: -Dusting walls, fixtures, windows, televisions, picture frames and mirrors; -Cleaning ledges and windowsills with disinfectant; -Privacy curtains: take privacy curtains down for cleaning; -Cleaning room furnishings: disinfect and clean bed and furniture; -Clean resident's bathroom: disinfect toilet and urinals; -Dust: including the door frames and hinges, ceiling vents, and tops of mirrors; -Sinks and counters: clean and polish; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Clean wall splashes and marks: clean all areas that need to be cleaned; -Doorknobs and switch plates; -Empty trash; -Dust mop and wet mop the floors. Inspect the room: after cleaning and before you leave, inspect the room according to the cleaning checklist and make sure you did not forget to perform any required clearing task. The Pest Control plan policy, revised May 2008, provided by the NHA on 2/22/22 at 10:18 a.m., read in pertinent part, Our facility shall maintain an effective pest control program. -This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. -Windows are screened at all times. -Only approved insecticides and rodenticides are permitted in the facility. II. Observations Observations of resident rooms was conducted on 2/17/22 from 1:20 p.m. to 2:08 p.m. room [ROOM NUMBER] was observed after a housekeeper had been observed cleaning the room. The room's floor was observed to have multiple dried red, pink and brown spills with crumbs stuck in the spills. The spills/stains were sticky underfoot. room [ROOM NUMBER] was observed with a soiled floor. There were several dried black and brown spots covering the floor by the door and across the floor's walkway. room [ROOM NUMBER] was observed with multiple dried black and brown spills and crumbs on the floor. room [ROOM NUMBER] was observed to have both privacy curtains pulled around the ceiling track. The curtain for the A bed had dried yellow, brown and orange substances on it, the curtain on the B bedside was stained with black, brown and pink spots. A fly strip was observed attached to the wall with a few flies stuck to it. The floor was observed to be cracked with two of the floor tiles curled and sticking up in the air and there were several missing tiles. The resident's bedside table was covering part of the floor that was damaged. There were power cords and cables observed plugged into an outlet at eye level by the resident closet that extended across the room into the B-side of the bed behind the privacy curtain. The cords were extended in a way that obstructed a clear path from the walkway to the B-side of the room, where the resident's roommate would have to duck under the cord to walk through the resident room to the B-side of the room. One window in the room was covered with a sheet and no blinds. The window blinds were leaning up against the wall by the resident's closet. The window screen was also missing. The other window was covered with a venetian blind that was bent and broken with parts of the blind fins missing. (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] at the C bed was observed to have dried sticky beige spills on the floor by the resident tube-feeding pump. The tube-feeding pump was caked with copious amounts of dried beige tube feeding substance dripped down the bottom of the pole and on the base of the stand. The dried sticky substance had dirt, dust and debris stuck to it. The privacy curtain was soiled in a large area with dried beige and black stains. room [ROOM NUMBER] at the C bed was observed to have missing baseboard heating coil covers and the heating device was bent and not affixed securely to the wall. Observations of resident rooms were conducted on 2/18/22 from 9:35 a.m. to 10:45 a.m. room [ROOM NUMBER] was observed to have trash (used gloves, a plastic cup and an empty soap dispenser) on the floor by the sink and a full trash can just inside the door to the hall. There were crumbs, crumpled up paper, torn plastic, and pieces of plastic on the floor by C bed. The floor by bed C was spotted with dried beige droplets of tube feeding substance caked with crumbs and dust. The tube feeding pole and base was caked with a copious amount of dried beige tube feeding substance. The floor along the backside of the room along the edge was covered with dust and crumbs. The privacy curtains in the room were soiled with black and brown stains and the curtain by bed C was still stained in large part with a dried beige, black/gray and brown substance. There were three plastic storage drawers affixed to the wall for residents' personal hygiene items; the tops and side surfaces were soiled with a blackened substance. The tops of the storage containers were covered with a golden orange dry dusty like matter that was stuck on to the surface. The substance was not able to be wiped away. The resident hygiene products were laying on the sink top without separation. The baseboard heating element was bent and the part of the cover of the heating element was missing. room [ROOM NUMBER] was observed to have a glove holder by the door; the glove holder was falling off the wall and not securely attached to the wall. room [ROOM NUMBER] was observed to have a small sticky uncovered bug trap (2-inches by 4-inches) with several small back bugs stuck in the trap. It was laying on the floor by the window near resident bed A. room [ROOM NUMBER] was observed in the same condition as documented above. In addition, the window missing the window screen was open. The sticky flytrap attached to the wall by the resident closet had approximately seven visible flies stuck to it. A plastic three drawer rolling cart was visibly stained and soiled on top with a rusty reddish stain and the frame drawer rails were caked with a stuck on dried golden brown and black matter under and around each drawer. The dresser and television in the room were dusty and paint was peeling off the windowsill next to the resident's bed on the B side of the room. There were smears of a dark brown dried matter on the wall underneath the gloves dispenser and unpainted white plaster repairs on the wall along the inside frame of the door. room [ROOM NUMBER] was observed to have heavily soiled flooring stained with a dried blackened substance and covered with dust. The resident over-the-bed table had a peeling top surface. The curtain rod was falling off the window and the curtains were falling off the hooks. The window application was not fully secured to the window frame. The resident privacy curtain was soiled with a dried pink and brackish water stain substance. (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] was observed to have peeling paint on the windowsills and the divider curtain was soiled with dried black and brown stains. room [ROOM NUMBER] was observed to have whole missing floor tiles, chipped tiles and other tiles were stained and soiled with black spots. The divider curtain was soiled with dried brown and black spots and stains. III. Interviews Certified nurse aide (CNA) #3 was interviewed on 2/18/22 at 10:22 a.m. CNA #3 said the resident room on the second floor had several areas needing to be repaired and cleaned. The CNA put in a work order to have several things repaired including the window screen in room [ROOM NUMBER]. The CNA tried to help the housekeepers by tidying up the rooms. CNA #3 was not sure where the sticky bug traps came from but knew that Resident #14 had complained several times about flies in her room, so that may be why someone put up a fly trap. Resident #9 was interviewed on 2/18/22 at 1:00 p.m. Resident #9 said she did not recall seeing the housekeepers come in to clean every day and was not sure how often her room was cleaned. Housekeeper (HSK) #1 was interviewed on 2/18/22 at 1:31 p.m. HSK #1 said there were two shifts of housekeeping staff (days and evenings); each resident room was to be cleaned daily. Resident #3 was interviewed on 2/18/22 at 1:33 p.m. Resident #3 said she had several concerns about delays in room repairs and had voiced concerns to the maintenance director (MTD) and only after several complaints were the repairs made. Resident #3 said the facility made several minor fixes related to broken items but that did not resolve broken and malfunctioning items, but one item she had complained about repeatedly was repaired this week. Resident #15 was interviewed on 2/18/22 at 2:33 p.m. Resident #15 said the housekeepers came in daily but felt they could do a better job cleaning her room and would like the privacy curtain washed. HSK #2 was interviewed on 2/21/22 at 11:15 a.m. HSK #2 said the resident rooms were cleaned daily and deep cleaned once a month. They were to clean and disinfect all high touch surfaces daily including door knobs, furniture, sinks and toilets, empty trash and sweep and mop the floors. If they noticed dirt on the walls, or other surfaces that were soiled, they were to clean that area during the daily cleaning. Privacy curtains were removed and washed as needed. If there was a large area and it needed to be cleaned before the room came into the rotation, they were not to wait but were to clean the area. They were to repair any broken item if they could or place a work order to request the repair. The NHA and independent nurse consultant (INC) were interviewed on 2/21/22 at 1:54 p.m. The NHA expected the facility staff to make the resident environment as clean, sanitary and homelike as possible. It was expected that the housekeeping staff would clean rooms daily and make sure the facility was odor free. Each resident room was to be cleaned daily and deep cleaned once a month. If a resident space was soiled and dirty, staff were to clean the area immediately and not wait for the monthly scheduled deep cleaning. Both housekeeping and nursing staff were responsible to keep resident rooms clean and report any areas of concerns that could not be resolved quickly and easily. If repairs were needed, staff was to complete a work order so maintenance staff could make timely repairs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA was not aware the building had exposed pest strips, they were not a part of the facility's pest control program and said they were not permissible in the community. The NHA acknowledged the building was old and had many areas of concern. The leadership program had alerted the corporate office of areas needing more than basic cleaning and the facility had developed a plan of corrective action they had been working on for the last four months. The facility started doing housekeeping rounds where members of the IDT could report environmental issues and then work through systemic problem solving for an equitable solution to the home-like environment concerns through the building. The NHA acknowledged the facility was still in phase one of the plan of correction and still had work to do to successfully accomplish the items on their improvement plan of corrective action. The NHA and INC said they would conduct an environmental tour of all rooms and prioritize cleaning and repair concerns.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on record review and interviews, the facility failed to ensure three residents (#5, #7 and #3) of five residents reviewed, out of 16 sample residents were kept free from neglect. The facility failed to ensure Resident #5 and Resident #7 were not neglected by staff and were provided the care and services required to maintain the highest practicable well-being. Specifically, Resident #5 and Resident #7's call lights were not answered for over two hours on 1/27/22, as evidenced by the call light record, resident and staff interviews. Resident #5 expressed fear and anxiety about having her call light answered timely in the future, if she had an emergency or fell . Resident #7 reported her legs and feet had gone numb, seated on the toilet on 1/27/22, waiting for help. She said she was afraid she was going to fall. Resident #7 reported continued fear of her call light being answered timely in the future when she was on the toilet. Furthermore, five additional residents had call light wait times over two hours. Additionally, Resident #3 alleged she was verbally abused by a dietary staff member on 2/16/22. Findings include: I. Facility policy and procedure The Abuse Prevention Program policy, revised December 2016, was received from the clinical resource nurse (CR) on 2:21 p.m., at 4:19 p.m. The policy documented in pertinent part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The administration will: Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. Implement measures to address factors that may lead to abusive situations, for example: Provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation; Instruct staff regarding appropriate ways to address interpersonal conflicts; and Help staff understand how cultural, religious and ethnic differences can lead to misunderstanding and conflicts. II. Failure to prevent neglect for Resident #5 and Resident #7 A. Resident #5 1. Resident status Resident #5, age 72, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included hemiplegia and hemiparesis on the left side following cranial hemorrhage (bleeding), expressive (difficulty conveying information in speech) language disorder, and blindness of the left eye. The 1/6/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status score (BIMS) of 15 out of 15. Resident #5 required supervision with bed mobility and personal hygiene, limited assistance of one person with transfers and toileting, and extensive one person assistance with dressing. She was occasionally incontinent of bladder and continent of bowel. She had no behaviors, or refusals of care. 2. Resident interview Resident #5 was interviewed on 2/21/22 at 12:01 p.m. She said a week or so ago, she waited two hours to be taken to the bathroom. She said the staff did not answer her call light for one and a half to two hours. She said she was afraid it could happen again. Resident #5 said, she was afraid and anxious if it was an emergency, or she fell , no one would come help her for two hours. She said he was still feeling anxious, and afraid about the lack of help. She said I am so afraid. Resident #5 said her voice had been affected by her stroke, and she had no way to call out for help. She said he had spoken to the staff regarding the incident, but she could not remember who. She said she was told the nursing home administrator (NHA) would be following up with her, but she had not spoken to NHA. 3. Record review and staff interviews (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Grievances or concern forms for Resident #5 and Resident #7 (see below) in the last 30 days were requested from the CR on 2/21/22 at 1:14 p.m. She said she did not have a grievance form for Resident #5 or Resident #7, but the NHA did have an investigation for both residents on 1/27/22. The Facility Investigation Template, dated 1/27/22 at 8:30 a.m., was received from the NHA on 2/21/22 at 1:47 p.m. It documented in pertinent part, Event-extended call light wait time, related information-one staff member on (the floor where the resident resided). Resident #5 pushed her call light and it took an extended period of time for her need to get met .LPN (licensed practical nurse) was suspended pending investigation for neglect. The ADON (assistant director of nursing) and CNA (certified nurse aide) immediately went and took ownership of the unit. Social services and the DON (director of nursing) checked with Resident #5 to make sure she didn't have any lingering fears about her call light not getting answered. The form documented the police and the State Agencywere notified. The form documented N/A (not applicable) under was the resident assessed for pain, and was the resident's skin assessed. The form documented the resident was assessed for emotional support, and the staff member was terminated and reported to the Board of Nursing. The investigation was signed by the NHA on 2/1/22. Included in the investigation was a statement from Resident #5, titled Investigation Interview, dated 1/27/22. It documented, I put my call light on. No one came. I was scared. Why didn't anyone come? I had to wait a long time. The staffing coordinator (SC) finally came and helped me. There was a form attached to the investigation dated 1/27/22, that listed seven resident names. The form documented the seven residents had no concerns with call light wait times or concerns they wanted to report. -It did not document that the five other residents were interviewed who had extended call light wait times over two hours that morning, according to the Call Light Detail Report (see below), on 1/27/22. Additionally, there was a statement from the SC dated 1/27/22, which documented Went to answer Resident #5's call light, and she reported that she had her call light on for a long time. She was upset and tearful. She said she is afraid that no one was in the building to assist her. -The investigation did not include an interview with LPN #3, who was working on 1/27/22. Resident #5's bladder care plan, initiated 10/24/21, documented in pertinent part, Resident #5 is continent of bladder. Clean peri-area with each incontinence episode. Encourage fluids during the day to promote prompted voiding responses. Ensure the resident has unobstructed path to the bathroom. Resident #5's bowel care plan, initiated 10/24/21, documented in pertinent part, Resident #5 is continent of bowel. Check resident every two hours and assist with toileting as needed. Provide loose fitting, easy to remove clothing. -The care plan did not document the limited assistance the resident needed with toileting on the 1/6/22 MDS assessment. (continued on next page)

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Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/27/22 at 11:27 a.m., a late entry nurses note documented,IDT (interdisciplinary team) Investigation of a grievance/concern that was shared with staff. Interview conducted with Resident #5: Resident #5 reports that she pressed her call light and it was not answered timely. A self-report via the state was made for possible neglect. MD (physician) made aware. PD (police department) made aware and message left with sister, the healthcare proxy. Resident #5 denies pain and she also reports that she feels safe here at the facility. SSD (social service director) will provide support and comfort. Line staff aware. Frequent checks implemented. Staff will encourage Resident #5 to share her feelings about the incident. On 1/27/22 at 3:35 p.m. a late entry nurses note documented the following, SSA (social services assistant) spent 20 mins with resident to give support and encourage Resident #5 to talk about her feelings regarding recent grievance. Resident #5 stated thank you I'll be fine. SSA checked on resident three times throughout the day to offer additional emotional support. On 1/28/22 at 10:05 a.m., the nurses notes documented,Checked in on resident today, she is doing well and has no concerns. All needs are being met by staff. Nothing adverse noted related to reported incident. On 2/2/22 at 3:37 p.m., the social service assistant (SSA) note documented in pertinent part, met with resident . needs are being met by staff. No concerns from Resident #5 today. -There were no further notes after 2/2/22 when reviewed during the survey on 2/22/22 regarding the resident's mental or psychological status related to the event on 1/27/22. Certified nurse aide (CNA) #7 was interviewed on 2/21/22 at 10:05 a.m. She said Resident #5 was continent of bowel and bladder, and will use her call light when she needs assistance going to the bathroom. B. Resident #7 1. Resident status Resident #7, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, morbid obesity, major depression and anxiety. The 1/11/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status score (BIMS) of 15 out of 15. Resident #7 required supervision with bed mobility. She was independent with transfers and personal hygiene. She required extensive one person assistance with toileting, and dressing. She was always incontinent of bladder, and continent of bowel. She had no documented behaviors of refusals of care in the assessment. 2. Resident interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Resident #7 was interviewed on 2/21/22 at 12:30 p.m. She said a few weeks ago she had to sit on the toilet for two hours, because no one would answer her call light. Resident #7 said she can ambulate to the bathroom herself, but needed assistance with wiping and getting off the toilet. She said that morning she waited for two hours, her legs had gone numb and she could not feel her feet. She said she was afraid she was going to fall. Resident #7 said she was still nervous and afraid it could happen again. 3. Record review and staff interviews A document titled Facility Investigation Template, dated 1/27/22 at 8:30 a.m., was received from the NHA on 2/21/22 at 1:47 p.m. It documented in pertinent part, Event-extended call light wait time, related information-one staff member on (floor where the resident resided). Resident #7 pushed her call light and it took an extended period of time for her need to get met .LPN was suspended pending investigation for neglect. The ADON and CNA immediately went and took ownership of the unit. Social services and the DON checked with Resident #7 to make sure she didn't have any lingering fears about her call light not getting answered. -The investigation had the exact verbiage that was documented for Resident #5 (see above). The form documented police and State Agencywere notified. The form documented the resident was assessed for pain, skin, adn emotional support. It documented the staff member was terminated and reported to the Board of Nursing. The investigation was signed by the NHA on 2/1/22. The investigation included a statement from Resident #7. It documented, I pressed my call button when I was in the bathroom. I need help after I use the toilet. I was sitting there waiting, I don ' t (sic) know how long it took, but it was a long time. The SC came to help me. I asked her what took so long and she didn't say anything. The investigation included a statement from the SC. It documented, I answered Resident #7's call light and she told me that she had been waiting a long time for someone to come help her in the bathroom. She said she walked to the bathroom by herself but she needed help to clean and that she was waiting a long time. -The investigation did not include an interview with LPN #3, who was working on 1/27/22. On 1/27/22 at 10:59 a.m. the nurses notes documented, late entry, Investigation of a grievance shared with staff. According to the resident she pressed her call light and it was not answered timely, please note that Resident #7 can independently ambulate herself using her FWW (front wheeled walker) to the bathroom she will do this then call for help for staff to assist her off the toilet.A self report of possible neglect was reported via the state portal. MD made aware. PD make aware and message left with sister .Skin assessment revealed no breakdown and Resident denies pain. When prompted Resident reports she feels safe here at the center. SSD will provide support and comfort. Line staff aware. Frequent checks implemented. Staff will encourage Resident to share her feelings. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 1/28/22 at 6:27 a.m., the nurses notes documented, This writer assisted resident to the toilet this AM (morning) and provided peri-care. No concerns noted this day. Mood is calm and cheerful, resident is talkative and joking with this writer. Soiled linens changed, needs met as requested by resident, and resident transferred back to her recliner. Call light within reach, ice water refreshed,and no questions or concerns verbalized. Will continue to monitor. On 1/31/22 at 10:14 a.m., the nurses notes documented, Resident #7 is doing well today, all needs are being met by staff. Nothing adverse noted related to the reported call light incident. On 2/2/22 at 3:39 p.m. the social service notes documented, SSA met with Resident. Resident's needs are being met by staff. No concerns from Resident #7 today .SSA spent 15 mins (minutes) with resident to give support and encourage resident to talk about her feelings regarding recent grievance. SSA checked on resident 3 times throughout the day to offer additional emotional support. -There was no further follow-up documentation regarding the effect on the resident as of 2/22/22. The continence care plan, initiated 11/16/21, documented in pertinent part, has occasional bladder, Clean peri-area with each incontinence episode, Encourage fluids during the day to promote prompted voiding responses, Ensure the resident has has unobstructed path to the bathroom, Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse,increased temp, Urinary frequency,foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. CNA #7 was interviewed on 2/21/22 at 10:15 a.m. She said Resident #7 was usually continent of urine and used her call light for staff assistance with wiping after using the bathroom. C. Administrative interviews The NHA and CR were interviewed on 2/21/22 at 1:47 p.m. The NHA said she had reported the incident that happened with Resident #5 and Resident #7 to the State Agency as neglect. She said on 1/27/22, licensed practical nurse (LPN) #3 was on duty the morning of 1/27/22. His shift started at 6:00 a.m. She said the unit where the residents resided was normally staffed with one licensed nurse and one certified nurse aide (CNA). The NHA said that morning the CNA did not show up, and no one in the facility knew that. She said the night shift left before the day shift arrived. The NHA said the facility had now identified this as a concern which contributed to the neglect that morning on 1/27/22. The NHA said LPN #3 was having a mental health crisis. He was not passing medications to residents, and not aware there were call lights going off. She said he did not know there was no CNA on the floor. The NHA said the SC came in around 7:45 a.m. and noticed multiple call lights were going off on the floor. The NHA said the SC thought LPN #3 was acting differently. The SC notified the NHA. The NHA notified the director of nursing (DON), and had the assistant director of nursing go to the floor to take over the medication pass from LPN #3. The NHA said the DON had a CNA from another floor cover the floor where LPN #3 was working. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The NHA said she did not know how many call lights were going off, but she knew the call light for Resident #5 and Resident #7 had been on. She said LPN #3 had been terminated and reported to the Board of Nursing. She said the facility did skin assessments on all residents on that floor on 1/28/22. There were no new concerns. She said she had not interviewed all the residents residing on that floor regarding the call light delays (see Call Light Detail Report below) and should have. The NHA provided a resident daily census sheet during the interview. It documented there were 21 residents on the floor where Resident #5 and Resident #7 resided. It documented that two residents were fall risks, five were dependent on staff for toileting, and four were dependent on staff for transfers. The NHA said since 1/27/22, the facility had implemented walking rounds between shifts so one shift did not leave before the next shift arrived, and she was reviewing the call light detail reports randomly. She said ideally, she would like the call lights answered within 10 minutes. Additionally, she has begun calling the facility daily at 6:00 a.m., to check the staffing, had moved the office of the social service assistant to the floor where the residents resided (#5 and #7), and had inserviced the staff on their mental health. A voice message was left for LPN #3 on 2/22/22 at 10:45 a.m. There was no return call by the end of the survey, or within 24 hours after. D. Call light reports for other residents on the floor 1/27/22 The Call Light Detail Report for 1/27/22 was received and reviewed with the NHA on 2/22/22 at 3:28 p.m. The NHA said she had not reviewed the report on 1/27/22. The Call Light Detail Report for 1/27/22, documented the call light for Resident #5 went on at 7:00 a.m. and was turned off at 8:56 a.m. It had been going off for one hour and 56 minutes. The Call Light Detail Report for 1/27/22, documented the bathroom call light for Resident #7 went on at 6:13 a.m. and was turned off at 8:22 a.m. It had been going off for two hours and nine minutes. Additionally, the following were documented for call light times: -The call light for a resident room on the floor went on at 6:01 a.m. and was turned off at 9:16 a.m. It had been going off for three hours and 15 minutes. The NHA said she did not interview this resident on 1/27/22. She said I am not sure what happened, or why he was not interviewed. -The call light for a resident room on the floor went on at 6:34 a.m. and was turned off at 12:35 p.m. It had been on for six hours and one minute. The NHA said the resident pushed his call light frequently and she felt the staff had call light fatigue (see or hear the call light, but your brain filters it out due to overuse). -The call light for a resident room on the floor went on at 7:06 a.m. and was turned off at 9:21 a.m. It had been on for two hours and 15 minutes. The NHA said she had not spoken to this resident on 1/27/22, and should have. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-The call light for a resident room on the floor went on at 7:07 a.m. and was turned off at 12:36 p.m. It had been on for five hours and 29 minutes. This resident was listed as interviewed in the 1/27/22 in the facility investigation. It documented she had no concerns with call lights. E. Additional interviews The ADON was interviewed on 2/22/22 at 10:26 a.m. She said she usually comes in between 7:45 a.m. and 8:00 a.m. and then gets a report from the nurses on the floors around 8:30 a.m. She did not recall what time she went to to the floor on 1/27/22. The ADON said she went to the floor that morning, she did not recall what time. She said LPN #3 seemed off. She said his eyes seemed tired and heavy. She said they began to review a resident's insulin dose, and he just seemed off. The ADON said she went and reported this to the DON. The ADON said the DON came to the floor and escorted LPN #3 downstairs, and the ADON took over the medication cart. The ADON said she remembered there were multiple call lights going off, and she did not recall if there was a CNA on the floor. She said she thought at some point a CNA was sent to the floor, but she did not know when that was. The ADON said she was not involved in the investigation of what occured. The SC was interviewed on 2/22/22 at 2:21 p.m. She said she was the staffing coordinator. She said she went up to the floor around 7:45 a.m. She said there were call lights going off everywhere, and there was no CNA on the floor. She said a CNA had been scheduled, but had not shown up. The SC said LPN #3 seemed, confused, like he wasn't all there. She said she reported what she had seen to the DON. The SSD was interviewed on 2/22/22 at 3:00 p.m. She said she worked with residents on the first and second floor. She said she did not know how long the residents were without help on the morning of 1/27/22. She said she did not talk to any of the residents about that specific morning. She said she had not visited Resident #5 or Resident #7 about what had happened on 1/27/22. She said she had not spoken to them regarding any specific call light concerns.The SSD said maybe her assistant spoke to the residents, but she said her assistant was unavailable today for an interview. The SSD said if she had known Resident #5 and Resident #7 had expressed fear, social services should have been following up with them daily. She said she had not discussed call light concerns with any of the residents on the floor where Resident #5 and Resident #7 resided. F. LPN #3 employee record The employee record for LPN #3 was received from the NHA on 2/22/22 at 4:43 p.m. The license verification record, printed by the facility 4/26/21, from the department of regulatory agencies ([NAME]) documented LPN #3 had a letter of admonition (warning) effective 3/20/2020. The NHA said she was unaware of the admonition. The [NAME] website documented, On or about August 30, 2019, you showed no sense of urgency to a declining patient who was having trouble breathing, you failed to contact a physician about potential change in the patient's condition and you failed to make essential entries in said patient's chart. The NHA said the facility was not aware of this history, however the license verification printed by the facility on 4/26/21 documented there was a letter of admonition. G. Facility follow-up (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/22/22 at 4:00 p.m., the NHA provided an undated document, titled, Abuse and Neglect Investigate, Prevent, Correct, Alleged violation. Corrective Action-Resident was assessed on 1/27/22 for psychological harm by SSD and on 1/31/22 by Administrator. Based on resident interviews Resident did not display any psychological harm. Resident had head to toe skin observation conducted by DON on 1/27/22 no skin issues identified. On 1/27/22 (LPN #3) was placed on suspension, reported to Board of Nursing, and terminated on 2/3/22. Identification of Others: All residents requiring toileting assistance are at risk of this alleged deficient Practice. A full house Toileting Assistance Audit was conducted on 2/1/22 by DON for residents requiring toileting assistance. No other residents were identified. A full house call Light Audit was conducted by IDT on 2/1/22 to ensure no other residents had issues with delayed call light response times. No other residents were identified. Systemic Changes: staff will be be re-educated by DoN/designee on or before 2/4/22 on importance of answering call lights timely.Nursing staff will be re-educated on providing toileting assistance timely for residents who need assistance.Nursing staff will be re-educated by HR (human resources)/designee on not coming to work if impaired.Education will be provided to new hires, annually and as needed.Weekly Ambassadors rounds will be conducted by IDT to include asking if a call lights are being answered timely and toileting needs are being addressed timely. Weekly Ambassador round concerns will be immediately addressed by Administrator/designee. Monitoring: Purposeful rounding, Ambassador rounds,. Shift to shift walking rounds to ensure that staff has shown up for their shift immediately, call at the start of shift when out of the building to confirm staff has arrived. When in the building, check in with the units to ensure that staff has shown up. -However, a full house call light audit had not been done by 2/1/22 as documented in the plan, and according to the NHA interview on 2/22/22. She had not reviewed the Call Light Detailed Event Report from 1/27/22 (see above) for other residents residing on the floor. She had not followed-up, and had no documentation of follow-up, with all residents who had extended call light times on the morning of 1/27/22. 33298 III. Resident #3 A. Resident status Resident #3, age under [AGE] years, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease (COPD), generalized anxiety disorder, chronic kidney disease, obstructive sleep apnea, urinary retention, adjustment disorder, [NAME] syndrome, borderline personality disorder, post traumatic stress disorder (PTSD), insomnia, bipolar disorder, and obsessive compulsive disorder. The 1/14/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. No behaviors were exhibited. She required supervision and set up help with mobility and transfers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Resident interview Resident #3 was interviewed on 2/17/22 at 1:35 p.m. She stated she was happy in the facility and they did a good job with most things. She stated meals had been arriving late to her room lately and this sometimes caused her to feel sick because she was so used to the routine of the normal meal times. She stated she had requested a grilled cheese sandwich the day before which was delivered to her room at 5:00 p.m., though the meal did not come with the milk she requested. She stated she walked down to the kitchen to request the milk and the dietary staff member yelled at her, telling her she only had two hands and that the resident needed to take an anxiety pill. She stated this interaction had upset her greatly and triggered her PTSD and gave her anxiety. She stated the interaction was witnessed by a staff member and then the interaction was reported to the nursing home administrator (NHA). She stated she felt it was verbal abuse. C. Facility investigation The facility investigation was reviewed and revealed the NHA received the report and the investigation was started on 2/16/22. The dietary staff member was suspended pending the investigation. The investigation revealed the resident was interviewed and confirmed the report. The resident was also noted to be forgiving to the staff member and understanding that staff members get rushed and feel frazzled, but did not want this to happen again. Additional residents were interviewed during the investigation with no reports of abuse. The investigation concluded that the incident did occur, the staff member received sensitivity training related to interacting with residents prior to returning to work. The remainder of the facility staff received the same training by 2/22/22. The resident received friendly support visits from social services and activities staff to ensure no lingering effects from the interaction. -The facility investigation acknowledged the incident occurred between Resident #3 and the dietary staff member, however it did not document as substantiated verbal abuse. Based on the resident's interview above, she felt it was verbal abuse towards her and triggered her PTSD. D. Interview The NHA was interviewed on 2/18/22 at 2:45 p.m. She stated the incident was reported to her immediately and the investigation was ongoing. She stated the staff member had been suspended during the investigation, though the resident was asking for the staff member to return to work and had forgiven her for yelling at her. She stated the incident did occur and the staff member would undergo sensitivity training for interacting with residents prior to returning to work. -The NHA acknowledged the incident occurred between Resident #3 and the dietary staff member, however it did not say it was substantiated as verbal abuse. Based on the resident's interview above, she felt it was verbal abuse towards her and triggered her PTSD.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, record review, and interviews, the facility failed to ensure residents were free from physical restraints imposed for staff convenience and not required to treat medical symptoms for two (#16 and #2) of two residents reviewed for restraints out of 16 sample residents. Specifically, the facility failed to: -Perform an initial assessment and subsequent quarterly assessments for the use of a bolster (raised edge on mattress) for Resident #16; -Obtain a physician's order with a specific medical diagnosis for the use of the bolster for Resident #16; -Obtain a consent from the resident's medical durable power of attorney (MDPOA) prior to the use of the bolster for Resident #16; -Develop a monitoring system for the safe utilization of the bolster for Resident #16; and, -Develop a care plan to reflect the use of the bolster on the mattress and the reason for use for Resident #16. The facility further failed to ensure Resident #2 had unrestricted access in and out of his bed. Findings include: I. Facility policy and procedures The Use of Restraints policy, dated 12/2008, was received from the nursing home administrator on 2/22/22 at 3:20 p.m. The policy documented in pertinent part, Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention and a restraint is required to: Treat the medical symptom; Protect the resident's safety; Help the resident attain the highest level of his/her physical or psychological well-being. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improve the symptoms. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: The specific reason for the restraint (as it relates to the resident's medical symptom); How the restraint will be used to benefit the resident's medical symptom; The type of restraint, and period of time for the use of the restraint. The resident is in restraints: Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. Physical restraints shall be applied in such a manner that they can be speedily removed in case of fire or other emergency. Restraints with locking devices shall not be used. A resident placed in a restraint will be observed at least every thirty (30) minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. Restrained residents must be repositioned at least every two (2) hours on all shifts. Benefits of all options under consideration, including the use of restraints, not using restraints. Should a resident not be capable of making a decision, the surrogate or sponsor may exercise the right of the use or non-use of a restraint. (Note: The surrogate/sponsor may not give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical condition.Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. Documentation regarding the use of restraints shall include: Full documentation of the episode leading to the use of the physical restraint. II. Resident #16 A. Resident status Resident #16, age 75, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included Parkinson's and dementia. The 12/31/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of 6 out of 15. He required extensive one person assistance with bed mobility, and was totally dependent on staff for transfers. He required extensive one person assistance with dressing, toileting and personal hygiene. He had no restraints and had two or more falls since his last assessment. B. Observation and interviews The resident was observed in bed on 2/21/22 at 10:40 a.m. His bed was pushed up against the wall, and on the opposite side there was a bolster in place which extended the entire length of the bed. C. Record review The resident's assessments were reviewed in the electronic medical record (EMR). There was no restraint assessment, or any assessment for the use of the bolster to the mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The EMR was reviewed for a consent from the MDPOA for the use of a bolster to the resident mattress. There was no consent. The February physicians orders were reviewed. There was no order for a bolster to the mattress for Resident #16. The care plan was reviewed, there was no care plan for the bolster to the mattress for Resident #16. The progress notes and treatment administration record were reviewed. There was no documentation the resident was monitored with the use of the bolster. The progress notes indicated the Resident had six falls between 1/12/22 and 2/19/22. On 1/12/22 the resident was lying on the mat next to his bed, the notes documented the resident was able to move past the wedge pillow. On 1/29/22, the resident fell trying to stand from the bed. On 2/6/22, Resident #16 fell from his wheelchair. On 2/13/22 he was on the floor in front of his bed. He had a bolster in place at the time. On 2/14/22 he was again on the floor, the nurse documented she suspected he rolled out of bed. However this was not witnessed, and the resident would have had a bolster in place. On 2/19/22 the resident attempted to stand and fell (cross-reference F689, accident hazards). On 2/16/22, the IDT (interdisciplinary team) documented, Fall on 2/13/22: Resident's intervention was to be screened by an external medicare/medicaid elderly program (referral sent), anti-thrust cushion, and adjustment to w/c. The occupational therapist (OT) from the external program screened resident and recommended that bolstered mattress should be removed. After team discussion, IDT fall team recommends bolstered mattress to bed d/t (due to) resident unable to determine mattress perimeter without bolsters. Resident has had falls out of bed prior to application of bolstered mattress. Discontinue intervention of anti-thrust cushion and change to w/c positioning. Due to time of residents fall, new intervention of monitoring of sleep hours for sleep hygiene, x 7 days. Fall on 2/14/22: Resident intervention changed to Offer toileting at HS. Continue to monitor sleep qshift to determine sleep schedule or inconsistencies with sleep. -However, there was no assessment done by the IDT on 2/16/22, no care plan written, no physician's order or consent obtained from the MPOA. There were no witnessed falls of the resident rolling out of the bed. The occupational therapy (OT) assessment from the external medicare, medicaid eldery program documented on 2/14/22, spoke with nurse on duty about having a bolster on the patient bed, and how this could be considered a restraint and I am not recommending this. Having a bolster is used for someone who rolls out of bed while sleeping, while patient tries to transfer himself, is not rolling out of bed. Nurse advised to remove this. Additionally, on 2/18/22 the facility certified occupational therapy assistant (COTA) screened Resident #16 for the use of the bolster. The form was blank under transfers, bed mobility and falls. The screening did not include an assessment of whether the bolster was inhibiting the resident's ability to transfer in and out of the bed. It did recommend a trial removal of the bolster to the mattress. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	However, based on observations, the bolster was still in place as of 2/21/22, four days later, during the survey. D. Interviews The clinical resource (CR) nurse was interviewed on 2/22/22 at 8:40 a.m. She said she had noticed the resident had a bolster on the bed last week. She said there was no restraint assessment for the bolster, no order, and no care plan. She said the facility had asked the director of rehabilitation (DOR) to have the bolster assessed last week. The CR said there was no documentation as to when the bolster was originally placed on the bed. She said there should have been an assessment, a physician's order, MDPOA consent and a care plan for the use of the bolster. The director of rehabilitation (DOR) was interviewed on 2/22/22 at 1:02 p.m. He was interviewed regarding the COTA screen done on 2/18/22. He said a screen involved observing the resident do tasks, looking at environmental safety and room modifications. He said because he did not do the screen, he did not know what was done, and the screen form was blank for transfers, bed mobility and falls. The DOR called the COTA on the phone during the interview. The COTA said she talked to a CNA who said the resident was able to navigate out of bed and around the bolster, but she did recommend a trial removal for 14 days. She said the bolster should be used to keep the resident from rolling out of the bed. She said she did not know if Resident #16 ever rolled out of the bed, or had difficulty identifying the edge of the bed. She said she did not screen him for his ability to transfer over the bolster, or whether the bolster was restraining his movement and transfer ability. The COTA and DOR said they did not know when the bolster was placed and neither had recommended the use of the bolsters. The DOR said normally, therapy would have been asked to evaluate the use of the bolster and make recommendations. The DOR said he did expect the screening therapist to assess how a resident transferred, or if they could, with the use of the bolster, as well as the effect on the resident's bed mobility. Additionally, the DOR said he did not know why the bolster was not removed after the outside OT recommended the removal on 2/14/22, or why it was still not removed when the facility COTA recommended it on 2/18/22. The NHA was interviewed with the CR on 2/22/22 at 1:47 p.m. She said she had received an email from the OT with the external medicare, medicaid eldery program on 1/17/22. She said the email alleged the bolster was a physical restraint and impeded the resident's mobility. The NHA said she asked the rehabilitation department to screen the resident for the use of the bolster. The NHA and CR reviewed the screen completed by the facility COTA on 2/18/22. The CR said the screen was not effective as it did not assess the resident's bed mobility or transfers with the bolsters. The NHA said the COTA should have actually looked at the ability to transfer, and whether the bolster was restraining the resident. The CR said again, there is no order for it and no assessment. The NHA could not explain why the bolster was still in place on 2/21/22, when observed by the surveyor, four days after the facility COTA had recommended removing it. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The OT from the external medicare, medicaid eldery program, was interviewed on 2/23/22 at 9:48 a.m. via telephone. She said she had assessed Resident #16 at the facility on 2/14/22. The OT said she had a physical therapist (PT) with her that day. The OT said, I told the staff that day, this was a safety hazard for Resident #16. He was impulsive and frequently trying to get out of bed. She said his Parkinson's was progressing and his cognition was declining. The OT said the bolster was not an appropriate intervention, and it made it difficult for him to transfer out of the bed. She said he did not have a history of rolling out of bed or difficulty finding the edge of the bed that would warrant the use of the [NAME]. She said the bolster was inappropriate. The OT said she had spoken to the facility DOR that day, and he had agreed with her that it was a restraint and a hazard for Resident #16. She said the DOR agreed that it was limiting his ability to transfer, and not being used for the appropriate reason. She said again, he did not roll out of bed that she was aware of, but he did frequently try to transfer himself. The OT did not know why the facility did not remove the bolster. III. Resident #2 A. Resident status Resident #2, age 76, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included dysthymic disorder (persistent depression), unspecified psychosis, muscle weakness and history of falls. The 12/31/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 12 out of 15. He required limited one person assistance with bed mobility, and extensive one person assistance with transfers, dressing, toileting and personal hygiene. Resident #2 had two or more falls since his last assessment. B. Observations and interviews Resident #2 was observed in bed on 2/21/22. His bed was pushed up against the wall. On the other side of his bed, a large recliner was pushed up against the bed covering the top three fourths, leaving only a one fourth opening toward the bottom of the bed. Certified nurse aide (CNA) #7 observed the resident's bed, and was interviewed on 2/21/22 at 10:30 a.m. She said the resident was pretty mobile. He climbed into bed at the bottom and then scooted to the top of the bed on his bottom. She said he sat at the bottom edge of the bed and scooted on his bottom up to the top. To get out of the bed, he scooted down to the bottom and put his legs out the open one fourth area. However, according to this MDS assessment on 12/31/22, the resident required limited one person assistance with bed mobility and extensive one person assistance with transfers. Licensed practical nurse (LPN) #1 observed the resident's bed, and was interviewed on 2/21/22 at 11:57 a. m. She said, I see an issue that he cannot get in or out of his bed, except at the foot of the bed. She said he had to get in at the foot of the bed and crawl to the top. She said she did not know if he was a fall risk, but he could fall if he tried getting out of the bed by climbing over the recliner. She said the recliner was blocking the entire upper half of his bed and limiting his ability to get in and out of his bed. LPN #1 said the room was too small for the recliner and there was no way to move it away from the bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The corporate nurse consultant (CNC) observed the bed and was interviewed on 2/21/22 at 1:14 p.m. She said, That is not acceptable. She said this situation created a fall risk and restricted his access in and out of the bed. The CNC said she did not know if the interdisciplinary team (IDT) had actually looked at his room after his multiple falls (cross-reference F689, accident hazards). She said she would get the NHA up to look at rearranging the room. On 2/21/22 at 4:17 p.m., the NHA said Resident #2 had agreed to move to a different room, to make the space safer. On 2/22/22, Resident #2 was observed in another room. His recliner was not pushed up against his bed. He had access in and out of the bed. Resident #2 said he was happy with his new room. However, the facility had failed to put non-skid strips in front of his bed as documented in his care plan. C. Record review The progress notes were reviewed. Resident #2 had a fall on 12/17/22. He was found on the floor by the bed leaning on the recliner. He said he was trying to go to the bathroom. On 1/5/22 he slid out of his recliner. On 1/11/22 he was found on the floor. On 1/12/22 he was on the floor in the hallway. On 1/16/22 he was found on the bathroom floor. He said he was going to the bathroom. The fall care plan, initiated 5/23/12, was reviewed and documented in pertinent part, Resident #2 is at risk for falls and has falls r/t (related to) psychotropic med use and hx (history) of falls, use of walker, slight shuffle gait and generalized weakness. OT will assess the need for a non-slip mat for (resident's) recliner. Therapy will assess the need for additional support. Non skid strips to the side of bed. Offer a night light to be on during night hours. Staff to educate to reach back for the chair before sitting. Encourage/assist to have proper non-skid footwear. Prefers to have his call light attached to the cord in his room. Encourage/remind to call for assist if needing assist with transfers/ADL's. Keep room free from clutter and pathways clear. Perform investigation to determine and address causative factors of the fall. Pharmacy consult to evaluate medications prn (as needed). PT/OT to evaluate and treat prn. Monitor for adverse effects to medications and report any findings to physician.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33298 Based on record review, observations, and interviews, the facility failed to ensure that two (#1 and #15) out of 16 sample residents received care and services to prevent the development and worsening of pressure injuries. Resident #1 was dependent on staff for mobility, transfers and repositioning and was identified at risk for developing pressure injuries. The facility failed to prevent the development and worsening of a pressure injury for Resident #1. On 1/7/22 an unstageable pressure injury was discovered on Resident #1's thoracic spine. The resident was noted to be resistant to care with minimal documentation done in response to the resident's resistance. Wound care treatment orders were not consistently followed. Due to the facility's failures, the resident developed an avoidable, facility-acquired unstageable pressure wound to his thoracic spine. The resident was transferred to the hospital on 2/14/22 where he was discovered to have an infected stage three pressure injury which required intravenous antibiotics, an invasive debridement and a wound vac to treat the infection and heal the wound. Resident #15 was dependent on staff for mobility, transfers and repositioning and was identified at risk for developing pressure injuries. The resident was admitted to the facility without any pressure ulcers and developed a pressure injure on the coccyx area two month after initial admission the facility. The pressure injury healed within two months but the pressure injury to Resident #12 coccyx redeveloped a month after healing. Upon reemerging the pressure injury was first noted to be a stage-3 pressure injury there was no documentation of the resident coccyx showing signs of breakdown at any stage prior to the injury bed observed as a stage-3 pressure injury. Due to the facility's failure to identify and treat the resident impaired skin condition the skin continued to breakdown and the resident developed a second stage-3 facility acquired pressure injury. This deficiency was cited previously during a recertification survey 10/27/21 and specifically for Resident #15. Although the facility corrected the deficiency, based on the findings below, the facility has not maintained compliance with this regulatory requirement. Findings include: I. Professional reference The National Pressure Ulcer Advisory Panel (2016) NPUAP Pressure Injury Stages, retrieved on 2/8/22 from: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf revealed the following pertinent information: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. II. Facility policy and procedure The facility Pressure Injury policy, revised March 2020, was provided by the nursing home administrator on 2/22/22 at 3:40 p.m. It read, in pertinent part: Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed: -Evaluation of the resident's clinical condition and risk factors; -Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; -Monitoring or evaluation of the impact of the interventions; or (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Revision of the interventions as appropriate. Tissue tolerance is the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects. Tissue tolerance affects the length of time a resident can maintain a position without suffering a pressure ulcer/injury. III. Resident #1 A. Resident status Resident #1, age 73, was admitted on [DATE] and discharged to the hospital on 2/14/22. He had not yet returned to the facility. According to the February 2022 computerized physician orders (CPO), the diagnoses included type 2 diabetes mellitus with ketoacidosis without coma, displaced intertrochanteric fracture of right femur, methicillin resistant staphylococcus aureus infection, unspecified fracture of upper end of right humerus, need for assistance with personal care, venous insufficiency, weakness, abnormality of gait and mobility, anorexia, history of falling, history of sepsis, and adult failure to thrive. The 12/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He exhibited rejection of care. He required extensive assistance of two staff members with transfers and bed mobility and extensive assistance of one with activities of daily living (ADLs). The resident's fall history was not assessed. The resident had a disease or condition that may result in a life expectancy of less than six months. He did not have a pressure ulcer, he was identified to be at risk for developing pressure ulcers, he had a surgical wound and a skin tear. He had a pressure reducing device for his bed and his chair. The MDS assessment documented the resident was not on a turning and repositioning program and was not receiving nutritional interventions. The resident received oxygen and hospice services in the facility. B. Record review A skin care plan updated 11/3/21 read: Resident has actual impairment to skin integrity related to self inflicted scratches. Pertinent interventions included: Educate (resident)/family/caregivers of causative factors and measures to prevent skin injury; and Encourage good nutrition and hydration in order to promote healthier skin. A skin committee meeting note dated 11/4/21 read: Full house skin sweep completed. Resident noted to have reddened coccyx. No open areas noted. Shearing to LLE. Resident states that it happened in the hospital when he brushed his leg while trying to go to the bathroom. Wound MD in to assess. New orders for protective barrier cream and protective dressing to coccyx. Wound to LLE to apply medihoney and bordered gauze. Air mattress ordered. Denies pain or discomfort when asked. Staff assists with positioning at times. Resident incontinent. Staff to assist with frequent positioning and incontinence cares. Will continue to observe for change. MD, POA and DON notified. An air mattress was ordered for the resident on 11/4/21 due to redness to his coccyx. An order on 11/5/21 read: Offer resident frequent repositioning as resident allows for offloading every two hours for prevention. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An IDT (interdisciplinary team) weight committee meeting note dated 11/11/21 read: Reason for review: Sig (significant) wt (weight) loss. Current wt: 97.2lbs (pounds) Previous wt: 100lbs. 71% meals consumed. Loss of 19.5% in 30 days; resident was hospitalized for DKA (diabetic ketoacidosis) and fall with fx (fracture) x (for) 3 days. Orders for glucerna (nutritional supplement) 1.5, QID (four times daily)- 100%, fortified foods, double portions and CCHO (controlled carbohydrate) diet. Under hospice care. Current nutrition regimen meets estimated needs. Comfort is goal. Will continue to follow. A hospice care initiated 11/11/21 read: Resident has a terminal prognosis and is on hospice services related to senile deterioration of the brain. Pertinent interventions included: Adjust provision of ADLs to compensate for resident's changing abilities. Encourage participation to the extent the resident wishes to participate; Work with nursing staff to provide maximum comfort for the resident; wound care. A skin committee meeting note dated 11/13/21 read: Late Entry: Note Text: Wound MD (medical doctor) in to assess stage 1 to coccyx 11/12/12-pressure #2 shearing to right shin. Measurement Healed #2 5.0 CM (centimeters) x 1.0cm drainage: none #2 no drainage odor: None. Treatment: continue to provide frequent repositioning and incontinence cares as resident allows. Barrier creams with each incontinent episode. Continue with air mattress for prevention. #2 continue as above and dressing change to left shin every other day. cleanse with NS (normal saline), pat dry, apply bacitracin or equivalent and cover with bordered gauze every other day and PRN (as needed). Interventions: daily observation by staff, remain on weekly follow up with wound MD, weekly skin checks, provide barrier creams with incontinent episodes. Resident to continue with daily dietary supplements. Weekly skin checks by licensed staff. #2 continue with daily and PRN dressing changes. Education: resident education on importance of frequent offloading, skin care, and barrier creams. Resident dietary intake including protein and supplements will be monitored by dietician and weight and skin team. Resident will be monitored with hospice care givers weekly and will be encouraged to eat foods appropriate for CCHO dietary recommendations. Resident barriers: Resident bed bound and often refuses to get out of bed and participate in therapies. Resident impulsive and at times will attempt to get out of bed without assistance. Unsteady gait and has poor memory recall. Resident hospice patient and Diabetic. Sugars are irregular as resident is brittle diabetic and often consumes items not recommended for diet, or does not consume recommended portions of CCHO diet. A braden scale (pressure ulcer risk) assessment dated [DATE] revealed the resident was at high risk for pressure ulcers. A skin note dated 11/19/21 read: Resident was seen by Wound Dr. (doctor) for Left shin wound, area is not improving as resident is resistant to repositioning and skin care. Continue current treatment and encourage resident to increase mobility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0686 Level of Harm - Actual harm Residents Affected - Few	An IDT weight committee meeting note dated 11/24/21 read: Sig weight loss-wound healed. Current weight: 101.4. Previous weight: 96.0. BMI (body mass index): 13.8 (underweight, normal range 18.5-24.9). Meal Consumption: 51-75% intake this week. Supplements: QID Glucerna 1.5, 95% intake of supplement. Amount of weight loss or gain: 5.4 lb increase. Medications: Lantus, Levothyroxine-BS's (blood sugars) unstable. Recommendations: Receiving hospice services. Fortified lunch and dinner in place. Glucerna is giving approx 1,400 calories to (resident). Orders obtained from provider to change weights to monthly due to Dx(diagnosis) of unavoidable wt loss secondary to terminal dx. Hospice notified. Continue current regimen with comfort focused care as goal. A nursing note dated 11/25/21 read: Blood sugar at 2130 (9:30 p.m.) was 384 (normal range 140 of lower), appropriate insulin given. Displays no S/S (signs/symptoms) of hyperglycemia at this time. Appears more confused, was asking for dinner, which he already had, Gave him snacks, fluids. Has denied pain/discomfort at this time. Refusing to allow staff to change his soiled linens, 'leave me alone.' Will try again later. Monitoring. On 12/14/21 the resident suffered a fall which resulted in hip fracture which required hospitalization and surgical repair. The resident returned to the facility on [DATE] and an updated braden scale was not completed upon return. (Cross reference F689 Accidents). A nursing note dated 12/17/21 read: Res S/P R. (status post right) hip surgery. Vs (vital signs) is wnl (within normal range). R. hip post-surgery precautions implemented this shift. Res c/o (complained) of pain during this shift and prn (as needed) oxycodone 10 mg administered with 1000 mg Tylenol TID (three times daily), effective. R. hip surgical incision noted with 8 sutures above and 6 sutures below, and is clean dry and intact. Surgical incision well approximated, and no s/sx of infection noted this shift. Dressing change order received from doctor today and updated in TARs (treatment administration). (Named) Hospice nurse in for the visit. Incoming shift notified to continue to monitor. A nursing note dated 12/19/21 read: Res(ident) noted calm at this time, received oxycodone 10 mg prn this am, effective. Repositioning offered for comfort. Res continues on S/P R. hip surgery and no s/x of infection noted at this time. VS stable. Dressing changed to site this am (morning). A weekly summary assessment dated [DATE] revealed a pressure ulcer was discovered on the resident's back during the skin assessment. A follow-up braden scale assessment dated [DATE] revealed the resident was at high risk for pressure ulcers. An interdisciplinary team (IDT) weight committee meeting note dated 1/7/22 read the reason for review was skin. The resident's current weight was 115 lbs with meal consumption of 50 - 75%. The resident was receiving supplements of Glucerna four times a day with 100% acceptance. The recommendations included: receiving hospice services, weight loss expected. Accepts fortified lunch and dinner provided. Continue current regimen with comfort focused care as goal. -There were no skin related recommendations from this meeting. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An order on 1/8/22 read: posterior left upper back pressure injury wound care, clean with wound cleanser, allow to dry, apply silvadene to wound bed, do not exceed wound margins, apply bordered foam dressing, change daily and prn every shift for wound care. -The January 2022 treatment administration record (TAR) revealed this wound care order was missed on 1/8/22 and 1/11/22. The resident was seen by the wound care physician on 1/11/22 for the wound to the resident's lower back. The note revealed an unstageable pressure injury obscured full thickness skin and tissue loss pressure injury and had received a status of not healed. Initial wound encounter measurements were 5cm x 5cm with no measurable depth, with an area of 25 sq cm (square centimeters). There is a moderate amount of serosanguinous drainage noted which had no odor. Wound bed was 70% eschar and 30% slough. The periwound skin exhibited Erythema (reddening). The resident was at increased risk of wound incidence due to impaired mobility, decrease in functional ability, co-morbid conditions, diabetic complicating factors, and resident refusal of care and treatment. Orders were written to cleanse and irrigate the wound with normal saline, apply honey-based ointment-Medihoney, cover with dry dressing. Change the dressing every day and as needed. Recommendations to implement pressure relieving measures and offloading as tolerated. Low air loss mattress, reposition every two hours while awake to offload pressure. -Repositioning was not added to the care plan. An order on 1/11/22 read: posterior left upper back pressure injury wound care, clean with wound cleanser, allow to dry, apply Medihoney to wound bed, do not exceed wound margins, apply bordered foam dressing, change daily and prn every shift for wound care. -The January 2022 TAR revealed this order was missed on 1/18/22. A pressure ulcer care plan was initiated on 1/11/22, it read: Pressure ulcer to mid back. The goal for the care plan read: Pressure injury heals without major complications. Pertinent interventions included: Doctor aware; encourage off loading; air mattress in place; registered dietician following; hospice aware; and wound orders in place. -Review of the resident's care plans revealed no mention of the resident refusing to reposition or offload, nor were there any interventions related to what to do when the resident refused. The resident was seen by the wound care physician on 1/18/22 during wound rounds. The note revealed an unstageable pressure injury obscured full thickness skin and tissue loss pressure injury and had received a status of not healed. Subsequent encounter measurements were 5cm x 5cm with no measurable depth, with an area of 25 sq cm. There was a light amount of serosanguinous drainage noted which had no odor. Wound bed was 100% slough. There was no change noted in the wound progression. The periwound skin exhibited Erythema. The resident was at increased risk of wound incidence due to impaired mobility, decrease in functional ability, co-morbid conditions, diabetic complicating factors, and resident refusal of care and treatment. The wound was debrided and post debridement measurements were 5 cm x 5 cm x .1 cm. There was noted to be a very thick layer of slough and debridement was difficult. -No changes were made to treatment orders or recommendations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An IDT committee note dated 1/18/22 read: Review of resident's weight and intake. Resident continues on hospice care and now presents with a new PU (pressure ulcer) that was identified recently. After a long discussion the team has concluded that this PU is unavoidable due to resident remaining on his back at all times. Staff continue to educate resident on the importance of off loading; he expresses understanding however continues to lay supine in bed. Prostat (nutritional supplement) was added BID (twice daily) to promote wound healing. An order on 1/18/22 read: Prostat two times a day for wound healing. -The January 2022 TAR revealed this order was missed on 1/21/22 on the day shift. The resident was seen by the wound care physician on 1/25/22 during wound rounds. The note revealed an unstageable pressure injury obscured full thickness skin and tissue loss pressure injury and had received a status of not healed. Subsequent encounter measurements were 4.5cm x 4.5cm with no measurable depth, with an area of 20.25 sq cm. There was a light amount of serosanguinous drainage noted which had no odor. Wound bed was 100% slough. There was no change noted in the wound progression. The periwound skin exhibited Erythema. The resident was at increased risk of wound incidence due to impaired mobility, decrease in functional ability, co-morbid conditions, diabetic complicating factors, and resident refusal of care and treatment. The wound was debrided to promote viable tissue and formation of granulation. Post debridement measurements were 4.5 cm x 4.5 cm x .1 cm. There was noted to be a very thick layer of slough so only the top layer was removed. -No changes were made to treatment orders or recommendations. A wound committee note dated 1/25/22 read: Wound committee met today to discuss resident's PU, it currently measures 4.5x4.5xUTD (undetermined depth) with 100% slough and scant drainage. Last week measurements 5.0x5.0xUTD. This wound currently shows evidence of improvement, wound MD made rounds this morning and made no changes in his orders. Current orders read medihoney to base of wound, cover with dry dressing daily. Wound doctor and I spoke in length with regards to santyl. Wound doctor mechanically debrided the top layer of the wound today and reports if he does not see significant change by next week's rounds he will add the santyl. Wound doctor is aware that hospice will not cover santyl and that the center has agreed to cover the cost if needed. Resident is continually educated on the importance of repositioning to his side to off load pressure to aid in healing, however he continues to lay supine on the air mattress. Staff will continue to encourage intake and hydration. An order on 1/26/22 read: Mid Left back pressure injury wound care - cleanse with wound cleanser, allow to dry, apply Medihoney to wound bed, do not exceed wound margins, apply bordered foam dressing, change daily and prn drainage. one time a day for wound care. -The January 2022 TAR revealed this order was missed on 1/28/22 and the February 2022 TAR revealed the order was missed on 2/7/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	An IDT weight committee note dated 1/29/22 read RD (registered dietitian) review for weight and wound. Weight up 0.8 lbs from 1/19/22 to 1/26/22. BMI of 14.6 remains underweight. Overall significant weight loss of 6.4% (7.4 lbs) from 1/1/22 to 1/26/22. Prostat added 1/18 and res consuming 100%. Glucerna w/carb steady 1.5cal 4x/day - consuming 100%. Meal intakes ~ (about) 50% and fluid intake ~1800 mls/day. Per recent wound rounds, PU currently shows evidence of improvement and wound MD made no changes to orders at this time. PU unavoidable d/t (due to) res remaining in supine position. Resident is noted to continually be educated on the importance of repositioning to his side to off load pressure to aid in healing, however he continues to lay supine on the air mattress. Staff will continue to encourage intake and hydration. Weight stable and wound improving - no further nutrition interventions recommended at this time. Will continue to monitor weekly with IDT. The resident was seen by the wound care physician on 2/1/22 during wound rounds. The note revealed an unstageable, obscured full thickness skin and tissue loss pressure injury and a status of not healed. Subsequent encounter measurements were 4.2 cm x 4.1cm with no measurable depth, with an area of 17.22 sq cm. There was a light amount of serosanguinous drainage noted which had no odor. Wound bed was 90% slough and 10% granulation. The wound was noted to be improving. The periwound skin exhibited Erythema. The resident was at increased risk of wound incidence due to impaired mobility, decrease in functional ability, co-morbid conditions, diabetic complicating factors, and resident refusal of care and treatment. The wound was debrided to promote viable tissue and formation of granulation. Post debridement measurements were 4.2 cm x 4.1 cm x .1 cm. There was noted to be a very thick layer of slough and debridement was difficult. No changes were made to treatment orders or recommendations. A wound committee note dated 2/1/22 read: Wound committee met today post MD wound rounds to discuss resident's PI (pressure injury) to his mid-back. Current measurements: 4.2x4.1cmxUTD, 0 odor with scant drainage, no sxs (signs or symptoms) of infection. Wound bed is 90% slough with 10% epi (epitheliazation). Resident tolerated assessment/treatment well. We will continue with current treatment orders and interventions. Hospice will be updated on wound progress. Staff continue to encourage resident to off load from the supine position, however this is a major barrier as we explain to resident the benefits of off-loading, he will recognize this however will go back to the supine position. Staff will continue to encourage this. Treatment will continue as medi-honey to base of wound, cover with dry dressing qday (every day) and PRN. Care plans updated. The resident was seen by the wound care physician on 2/8/22 during wound rounds. The note revealed an unstageable obscured full thickness skin and tissue loss pressure injury and a status of not healed. Subsequent encounter measurements were 4.7 cm x 4 cm with no measurable depth, with an area of 18.8 sq cm. There was a moderate amount of serosanguinous drainage noted which had no odor. Wound bed was 80% slough with 20% granulation. The wound was noted to be deteriorating. The periwound skin exhibited Erythema. Other observations included cellulites (bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), moderate to large amount of purulent (pus) drainage. The resident was at increased risk of wound incidence due to impaired mobility, decrease in functional ability, co-morbid conditions, diabetic complicating factors, and resident refusal of care and treatment. The wound was debrided and post debridement measurements were 4.7 cm x 4 cm x .1 cm. The purulent fluid was evacuated from the site during the debridement. Wound treatment orders were changed to cleanse wound with normal saline, apply Santyl ointment, cover with dry dressing. Change dressing every day and as needed. An order was also added for an antibiotic and to discuss with hospice providers prior to starting the medication. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Wound infection had developed. A wound committee meeting note dated 2/9/22 read: Wound committee met today post MD wound rounds to discuss resident PI to his med-back. Current measurements: 4.7x4.0cmxUTD. Wound bed is 80% slough with 20% granulation. Moderate to large amounts of purulent fluid was evacuated from site using scissors/forceps. Periwound noted to have cellulites and erythema present. 50% of wound debrided with [NAME]. (Resident) does not tolerate treatment well so Dr is only able to do little at a time. Hospice will be updated on wound progress. Staff continue to encourage resident to off load from the supine position, however this is a major barrier as we explain to resident the benefits of off-loading, he will recognize this however will go back to the supine position. Staff will continue to encourage this. Treatment will be updated to use Santyl to base of wound, cover with dry dressing qday and PRN. Care plans updated. -However, the care plan was not updated to reflect the resident's current wound status and refusals. An order on 2/9/22 read: Keflex Capsule 500 MG (Cephalexin, antibiotic) Give 1 capsule by mouth three times a day for Infection. For 7 Days. -The February 2022 medication administration record (MAR) revealed the resident received this medication as ordered. An order on 2/9/22 read: Mid Left back pressure injury wound care - cleanse with wound cleanser, allow to dry. Apply Santyl to wound bed, do not exceed wound margins, apply bordered foam dressing. Change daily and prn drainage. One time a day for wound care. -The February 2022 TAR revealed this order was missed on 2/13/22 and 2/14/22. See interviews below A nursing note dated 2/10/22 read: Res. continues on an antibiotic for back wound infection. No adverse effects noted to the antibiotic. Dressing soiled with purulent drainage and changed as per orders. Fluids encouraged et (and) res tolerated well. Res afebrile (no fever). An IDT weight committee note dated 2/10/22 read: NAR (nutrition at risk) review for weight and wound status. Current body weight: 104.6, Previous body weight: 106.4. Weight gain or loss: loss of 1.8 lbs. Diet: CCHO/reg/thin Meal consumption: 26-50%, Fluids 400 mls w/meals +360 mls Q12H (every 12 hours). Nutrition interventions: Prostat 30 mls BID, fortified meals. Recommendations: Reduced sugar med pass. DC (discontinue) glucerna New TSH (thyroid stimulating hormone blood test) to r/o (rule out) related weight loss. Wound is noted to be infected, encourage fluids and maintain comfort focused measures. Continue all other nutrition interventions as ordered. Will continue to monitor weekly with IDT. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nursing note dated 2/12/22 read: Resident alert and oriented to self, continues with keflex 500mg 3x a day, afebrile, black eschar (dark, dry scab) on the wound on mid upper back, yellow drainage, erythematous to surrounding area, bulge when palpated. Dressing changed per orders. Resident encouraged to be up with meals to relieve pressure from his back. Resident receptive. Encourage good nutrition and hydration. Continue to monitor for signs and symptoms of infection. A nursing note dated 2/13/22 read: Resident found on floor by MOD (manager on duty). Resident stable, VS WNL, no new injuries found. Neuro checks started, Hospice notified and will visit this morning, MOD aware, Daughter notified. Resident educated to use call light and ask for help to move to WC (wheelchair). (Cross reference F689 Accidents). A nursing note dated 2/14/22 read: Per the dayshift nurse report, culture of the resident's wound to the back was requested by hospice. Culture obtained this shift and sent to the lab. A nursing note dated 2/14/22 read: Resident remains on antibiotic for a wound infection to the back. No adverse reactions noted to the antibiotics. Resident afebrile, vital signs stable through this shift. Wound continues to have purulent drainage and minimal odor. Wound culture sample sent to the lab during this shift. Fluids encouraged and resident tolerated well. A nursing note dated 2/14/22 read: While completing wound care on resident noted change in skin area around the wound. An area of three inches on all sides of the wound was increasingly red and inflamed from previous day. Notified the DON (director of nursing) that resident asked to go to the hospital. Transport company contacted to transport the resident to the hospital, daughter notified, hospice notified. -The resident had not returned from the hospital as of the exit of the onsite investigation. C. Hospital records The resident's hospital records from admission on 2/14/22 were reviewed and revealed the resident was admitted with multiple comorbidities and issues with an acute stage three decubitus ulcer in the thoracic region. The wound was between thoracic T5 to T7 and measured 4 cm with black eschar oozing pustular discharge in a large square of erythema. The resident's daughter elected to stop hospice services to treat the wound and infection. Laboratory values in the hospital revealed the resident met sepsis criteria and was started on two intravenous antibiotics. Notes from the infectious disease specialist revealed a decubitus ulcer overlying thoracic region, stage three with associated staph aureus bacteremia. Status post bedside debridement down to muscle. Notes from the wound specialist revealed a bedside debridement was performed on the resident to remove all devitalized and infected tissue. The post debridement measurements resulted in a stage 4 pressure injury which was 5 cm x 3 cm x 2 cm with a large amount serosanguineous, tan and green drainage. A wound vac was placed on the resident for treatment and healing of the wound. D. Family interview A family member of the resident was interviewed[TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33298 Based on record review, interviews and observations, the facility failed to ensure the resident environment remained as free from accident hazards as was possible and that residents received adequate supervision to prevent accidents for four (#1, #2, #16, and #6) out of five residents reviewed for accidents out of 16 sample residents. The facility failed to implement effective interventions and provide adequate supervision to prevent falls for Resident #1, who was a known fall risk, had a recent history of a fall with major injury, and was dependent on staff for assistance. On 12/14/21, Resident #1 experienced an unwitnessed fall in the facility resulting in hip pain. The resident was sent to the hospital on 12/15/21 due to unrelieved pain and was discovered to have a right intertrochanteric femur fracture which required surgical repair. The interventions the facility implemented in response to the resident's fall risks and past falls were not effective in preventing future falls as the resident experienced a subsequent unwitnessed fall on 2/13/22. Additionally, neurological checks and follow ups were not completed and documented for the resident to rule out possible brain and latent injuries. The facility further failed to implement effective interventions to prevent falls, and complete neurological checks after unwitnessed falls, for Residents #2, #16 and #6; and, The facility failed to ensure environmental safety hazards were identified and remediated in resident rooms. Findings include: I. Facility policies and procedures The Resident Safety and Supervision policy, revised July 2017, was provided by the nursing home administrator on 2/21/22 at 4:17 p.m. It read, in pertinent part: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities. Our facility oriented approach to safety addresses risks for groups of residents. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (quality assurance process improvement) reviews of safety and incident/accident data; and a facility wide commitment to safety at all levels of the organization. When accident hazards are identified, the QAPI/Safety Committee shall evaluate and analyze the cause of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. Employees shall be trained on potential accident hazards, on how to identify and report accident hazards and try to prevent avoidable accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. Our individualized, resident-centered approach to safety and accident hazards for individual residents. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. Implementing interventions to reduce accident risks shall include the following -Communicating specific interventions to all relevant staff; -Assigning responsibility for carrying out interventions; -Providing training as necessary; -Ensuring interventions are implemented; and -Documenting interventions. Monitoring effectiveness of interventions shall include the following: -Ensuring that interventions are implemented correctly and consistently; -Evaluating the effectiveness of interventions; -Modifying or replacing interventions as needed; and -Evaluating the effectiveness of new or revised interventions. The Neurologic Check Policy, dated 10/10/06, was provided by the clinical resource (CR) on 2/22/22 at 11:30 a.m. It read, in pertinent part: Residents who have a fall involving striking the head or unwitnessed falls where it is not apparent if head injury occurred will have neurologic checks done by the nurse in charge of their care. The only exception would be if the resident is alert and oriented and has no evidence of head injury and denies hitting the head. Assess vital signs, temperature, pulse, respirations and blood pressure. Check orientation via verbal responses to questions regarding name, place, person, date, time, and events, attention span, mood, affect and behavior. Check ability to respond to verbal commands, raise arms, close eyes, move in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Check responses to tactile stimuli, squeeze hand, apply pressure to arm or leg on both sides of body. Check eyes for size and shape and ability to open and close; note symmetry of both eyes, compare pupil size to chart and equality. Use a penlight to check response to pupils to light. Check eye movement by noting ability to follow finger with eyes in all directions. First group of neurologic checks will be done at 15 minute intervals times four. Second group of neurologic checks will be done at 30 minute intervals times four. Third group of neurologic checks will be done at one hour intervals times four. Fourth group of neurologic checks will be done at four hour intervals times four. Fifth group of neurologic checks will be done at each shift times four. Sixth group of neurologic checks will be continued at each shift intervals through 72 hours. Document results of the neurologic checks on approved form per the policy. Documentation additional nurses notes for any abnormal finding and notify the physician of these finds for intervention. Continue documentation for the full 72 hours after the fall or head injury incident. II. Resident #1 A. Resident status Resident #1, age 73, was admitted on [DATE] and discharged to the hospital on 2/14/22. He had not yet returned to the facility. According to the February 2022 computerized physician orders (CPO), the diagnoses included type 2 diabetes mellitus with ketoacidosis without coma, displaced intertrochanteric fracture of right femur, methicillin resistant staphylococcus aureus infection, unspecified fracture of upper end of right humerus, need for assistance with personal care, venous insufficiency, weakness, abnormality of gait and mobility, anorexia, history of falling, history of sepsis, and adult failure to thrive. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 12/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He exhibited rejection of care. He required extensive assistance of two staff members with transfers and bed mobility and extensive assistance of one with activities of daily living (ADLs). The resident's fall history was not assessed. The resident had a disease or condition that may result in a life expectancy of less than six months. He did not have a pressure ulcer, he was identified to be at risk for developing pressure ulcers, he had a surgical wound and a skin tear. The resident received oxygen and hospice services in the facility. -Review of Resident #1's medical record revealed although he had a BIMS score of 15 out of 15, his cognition was at times severely impaired. B. Record review A fall care plan, initiated on 10/30/19 and last revised on 2/14/22 read: Potential for falls and has had falls related to low blood glucose, weakness and fall with fractured clavicle. The goals of the care plan included: The resident will be free from falls initiated 10/30/19, and Will be free from further major injury related to falls initiated 12/22/21. Pertinent interventions included: 10/30/19: Encourage/assist to have proper non-skid footwear; Keep room free from clutter and pathways clear; PT/OT to evaluate and treat prn (as needed); 3/29/21: Call light within reach of resident; 8/6/21: Resident prefers to wear wide shoes at times, family to provide new shoes to reduce tripping hazard; 8/9/21: Nightstand in resident's room to be padded to prevent future injuries from bumping against or falling against while ambulating independently in room; 10/28/21: Staff to provide frequent rounding to assess for incontinence issues. Record review revealed Resident #1 had a past fall with injury on 10/27/21 at 6:55 a.m. where the nurse was at the medication cart, heard a loud noise and found the resident on the floor on his right side. He stated his right shoulder hurt. His blood glucose was checked and was too high to detect. The resident was sent to the hospital where a right humerus fracture was discovered upon x-ray. An intervention was added to his care plan on 10/28/21 to call for assistance with incontinence cares and staff to do more frequent rounding to monitor for incontinence and nonskid footwear. -After Resident #1's falls on 10/27/21 and 12/14/21 (see below) high blood glucose levels were identified, yet there were no interventions related to high blood glucose possibly being related to his falls. A fall risk assessment dated [DATE] revealed the resident was at high risk for falls with a score of 16. A fall note dated 12/14/21 at 5:00 p.m. read: Found resident on floor on his right side. Resident had empty cup in his hand. Resident says he was trying to empty his cup and fell . He states he did not hit his head only hurts on his right hip. Pain is 8/10. Called CNAs to assist, VS taken, all WNL. BG 264, 2 units insulin lispro given. Neuro assessment normal. Resident able to move all extremities. Resident's brief changed and placed back in bed. Notified daughter, Hospice and DON. Hospice sending on call nurse to assess pt. 72 hour neuros started. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing note dated 12/14/21 at 8:30 p.m. read: Hospice came to assess the resident at 2200 (8:00 p.m.) due to continuous c/o (complaints) of pain at the right hip following an unwitnessed fall. New order received 50mg of tramadol tablet via mouth prn. The hospice nurse administered the first dose of tramadol. No effectiveness of pain. continue to monitor. A nursing note dated 12/14/21 at 11:40 p.m. read: Resident continues with neuros following fall. Vital signs 122/78, 98.2, 88, 18, 94%. Refused ADLs and complains of severe pain. Informed hospice nurse. No new orders received at this time. Continue to monitor. A nursing note dated 12/15/21 at 1:44 a.m. read: The resident was being monitored for neuros due to a fall that happened at 4:30 p.m. last evening. He complained of severe pain to the right hip. Tramadol was administered as ordered. Ineffective pain control. Resident states pain is still severe and interferes with ADLs. Called hospice and spoke with nurse. Hospice nurse stated resident to be sent to hospital as per family request. Call placed to transport company to transfer the resident to the hospital. EMS (emergency medical services) arrived at 1:30 a.m. and resident left facility at 1:40 a.m. A fall IDT (interdisciplinary team) note dated 12/15/21 revealed the resident fell on [DATE] at 4:45 p.m. The resident was assessed by a registered nurse (RN), appropriate notifications were made. The fall was unwitnessed and neurological checks were performed. The resident complained of pain 8/10 after the fall and PRN pain medications were administered and non-pharmalogical pain interventions were implemented. The root cause was identified as the resident had severe cognitive deficits. Resident may have been confused about his fluids and wanted a drink of water. The intervention added was Offer fluids frequently. The fall care plan was updated on 12/14/21 to reflect the intervention of offer fluids frequently. -This intervention was also a nutritional intervention already in place and is a basic care activity. -Records of the resident's neurological checks were requested and were not received. C. Hospital records Review of the resident's hospital records revealed the resident presented to the emergency department on 12/15/21 after a mechanical fall at the nursing facility and complained of right hip pain. X-rays of the right hip revealed a comminuted intertrochanteric fracture of the right proximal femur. Laboratory results from the hospital revealed the resident also had a urinary tract infection. The resident underwent surgical repair of the fracture. D. Additional record review An admission summary note dated 12/16/21 revealed the resident returned from the hospital with new orders for as needed pain medications, a muscle relaxer, and a laxative. Hospice, administration, and the physician were informed of the resident's return. The resident was alert and oriented x 1 (to person) as per usual baseline. He denied pain at the time. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A fall risk assessment dated [DATE] revealed the resident was at high risk for falls, though with a lower score of 13 than the previous assessment on 11/10/21 (see above). A nursing note dated 12/17/21 revealed the resident was status post right hip surgery. Vital signs were normal. Right hip post surgery precautions were implemented. Resident was complaining of pain and pain medications were administered which were effective. Surgical wound care orders were received and performed. A nursing note on 12/19/21 revealed the resident was calm, and received pain medications which were effective. Repositioning was offered for comfort. A nursing note dated 1/7/22 revealed the resident developed a new skin issue, an unstageable pressure injury to his thoracic spine. (Cross Reference F686 Pressure Injuries). The wound was treated in the facility, though worsened and became infected on 2/8/22. A nursing note dated 2/13/22 at 10:57 a.m. revealed the resident was found on the floor by the manager on duty. The RN assessed the resident and was determined to be stable, vital signs within normal limits, and no injuries found. Neurological checks were started. Hospice was informed and scheduled a visit to the resident. Daughter was notified and the resident was educated to use his call light and ask for help to move to his wheelchair. An activities note dated 2/13/22 at 5:22 p.m. revealed the resident was found on the floor by activities staff at 9:15 a.m. The activities staff called the RN and CNA on duty to assess and assist him. Review of the resident's fall care plan revealed an intervention of a physical and occupational therapy evaluation was added on 2/13/22. -While the resident could be evaluated by physician and occupational therapy, despite hospice status, this intervention was already in place for the resident and was not related to the root cause of the fall. A fall note dated 2/14/22 at 1:40 a.m. revealed the resident was on fall follow up and no delayed injuries related to the fall. Vital signs and neurological checks were within normal limits. A post fall risk assessment dated [DATE] revealed the resident was at high risk for falls with a score of 18. A nursing note dated 2/14/22 at 4:18 p.m. revealed the resident's wound had deteriorated. The resident requested to go to the emergency room . The resident was on hospice and the writer revealed the resident had requested to go to the emergency department the day before, though hospice wanted to wait for the results of the wound culture to return. The resident was transported to the emergency department per resident and family request. -Documentation of the resident's neurological checks for this period were requested, though were not received. -The resident had not returned to the facility as of the exit of the onsite investigation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	E. Interviews Licensed practical nurse (LPN) #1 was interviewed on 2/22/22 at 10:30 a.m. She stated when a resident fell , the nurse completed an assessment for injuries and neurological checks for all falls. She stated the nurse needed to complete a risk management note, call the director of nursing and physician and also document the fall. Certified nurse aide (CNA) #3 was interviewed on 2/22/22 at 10:35 a.m. She stated when a resident fell , she would get the nurse to assess, do vitals and neurological checks. The administrative team, including the nursing home administrator (NHA) , director of nursing (DON), clinical resource (CR), and assistant director of nursing (ADON) were interviewed on 2/22/22 at 11:05 a.m. They stated issues with the facility fall program were identified prior to the onsite investigation and a house wide fall audit was conducted on 1/24/22. They stated there was an attempt to improve the facility fall program at that time. They stated the fall program still needed work in terms of follow up, ensuring appropriate interventions were added to resident care plans and a process to ensure the interventions were in place and effective. They stated the IDT team met weekly to review all falls and discussed all falls in the daily morning meeting. They stated the IDT team had not been effectively monitoring interventions. They stated unwitnessed falls and witnessed falls with head involvement should have neurological checks. They stated the previous DON kept a binder of neurological check forms, though the binder could not be located. They stated the neurological check forms would now be uploaded into the electronic health record when completed, so they could not get lost. They stated residents were assessed for fall risk upon admission, after a fall, after a change in condition, and at least quarterly. They stated all residents who were identified as a fall risk should have interventions in place to prevent falls. They stated a new intervention should be added for the resident after each fall and should be related to the root cause of the fall and should be monitored for effectiveness. The CR was interviewed on 2/22/22 at 11:35 a.m. She stated Resident #1 was a fall risk and had experienced falls with injury in the facility. She stated the interventions added to the resident's care plan for the falls on 12/14/22 and 2/13/22 were not related to the root cause of the falls and were not appropriate or effective interventions for the resident, specifically because they were already attempted and should already be in place as regular care activities. She stated the intervention of reminding the resident to use his call light was not appropriate due to the resident's dementia. She stated if a resident requests to go to the hospital, whether they are on hospice or not, it was their right to go to the hospital for evaluation. She stated the record of the resident's neurological checks could not be located. 41172 III. Resident #2 A. Resident status Resident #2, age 76, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included dysthymic disorder (persistent depression), unspecified psychosis, muscle weakness and history of falls and urinary tract infections (UTIs). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 12/31/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score (BIMS) of 12 out of 15. He required limited one person assistance with bed mobility, and extensive one person assistance with transfers, dressing, toileting and personal hygiene. Resident #2 had two or more falls since his last assessment. B. Observations and interviews Resident #2 was observed in bed on 2/21/22. His bed was pushed up against the wall. On the other side of his bed, a large recliner was pushed up against the bed covering the top three fourths, leaving only a one fourth opening toward the bottom of the bed (cross-reference F604, physical restraints). Licensed practical nurse (LPN) #1 observed the resident's bed, and was interviewed on 2/21/22 at 11:57 a.m. She said, I see an issue that he cannot get in or out of his bed, except at the foot of the bed. She said he had to get in at the foot of the bed and crawl to the top. She said she did not know if he was a fall risk, but he could fall if he tried getting out of the bed by climbing over the recliner. She said the recliner is blocking the entire upper half of his bed and limiting his ability to get in and out of his bed. LPN #1 said the room was too small for the recliner and there was no way to move it away from the bed. On 2/22/22 the resident was observed in a new room. He did not have non-skid strips on the floor by his bed, as documented in his care plan. C. Record review and interviews The NHA, CR, ADON, and DON were interviewed on 2/22/22 at 11:12 a.m. The CR had her laptop and the resident's falls since 12/17/21 were reviewed as follows: Fall 12/17/21 On 12/17/21 at 7:13 p.m. the nurse notes documented, the resident was found on the floor sitting by his bed, leaning against his recliner. He said he was trying to put his shoes on, to go to the bathroom. He slid as he was trying to get his shoes. There was no injury. On 12/20/21 at 9:55 a.m., the IDT (interdisciplinary team) documented a review of the fall. The intervention was non skid tape to side of bed. However, the intervention did not address the root cause, the resident had to go to the bathroom. He needed extensive one person assistance with transfers. The CR looked at her laptop, and said the root cause was not addressed. She said the resident's need to use the bathroom was the root cause. Additionally, she said the facility had no record of neurological checks for this unwitnessed fall, per the facility policy. Fall 1/11/22 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/11/22 at 10:19 p.m., the nurse notes documented, Summoned by nurse LPN assigned to this resident to further assess him for falling and landing on his buttocks outside his room. Neuros and vs (vital signs) taken and is wnl (within normal limits). Res(ident) denied pain. BLE (bilateral lower extremities) and BUE (bilateral upper extremities) within normal power. Legs length equal and strength strong. Hand grip strong, no deformities noted at this time. Eyes PERRLA (pupils, equal, round, reactive to, light, accomodation). Res stated he was trying to ambulate without a walker lost balance and fell . Res reminded to always use walker for safety while walking. Res stated 'ok.' On 1/12/22, the IDT documented the resident was attempting independent mobility in the room, and was attempting to locate his walker. Will have PT (physical therapy) assess resident to ensure staff are using and teaching safest mobility. Staff will place his walker within arms reach. However, the resident had already been on therapy and was discharged on [DATE]. The physical therapy discharge summary, dates of service 11/2/21 to 1/5/22, documented the resident required supervision with ambulation. The CR looked at her laptop, and said the root cause was not addressed. The resident should not have been ambulating with his walker independently, he required stand by assistance. Additionally, she said she did not have a record of the neurological checks after this unwitnessed fall. Fall 1/12/22 On 1/12/22 at 3:49 a.m., the nurse's notes documented, The resident was overheard calling for help. Upon responding, the resident was observed laying on his back in the hallway. RN was from the 1st-floor was alert for assessment. Denies pain and no physical injury was noted at this time, VS WNL. Resident's to be within reach at all times. Neuros initiated as per protocol. There were no IDT notes or record of the neurological calls for this unwitnessed fall in the progress notes or medical record. The ADON said she did not know why there was no IDT note. The CR reviewed her laptop and confirmed there were no neurological checks, and no new intervention or IDT note. Fall 1/15/22 On 1/15/22 at 11:00 p.m., the nurse notes documented, CNA found resident on the floor when she was doing her rounds, Nurse asked resident what had happened, he stated he slipped off his chair. Nurse asked if he had any pain, he stated he did not. Nurse assessed resident no injuries found. CNA and Nurse lifted resident back up onto his chair. On 1/15/22, the care plan was revised, OT will assess the need for a non-slip mat for recliner. On 1/18/22, the IDT documented, the resident had slipped out of his reclining chair . OT will assess need for a non-slip mat for recliner. However, the resident had fallen again since that note on 1/16/22, see below. The CR was interviewed previously on 2/21/22 at 4:24 p.m. She said there were no therapy notes that OT assessed Resident #2 for a non-skid mat in front of his wheelchair. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The NHA said therapy would have been at the IDT meeting, when placing a mat in front of the recliner was discussed. She did not know why the assessment was not completed. She said there was no non skid fall mat that had been placed in front of his recliner. The CR again looked at her laptop and said there were no neurological assessments and no assessment by OT related to a mat in front of the resident's recliner. Fall 1/16/22 On 1/16/22 at 1:00 a.m., the nurse's notes documented, CNA found resident on the floor of the bathroom, when Nurse asked what happened he stated he was trying to go to the bathroom on his own. Asked resident if he had any pain, he stated his neck was hurting, nurse assessed neck and head and found no injuries. The neurological checks were received from the CR and were completed. On 1/17/22 at 6:09 a.m., the nurse's notes documented, The resident noted frequent bathroom visits than usually. Denies pain with voiding at this time .On-call doctor notified. An order for UA was received. On 1/20/22 he was diagnosed with a UTI (urinary tract infection), and started on antibiotics on 1/21/22. -The resident had a history of UTIs. However, he was not assessed for a UTI until 1/17/22. The IDT notes dated 1/18/22, the resident ambulated to the bathroom independently. Therapy to assess the need for additional support. The CR said therapy was not an effective new intervention, asd the resident was already on therapy at that time. The NHA said it was not an appropriate intervention to have therapy assess the resident. She said she was already on therapy, and the IDT should have addressed the toileting needs, and reviewed the nurses notes related to his urinary symptoms. The fall care plan, initiated 5/23/12, was reviewed and documented in pertinent part, Resident #2 is at risk for falls and has falls r/t psychotropic med use and hx of falls, use of walker, slight shuffle gait and generalized weakness. OT will assess the need for a non-slip mat for (resident's) recliner. Therapy will assess the need for additional support. Non skid strips to the side of bed. Offer a night light to be on during night hours. Staff to educate to reach back for the chair before sitting. Encourage/assist to have proper non-skid footwear. Prefers to have his call light attached to the cord in his room. Encourage/remind to call for assist if needing assist with transfers/ADL's. Keep room free from clutter and pathways clear. Perform investigation to determine and address causative factors of the fall. Pharmacy consult to evaluate medications prn. PT/OT to evaluate and treat prn. Monitor for adverse effects to medications and report any findings to physician. -However, OT did not assess the resident for non skid strips in front of his recliner. The pathways were not kept clear, with a recliner pushed up against his bed. Investigations did not look at causative factors for falls. IV. Resident #16 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A. Resident status Resident #16, age 75, was admitted on [DATE]. According to the February 2022 computerized physician orders (CPO), the diagnoses included Parkinson's and dementia. The 12/31/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of 6 out of 15. He required extensive one person assistance with bed mobility, and was totally dependent on staff for transfers. He required extensive one person assistance with dressing, toileting and personal hygiene. Resident #16 had two or more falls since his last assessment. B. Observations The resident was observed in bed on 2/21/22 at 10:40 a.m. His bed was pushed up against the wall, and on the opposite side there was a bolster in place which extended the entire length of the bed. The bed was not in the low position. There was a mat on the floor next to the bed. On 2/22/22 at 9:00 a.m., the resident was observed in bed. There was no mat on the floor next to his bed. C. Record review and interviews The resident's assessments were reviewed in the electronic medical record (EMR). There was no restraint assessment, no consent from the MDPOA for the use of a bolster to the resident mattress, no physician's order on the February 2022 CPO, and no care plan for the bolster. The NHA, CR, ADON, and DON were interviewed on 2/22/22 at 11:12 a.m. The CR had her laptop, and the residents falls since 1/12/22 were reviewed as follows: Fall 1/12/22 On 1/12/22 at 11:51 a.m., Resident found on floor on fall mat during med pass. Resident was lying on left side. Resident was able to move past wedge pillow during fall .resident very lethargic due to recent hospital stay. States no pain, no injuries found, can move all extremities. DON, Administrator and family (POA) notified of fall. Started 72 hour neuro checks. Neurological checks were completed and reviewed. There was no IDT note in the progress notes. The CR said the risk management form documented the bed was to remain in a low position. She said that was not an effective intervention, as the bed should have already been kept in a low position. A copy of the risk management form was requested and not received by the end of the survey. The fall care plan, initiated 4/7/21, was reviewed. There were no changes to the care plan after this fall. The care plan did not address keeping the bed in a low position. On 1/16/22 at 2:08 a.m., the nurse's notes documented, Resident remains on one to one due to frequent falls. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-There was no documentation in the progress notes regarding when the one to one began or ended for Resident #16. On 1/24/22 at 1:48 p.m., 12 days after the fall, the IDT documented, Fall committee met today to discuss (resident's) most recent frequent falls, post review IDT has concluded that the staff will follow a up/down schedule so as to anticipate when (resident) would like to get up in his wheelchair. Staff will continue to remind to ask for help when he needs assistance with ADLs. Activities will review their program and the need to increase visits. MD will be contacted for psych consult. There was no update to the fall care plan regarding an up/down schedule or psych consult. Fall 1/29/22 On 1/29/22 at 5:52 p.m. the nurse notes documented, Resident was found lying on the floor in his room beside his bed. Resident unable to describe what led to the fall. The fall probably resulted from resident attempting to stand from bed while supporting self-using the bedside table which he had used during lunch meals. No injuries noted. Skin was intact. No redness noted. Redness denied pain. Resident was assessed and assisted WC. Neuros initiated per the protocol. He was moved close to the nurses station for closer supervision. Notifications made to family, DON .Neuros and VS are stable and within his baseline. We will continue to monitor. On 1/31/22 at 2:33 p.m., the IDT documented, Current interventions: Low bed, mat on floor, Call don't fall signage, .OT contacted via email asked to address his frequent falls and encourage up in wheelchair for all meals. Please note that IDT has concluded that (resident) will continue to fall, interventions will be in place to minimize injury. Neurological checks were completed and reviewed. On 1/29/22 the fall care plan was updated to include, staff will offer resident to sit up in his wheelchair for meels. -The care plan did not include low bed, mat on the floor, fall signage, encourage to

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on observations, record review and interviews, the facility failed to provide a therapeutic diet prescribed by the physician to one (#6) of three residents reviewed out of 16 sample residents. Specifically, the facility failed to consistently provide Resident #6 with a diet that met the physician's order for fortified meals. Findings include: I. Facility policy The therapeutic diets policy revised October 2017, provided by the nursing home administrator (NHA) on 2/22/22, read in part: Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his and her goals and preferences. Policy interpretation and implementation -Diet will be determined in accordance with the resident's informed choices, preference, treatment goals and wishes, Diagnosis alone will not determine where the resident was prescribed a therapeutic diet. -A therapeutic diet must be prescribed by the residents attending physicians (or non-physician providers). The attending physician may delegate this task to a registered dietitian as permitted by law. -Diet order should match the terminology used by the food and nutrition service department -A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet or to alter the texture of a diet for example; -The resident has the right to not comply with therapeutic diets. -The dietitian nursing staff and attending physician will regularly review the need for, and resident acceptance of prescribed therapeutic diets -The dietitian and nursing staff will document significant information relating to the residents response to his or her therapeutic diet in the resident's medical record, -The attending physician may liberize the diet at the request of the interdisciplinary team (IDT) (if the resident was losing weight or not eating well) or the resident. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If the resident or the resident's representative declines the recommended therapeutic diet, the interdisciplinary team will collaborate with the resident or representative to identify possible alternatives. II. Resident #6 status Resident #6, age 78, was readmitted on [DATE]. According to the February 2022 computerized physician orders (CPO), pertinent diagnoses included heart failure, malnourishment, protein-calorie deficiency and chronic obstructive pulmonary disease. The 12/27/21 minimum data set (MDS) assessment revealed the resident had a moderate cognitive deficit with a brief interview for mental status (BIMS) score of seven out of 15. He required extensive assistance of one person for dressing and toileting. He had supervision of one person for bed mobility, transfers and meal intakes. He had no rejection of care. He had no special diet needs. III. Observations and interview Resident #6 was observed on 2/21/22 at 11:15 a.m. He lay in the bed and faced the wall. He appeared thin. He was dressed and his clothes were big on him. He said he ate his own meals in his room. Continuous observation on 2/21/22 from 11:00 a.m to 12:25 p.m. of the lunch meal preparation line revealed Resident #6's food ticket read regular diet fortified. His food tray was served with a sloppy [NAME], carrots, roasted potatoes and cornbread. The food served was not fortified. On 2/21/22 at 12:30 p.m. Resident #6 was served lunch in his room, which consisted of sloppy [NAME] meat on a bun, sliced up roasted potatoes, carrots, cornbread and cranberry juice. He picked at his food and did not eat much. There was no encouragement during the meal from any staff and his food tray was picked up at 12:50 p.m. IV. Record review The February 2022 CPO for Resident #6 included an order for Regular diet thin liquids and fortified foods. Order date was 2/7/22. The nutritional care plan revised on 2/7/22 for Resident #6 read in pertinent part: Resident #6 was a nutrition and hydration risk. Resident #6 will remain adequately hydrated. Encourage fluid intakes during and between meals and as ordered. Encourage good meal intakes. Independent at meals. Monitor and document food and fluid intakes. Monitor and record weights per facility protocol and monitor weight trends. Offer a magic cup (supplement) two times between meals for weight maintenance. Offer substitutes for uneaten food. Received med pass (supplement) four times a day for meal refusals.Will receive a regular diet with thin liquids. Fortified meals. V. Interviews (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The cook was interviewed on 2/21/22 at 1:00 p.m. She said she fortified foods with a powder they used to mix in the foods. She said she fortified oatmeal and mashed potatoes. She said when a food ticket read fortified foods she used the powder to mix with the foods being served. She said the only residents with fortified foods were the two residents on pureed foods. She did not mix any fortified powder into any food during the continuous observation today. She said fortified foods helped the residents get extra calories. She walked over to a shelf in the kitchen and pulled down the fortified powder she used. The dietary manager (DM) was interviewed on 2/21/22 at 1:10 p.m. She said the meal ticket was essentially the order for the diet used. She said she expected the cooks to follow the diet orders. When the diet was fortified the cook used a powder which gave extra calories to the resident. She said Resident #6 was on a fortified diet and he received fortified oatmeal and mashed potatoes. They put the powder in milk and butter as well. She said she would educate the kitchen staff tomorrow to follow the diet order. The registered dietitian (RD) was interviewed on 2/21/22 at 3:25 p.m. She said she recommended therapeutic diets for the residents who had high risks. She said Resident #6 was ordered fortified foods to help increase his calorie intake. She expected the order to fortify the foods to be followed for every meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 41968 Based on observations, record review and interviews, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety. Specifically, the facility failed to ensure: -Food was prepared and handled in a sanitary manner, including proper hand hygiene and glove use; and -Failed to ensure the dishwasher was working. Findings include: I. Food preparation and handling A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 3/1/22 from: https://www.colorado.gov/pacific/sites/default/files/Reg_BOH_RetailFoodRegulations.pdf. It read in pertinent part: Single-use gloves shall be used for only one task, such as working with ready-to-eat food, or with raw animal food. Single-use gloves shall be used for no other purpose, and discarded when damaged, when interruptions occur in the operation, or when the task is completed. B. Facility policy The hand hygiene policy not dated was provided by the dietary manager (DM) on 2/22/22, read in pertinent part: Performing hand hygiene at the right time or moment was important to prevent the spread of infection. Process for hand hygiene: before putting on gloves and removing gloves. No other policy was provided. C. Observations (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The cook was observed on 2/21/22 at 11:50 a.m. to dish up food on plates at the lunch meal. She wore gloves and used the same gloved hands to touch the buns for the food product each time, touched the plate on top and the bowls, putting her gloved fingers in the bowl and served the next resident. She used the same gloved hands to cut up some pork into small bites and she scooped up the cut pork with her gloved hand and put it on the plate. She continued to touch the utensils and cleaned a few pans before she took off the gloves and washed her hands. She failed to change her gloves after touching food products each time and failed to perform hand hygiene. D. Interviews The dietary manager (DM) was interviewed on 2/21/22 at 3:00 p.m. She said she was responsible for training the kitchen staff about hand hygiene and food preparation. She said she just had a class on 2/17/22. She said hand hygiene was important as to not cross contaminate germs. She said hand hygiene was performed after glove use and anytime a food product was touched. She said she expected her staff to not touch the food product with a gloved hand. She said they used utensils to pick up bread or buns. She said she would provide further training to the kitchen staff on hand hygiene and food handling. The registered dietitian (RD) was interviewed on 2/21/22 at 3:35 p.m. She said she expected the kitchen staff to use utensils to serve ready to eat foods to avoid cross contamination. She said gloves were changed after each use and each time a food product was touched and hand hygiene was performed. She said she would educate the staff on the importance of this. II. Dishwasher A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 3/1/22 from: https://www.colorado.gov/pacific/sites/default/files/Reg_BOH_RetailFoodRegulations.pdf. It read in pertinent part: A warewashing machine shall be equipped with a temperature measuring device that indicates the temperature of the water: In each wash and rinse tank; and as the water enters the hot water sanitizing final rinse manifold or in the chemical sanitizing solution tank. B. Observations and interviews Dishwasher observations were conducted on 2/18/22 at 11:16 a.m. The dishwasher was observed to have a sign that read: This is a low temp machine. All sanitation is done through chemical processes. It was also observed that there was a blue plate cover lodged in the top of the dishwasher. -A dishwasher tray full of silverware was observed sitting next to the dishwasher. The cook stated the dishwasher should get up to 165 degrees. The dietary aide (DA) said there was no latch on the dishwasher since the last time it was fixed and the plate cover had to be used on the top of the machine to keep it closed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 11:22 a.m. the dishwasher was tested and in the first cycle the temperature reached 80 degrees and the 2nd cycle reached 102 degrees. -At 11:24 a.m. a second test of the dishwasher showed the first cycle reached 125 degrees. Three tests were performed to test the sanitizer ppms of the dish machine and none of the test strips showed a measurable amount of sanitizer. The dish machine testing log for February 2022 was observed hanging on the wall. It revealed the dish machine was fixed on 2/9/2022. The dish machine was supposed to be monitored for temperature and ppms three times a day. However, from 2/9/22 to 2/17/22 through lunch, the log revealed the dish machine was at 120 degrees and the sanitizer levels were at 100 ppm consistently for every meal. The log was blank for dinner on 2/17/22 and breakfast for 2/18/22. The dishwasher was interviewed on 2/21/22 at 12:02 p.m. He said the dishwasher was working today. He ran a cycle of dishes through the machine. The dietary manager (DM) was interviewed on 2/21/22 at 12:10 p.m. She said the dishwasher was fixed on 2/20/22. She said she was unaware to check for temperatures and she was going to assure staff checked those daily and recorded the temperatures. She said she would check the temperatures daily to make sure everything was running properly. She worked with the maintenance person to ensure the dishwasher was working.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 41032 Based on record review and interviews, the governing body failed to implement policies regarding the management and operations of the facility. Specifically, the facility failed to ensure the governing body was providing effective oversight to the facility to ensure the facility was in compliance with state and federal regulations. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program Governance and Leadership policy and procedure, last revised March 2020, was provided by the nursing home administrator (NHA) on 2/22/22 at 10:18 a.m. It read in pertinent part: The governing body is responsible for ensuring that the QAPI program: -Is implemented and maintained to address identified priorities; -Is sustained through transitions of leadership and staffing; -Is adequately resourced and funded, including the provision of money, time, equipment, training and staff coverage sufficient to conduct the activities of the program; -Is based on data, resident and staff input, and other information that measures performance; and -Focuses on problems and opportunities that reflect processes, f functions and services provided to the residents. Cross-reference F867-failed to reassess and provide timely intervention to address repeated concerns related to quality of life and quality of care. II. Identified failures A. Findings in the area of abuse and neglect - failure of the facility to prevent neglect. Cross reference F600. Facility administration failed to have a system to ensure residents were not neglected by staff by providing the care and services the resident required to maintain the highest practicable well-being. The facility failed to respond to resident call lights for several hours. One resident was left on the toilet for an extended period of time and was left with increased anxiety and feeling fearful that she would not be cared for properly. Another resident was the victim of verbal abuse by a staff member leaving the resident feeling bad about herself. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Findings in the area of skin integrity-failure to prevent facility acquired pressure injuries. This deficiency was cited previously during a recertification survey 10/27/21. Although the facility corrected the deficiency, based on the findings below, the facility has not maintained compliance with this regulatory requirement. Cross-reference F686. Facility administration failed to have a system/plan to ensure residents received care and services to prevent residents from developing facility acquired pressure injuries and worsening of pressure injuries. The facility failed to ensure thorough assessments and timely implement treatments to prevent pressure injuries from worsening. C. Findings in the accidents hazards - failure to have a system to ensure the resident environment remains as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents. Cross-reference F689. Facility administration failed to have a system in place to prevent resident falls, assess interventions, and assess residents after falls. D. Findings in the area of kitchen sanitation - failure to have a system to ensure resident meals were prepared in a sanitary manner. Cross-reference F812. Facility administration failed to provide a sanitary kitchen where meals were handled and prepared in a sanitary manner ensuring residents received the care and services required to maintain their highest practicable level of well-being. E. Findings in the area of infection control - failure to have a system to ensure an infection control program whereby residents were protected from unvaccinated staff. Cross-reference F880. Facility administration failed to ensure unvaccinated staff were engaged in safe practices while care for residents to ensure residents received the care and services required to maintain their highest practicable level of well-being. F. Current findings in the area of environment - failure to have a system to provide residents a safe, comfortable, home like environment free from hazards. Cross reference F684, F921, and F689. Facility administration failed to provide residents a safe comfortable home like environment free from hazards to ensure residents received the care and services required to maintain their highest practicable level of well-being. G. Current findings in the area of therapeutic diet - failure of the facility to provide the resident their prescribed diet. Cross-reference F808. Facility administration failed to ensure a resident consistently received a fortified diet as was prescribed, ensuring the residents received the care and services required to maintain their highest practicable level of well-being. H. Current findings in the area of restraints - failure of the facility to residents were free from restraints. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F604. Facility administration failed to assess a resident's need for a bolstered mattress and identify the mattress as a restraint that prevented the resident from getting out of bed. This led to failure to ensure residents received the care and services required to maintain their highest practicable level of well-being. I. Current findings in the area of choices regarding activities of daily living - failure of the facility to provide bathing assistance Cross reference F561. Facility administration failed to ensure residents received bathing services in accordance with their choice and plan of care. A resident was left feeling unclean and uncomfortable after not being provided bathing services. III. Leadership interviews The director of nursing (DON) was interviewed on 2/22/22 at 1:01 p.m. The DON said this was her second day working in the facility. The DON realized the facility had many care issues that needed attention. The DON acknowledged she had not yet been provided training on the corporate processes and was in the process of learning about the expectation of the corporate office. The DON had a lot of plans for improvement in the facility. The DON acknowledged that wound care was one of the areas needing attention and she planned to take over the role of wound care management and work alongside the assistant director of nursing (ADON) who had been placed in the role of wound care nurse. The ADON was tasked with the role of wound care nurse but she was a novice in the area of wound care. The facility planned to send the ADON for further training in the area of wound care management and have her obtain wound care certification. The nursing home administrator (NHA) and independent nurse consultation (INC) were interviewed on 2/22/22 at 2:30 p.m. The NHA said she has been working for the facility since November 2021. The facility had experienced a number of management turnover. Each time a member of the leadership changed the implementation of the improvement plans was hindered while the new member of the management team was trained on facility and corporate procedures. The NHA started employment by becoming familiar with the existing quality assurance process improvement (QAPI) plans. There were several areas identified as needing improvement; the initial implementation was set in place just before her employment with the facility. In review of the implemented plans of improvement the NHA in cooperation with the facility's interdisciplinary team (IDT) found several instances when the interventions were not working and they had to go back to the assessment and development. The NHA said she provided the corporate office with information and updates on their progress so the corporate representatives would have an understanding of what was occurring, because the corporate representatives were based out of state and not able to be directly in the community to see what was occurring within the facility. The NHA said one of the biggest challenges they faced was providing sufficient staffing. The facility had a high turnover in direct care staff leaving for other higher paying jobs, and current pay scales did not permit the facility to compete with other higher paying jobs within the local community. The corporation was aware of this problem. The facility was approved to contract with a number of agency staff who were not permanent and not fully trained to understand and perform at the facility's expected performance level. Agency staff were transient and though they had the option to contract, they were not permanent staff. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The corporate offices would review daily reports provided and give feedback. They hired an independent nurse consultant to be in the building a couple days a week as there were many broken systems needing attention. The facility needed more attention than typical day-to-day oversight of an NHA. The NHA said she managed by being on the floor, she has been getting to know the residents and direct care staff by having a presence on each unit. At first, the staff did not know what to think of her being out of the office asking for their input, but soon staff started to open up and provide their thoughts on what was and was not working. The NHA believed staff turnover and lack of follow through were the facility's challenges. The NHA reached out to the corporate office for more assistance and the corporation recently sent a consultant to be in the facility a couple days a week. They now had daily online meetings with the corporate consultants and had developed a quality road map with the governing body to guide the facility on a path to improve care and services within the facility. Part of the plan was to continue to assess and identify areas of opportunity, consult with the corporate consultant and have a presence on the floor to hear and observe concerns to bring forward to the QAPI committee for needed attention. The regional clinical consultant (RCC) was interviewed on 2/22/22 at 4:28 p.m. The RCC said she had been working with the facility for the last three weeks. The RCC reviewed facility reports remotely and gave feedback based on facility reports. There was another RCC who was in the facility two to three days a week. The director of operations (DO) was stationed out of state and was available remotely, but visited the facility approximately once a month. The RCC's identified concerns in staffing and leadership turnover included: The prior director of nursing (DON) was with the facility only five to six weeks; that DON was not effective at implementing improvement plans and was resistant to feedback. After a few weeks in the position, the DON resigned the position. They had an interim director of nursing (IDON) for a short time until this week when a new DON took over the role. The new DON had a lot of experience in the field and was highly recommended. The facility was in process of implementing a plan of correction developed this past November 2021, but a mock survey conducted by the direction of the corporate office found the facility was not performing at the expected level. The IDT with corporate input relaunched a rapid response action calling for all members of leadership and those at the corporate level to reassess the facility's improvement plans. The team found concerns with several care areas and questioned if care plans were being followed. The team was not able to fully assess the progression or quality of care due to a lack of documentation to be able to prove what aspects of care were occurring. Risk management assessments were missing crucial pieces of information making the assessment of findings impossible to assess. What was found was the prior leadership team DON and NHA were not guiding the facility staff as to what they needed to do and where improvements needed to be taken. The RCC acknowledged the corporate team should have acted sooner but they eventually made the decision to make changes in the leadership team and replaced the NHA and DON positions. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DO said he found talking with the residents and floor staff to be a valuable resource for uncovering care concerns. It was very important for him to do these types of rounds in the facility so he could get to know the facility's operating practices better. The DO anticipated being in the facility every other week, supplemented with frequent phone support when he was unable to have a presence in the building. The DO said the NHA hired by the facility was a brand new NHA recently licensed, and would need a lot of support if the NHA was to be successful in the role. The DO had implemented an orientation and onboarding program for the NHA with a daily, weekly and monthly task accomplishment checklist. The NHA had been provided a cluster of experienced leaders in the corporation to connect to as a resource and support. The onboarding process was expected to take 100 days to accomplish. The DO's responsibility was to make sure the NHA was working the plan and had the tools and support to work through the process. The DO reviewed the NHA's progress with the NHA during weekly check in calls. -It was unclear of the exact day that the onboarding process began, as the NHA's hire date was mid November 2021. It had been more than 100 days since hire, but the NHA confirmed they were currently working through the onboarding/orientation process. The DO said the newly hired DON would receive orientation and onboarding as well, but it would be slightly different with a task oriented clinical focus. The DO said following the October 2021 review, the facility began an in-depth look into several identified operating concerns and implemented a plan of improvement to address each concern. Corporate leadership took a hard look at performance measures and compared them to the national average and looked into potential root causes for concern as a method of developing and implementing corrective actions. The resource team supplied feedback numerous times in order to help the facility leadership to troubleshoot their action towards systems improvement. The corporation had made many changes, testing facility practices and found they were repeating the same less effective practices resulting in continued problems. The corporation had to implement new methods to address the failed systems. Each time the facility had to replace staff, particularly the leadership team, it set the facility back, having to start over with training. The DO said he realized he would have to change his approach with the facility and look at how the corporation was focused on each area identified as needing to be improved. The DO acknowledged that corporate leadership would no longer be able to assume that facility leadership would be able to manage and correct the identified clinical concerns on their own. Corporate leadership would have to focus more direct and onsite attention to the matter.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 41032 Based on interviews and record review, the facility failed to ensure an effective quality assurance program that identified and addressed facility compliance concerns were implemented, in order to facilitate improvement in the lives of facility's 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 reassess and provide timely intervention to address repeated concerns related to quality of life and quality of care. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program policy last revised February 2020 was provided by the nursing home administrator (NHA) on 2/22/22 at 10:18 a.m. The policy read in pertinent part: This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI Program are to: -Provide a means to measure current and potential indicators for outcomes of care and quality of life. -Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. -Reinforce and build upon effective systems and processes related to the delivery of quality care and services. -Establish systems through which to monitor and evaluate corrective actions. Authority: -The owner and/or governing board (body) of our facility is ultimately responsible for the QAPI Program. (cross-referenced to F837) -The governing board/owner evaluates the effectiveness of its QAPI Program at least annually and presents findings to the QAPI Committee. -The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The QAPI Committee reports directly to the Administrator. II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct. F600 prevention of resident abuse and neglect -During an abbreviated survey on 10/22/2020, resident to resident abuse was cited at a E level. -During a recertification survey on 10/27/21, the facility was cited for failure to prevent resident abuse and neglect at an increase of scope and severity for abuse at a G (harm) level. -During the abbreviated survey on 2/22/22, the facility was cited for failure to prevent resident abuse and neglect at a scope and severity for abuse at a G (harm) level. F686 skin integrity and pressure injuries -During a recertification survey on 10/27/21, the facility was cited for failure to assess and implement treatment for pressure injuries in a timely manner at an increase of scope and severity at a G (harm) level. During the abbreviated survey on 2/22/22, the facility was cited for failure to prevent facility-acquired pressure injuries; promotion of the healing process for facility acquired pressure injuries; and the worsening and infections of facility acquired pressure injury, at a scope at a G (harm) level. Specifically for Resident #15. F689 Accident hazards related to resident falls -During a recertification survey on 3/4/21, the facility was cited for failure to provide adequate supervision to prevent a resident from falling and investigate the root cause for the resident fall at scope and severity at an E level. -During the abbreviated survey on 2/22/22, the facility was cited for failure to prevent a resident from falling an sustain a major injury and failure to fully assess a resident for partial injuries following a fall in the facility at an increased scope and severity at a G (harm) level. III. Cross-referenced citations Cross-reference F600: The facility failed to protect residents after allegations of abuse and neglect. Cross-reference F686: The facility failed to prevent facility acquired pressure injuries, promote healing and prevent worsening of pressure injuries. Cross-reference F689: The facility failed to ensure that residents were free from accidents and hazards and prevent a resident from falling and sustaining a major injury requiring hospital treatment. IV. Interview (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The director of operations (DO) was interviewed on 2/23/22 at 10:26 a.m. The DO said he and the corporate consultants were involved with reviewing facility reports provided by the NHA. The governing body was very aware of the identified concerns as they had already identified similar concerns and were in the process of implementing corrective measures. The DO acknowledged that the manner of approach needed to change, and that the corporate consultants and leadership would have to have more of a presence in the facility to ensure improvement plans were being followed and reassessed timely if needed. Having eyes on the problems would enable the identification of the root cause of the issues and identify the cause for the ineffectiveness of corrective actions. The DO acknowledged that the newly hired director of nursing (DON) and NHA would need more corporate support.

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure staff are vaccinated for COVID-19 41032 Based on observations, record review and interviews, the facility failed to develop and implement COVID-19 staff vaccination process to address facility staff, including unvaccinated staff, who provided care, treatment and other services to facility and/or residents. Specifically, the facility failed to ensure unvaccinated staff practiced appropriate source control measures (including use of NIOSH approved N95 masks) to protect residents, staff and visitors from potential situations causing COVID-19 spread and adhere to facility identified policies currently in place. Findings include: I. Professional reference According to Centers for Disease (CDC) guidance, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, last revised 2/2/22, retrieved on line 2/23/22, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person ' s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals . who: Are not up to date with all recommended COVID-19 vaccine doses . -While it is generally safest to implement universal use of source control for everyone in a healthcare setting, . allowances could be considered for individuals who are up to date with all recommended COVID-19 vaccine doses (who do not otherwise meet the criteria described above). Source control options for HCP (health care providers) include (for respiratory precautions): NIOSH-approved N95 or equivalent or higher-level respirators should be used for: -All aerosol-generating procedures: -NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses, unable to use source control, and the area is poorly ventilated. Source control and physical distancing are recommended for everyone in a healthcare setting. This is particularly important for individuals .who: Are not up to date with all recommended COVID-19 vaccine doses. (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	-HCP who are up to date with all recommended COVID-19 vaccine doses: should wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors). According to CDC guidance Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, last revised 2/2/22, retrieved on line 2/283/22 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html: While it is generally safest to implement universal use of source control for everyone in a healthcare setting, the following allowances could be considered for individuals who are up to date with all recommended COVID-19 vaccine doses. -HCP who are up to date with all recommended COVID-19 vaccine doses: Could choose not to wear source control or physical distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen). They should wear source control when they are in areas of the healthcare facility where they could encounter patients (e.g., hospital cafeteria, common halls/corridors). -Residents who are not up to date with all recommended COVID-19 vaccine doses . HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). II. Facility policy The COVID-19 Vaccine Mandate policy, undated, was provided by the independent nurse consultant (INC) on 2/17/22 at 6:00 p.m. The policy read in pertinent part: To protect the health and safety of our residents, employees, visitors, vendors, and the community from COVID-19 infection, and in accordance with the facility ' s duty to provide and maintain a workplace that is free of known hazards, we are adopting this policy to safeguard the health of our employees and their families, our customers and visitors, and the community at large from infectious diseases, such as COVID-19, that may be reduced by vaccinations. -This policy will comply with all applicable laws and is based upon guidance from the CDC and local health authorities. -All employees are required to receive vaccinations. -Employees may be exempt from receiving the vaccine but are very limited,,, -In order to be approved for a religious exemption, the individual must complete the Religious Accommodation Request form and sign a legal affidavit attesting to their sincerely held religious belief. Employees determined and approved for an exemption are required to comply with preventive infection control measures established by the corporate partners to reduce the risk (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	of transmitting COVID-19. A request for exemption does not imply an approval. These restrictions may include, but shall not be limited to: 1. Work using an N95 mask over the mouth, nose and chin, wearing a face shield/approved goggles, daily temperature-monitoring, COVID-19 daily testing based on CDC/CDPHE guidance, social distancing, and frequent hand washing. -If these restrictions are not followed: employee will be placed on a personal unpaid leave of absence. The Immunizations: SARS-CoV-2 (COVID-19) Mandatory vaccination program for employee ' s policy, undated, was provided by the INC on 2/22/22 at 3:15 p.m. The policy read in pertinent part: The Company recognizes the major impact and the associated morbidity and mortality of COVID-19 infection on residents and employees of nursing homes and the effectiveness of vaccines in preventing illness, hospitalization s and death and reducing health care costs. At this time, the Company will require eligible employees to include agency staff, providers, contractors, and consultants to be vaccinated against COVID-19 unless they meet exemption requirements, as outlined by CMS. Infection Prevention and Control Practices: -All infection control policies, procedures and protocols will remain in place until further notice. -As of December 6, 2021, all employees that do not meet the criteria of being 'fully vaccinated' are required to follow additional precautions which include the need to wear a mask at all times while in the center/office as part of source control measures, social distancing where practicable, and routine SARS-CoV-2 viral testing at a frequency based on level of community transmission. -The above policy did not specify the type of mask required for unvaccinated staff while working; the NHA said in interview unvaccinated staff were expected to wear N95 masks while working in the facility (see below). III. Observations Observations from 2/17/22 at 1:33 p.m. thought 2/22/22 at 2:12 p.m. revealed several unvaccinated staff in resident care areas performing direct resident care services while failing to wear NIOSH approved N95 masks. Observations were as follows: On 2/17/22 from 1:33 p.m. to 7:30 p.m., the following unvaccinated staff were observed: -Certified nurse aide (CNA) #2 was wearing a surgical mask while in resident care areas and while caring for residents; -Social services assistant (SSA) #1 was wearing a KN95 mask while in resident care areas and while in close proximity to residents; (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	-The assistant director of nursing (ADON) was wearing a surgical mask, then later in the shift a KN95 mask, while in resident care areas and while caring for residents; and, -Housekeeper (HSK) #3 was wearing a surgical mask while in resident care areas and in close proximity to residents. An unnamed CNA was sitting at the nurse ' s station desk, without any mask or face-covering at all. This was an area where residents were observed stopping earlier in the shift. On 2/18/22 from 10:59 a.m. to 3:00 p.m., the following unvaccinated staff were observed: -CNA #10 was wearing a surgical mask while in resident care areas and while caring for residents; -CNA #2 was wearing a surgical mask while in resident care areas and while caring for residents; and, -The ADON was wearing a KN95 mask while in resident care areas and while caring for residents. On 2/21/22 from 10:55 a.m. to 3:45 p.m., the following unvaccinated staff were observed: -Receptionist (REC) #1 was wearing a surgical mask while in resident care areas and while in close proximity to residents; -CNA #10 was wearing a surgical mask while in resident care areas and while caring for residents; -CNA #2 was wearing a surgical mask while in resident care areas and while caring for residents; -CNA #11 was wearing a surgical mask while in resident care areas and while caring for residents; -Social services assistant (SSA) #1 was wearing a KN95 mask while in resident care areas and while in close proximity to residents; -The ADON was wearing a KN95 mask while in resident care areas and while caring for residents; -The maintenance assistant (MA) was observed wearing a KN95 mask while in resident care areas; and, -Activities assistant (AA) #1 was wearing a surgical mask while in resident care areas and while in close proximity to residents. On 2/22/22 from 11:59 a.m. to 4:06 p.m., the following unvaccinated staff were observed: -CNA #2 was wearing a surgical mask while in resident care areas and while caring for residents; -The MA was observed wearing a KN95 mask, while in resident care areas; -CNA #12 was wearing a surgical mask while in resident care areas and while caring for residents; (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	-AA #1 was wearing a surgical mask while in resident care areas and while in close proximity to residents; -SSA #1 was wearing a KN95 mask while in resident care areas and while in close proximity to residents; -REC #1 was wearing a surgical mask while in resident care areas and while in close proximity to residents; and, -REC #2 was wearing a surgical mask while in resident care areas and while in close proximity to residents. V. Interviews with unvaccinated staff CNA #2 (who per facility records was unvaccinated) was interviewed on 2/22/22 at 9:30 a.m. CNA #2 said the facility used to have signs up instructing staff and residents what precautions to follow to prevent the spread of COVID-19, but the residents took the signs down and no one replaced them. CNA #2 said he usually wore a surgical mask when working with the residents and was not provided any specific training regarding a need to wear an N95 mask due to COVID precautions. He had not been told to promote social distancing for himself or amongst any of the residents. CNA #12 (who per facility records was unvaccinated) was interviewed on 2/22/22 at 10:02 a.m. CNA #12 said staff only had to wear an N95 mask if there was a COVID-19 outbreak in the facility and if anyone was unvaccinated they had to wear the N95 and take a daily rapid test prior to entry into the facility. CNA #12 confirmed she was unvaccinated and said she was able to wear a surgical mask today because of testing negative for COVID-19 today with a rapid test. CNA #5 (who per facility records was unvaccinated) was interview on 2/22/22 at 12:15 p.m. CNA #5 said she had to wear an N95 mask, all shift, during every shift, even in the employee break room because she was unvaccinated. There were no instructions to socially distance or restrictions to working with either unvaccinated or vaccinated residents. The MA (who per facility records was unvaccinated) was interviewed on 2/22/22 at 12:33 p.m. The MA said he wore a KN95 mask he purchased himself and was not instructed/educated on which type of mask was required for unvaccinated employees while working in the facility. He was screened daily for symptoms of COVID-19 but was never instructed to change his mask from the KN95 mask to an N95 mask, nor was he ever provided any other type of mask to wear while in the facility. The MA just knew he had to wear a mask and eye protection. HSK #3 (who per facility records was unvaccinated) was interviewed on 2/2/22 at 12:45 p.m. HSK #3 wore an N95 mask during the interview. HSK #3 said she was required to wear an N95 mask because she was unvaccinated, but had no specific training on social distancing from unvaccinated residents. AA #1 (who per facility records was unvaccinated) was interviewed on 2/22/22 at 12:59 p.m. AA #1 said she wore a surgical mask because the facility was not in outbreak status and only needed to wear an N95 mask in the outbreak status situation. VI. Other staff interviews (continued on next page)

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F 0888 Level of Harm - Potential for minimal harm Residents Affected - Many	The social services director (SSD) was interviewed on 2/22/22 at 10:55 a.m. The SSD said she had on a surgical mask because she was fully vaccinated. All unvaccinated staff were required to wear an N95 mask while working in the facility. The nursing home administrator (NHA) and INC were interviewed on 2/22/22 at 2:30 p.m. The NHA said unvaccinated staff were expected to wear NIOSH approved N95 masks while working in the facility. The NHA was not aware of any failure in this requirement. The NHA acknowledged that an unvaccinated staff's failure to wear an N95 mask could potentially put residents, especially unvaccinated residents, at a higher risk of contracting COVID-19 infections. The facility supplied N95 masks to unvaccinated staff, and had no shortage of N95 masks to do so. There was no reason for an unvaccinated staff not to be wearing an N95 mask. The NHA said the facility was experiencing contingency staffing levels and was not able to ensure that unvaccinated staff did not assist or work with unvaccinated residents. This was why it was important for unvaccinated staff to wear N95 masks while in the facility. Staff should be encouraging unvaccinated residents to wear a surgical mask throughout the facility and while receiving care assistance, especially if the staff providing services was unvaccinated.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 41032 Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to: -Ensure safe hallway handrails, by repairing loosely affixed handrails and handrails with missing and broken end caps causing sharp edges, in two of five hallways. -Ensure handrails were of a material which could be disinfected properly (taped end caps caused uneven surfaces making it harder to disinfect the hallway handrails), in two of five hallways; -Eliminate trip hazards by removing boiler pipes from an old heating unit that were left sticking up through the floor in the hall, under hallway handrails, in one of five hallways; and -Ensure a comfortable community environment with upkeep of hallways to include repair of damaged areas including cleaning walls, removing chipped paint, and painting plastered areas of the walls, in one of five hallways. Cross-referenced to F584 failure to provide a homelike environment, and F689 failure to provide individual residents a safe functional environment free from accident hazards. Findings include: I. Facility policy and procedure The Safety and Supervision of Residents policy, revised July 2017, provided by the nursing home administrator (NHA) on 2/21/22 at 4:17 p.m., read in part: Our facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. -Our facility-oriented approach to safety addresses risks for groups of residents. -Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; quality assurance and performance improvement (QAPI) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. -When accident hazards are identified, the QAPI/Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. -Employees shall be trained on potential accident hazards, on how to identify and report (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accident hazards, and try to prevent avoidable accidents. -The QAPI Committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. II. Observations Two environmental tours of the facility were conducted on 2/17/22 at 3:30 p.m. and 2/21/22 at 11:15 a.m.; observations revealed: -There were loose handrails in the first floor hallway by resident rooms 117, 118, 119 and 120 in a highly trafficked hall where residents walked to access their rooms and the second floor elevator. The handrails were also missing end caps to protect residents, staff and visitors from sharp edges. The handrail by the front lobby was missing the endcap completely and had a sharp edge. The other four handrail ends were covered with a black tape, making proper disinfection of the handrail difficult. This caused a potential fall hazard, placed residents at risk for being cut on the sharp edges of the handrail ends, and created a hygiene/sanitation concern. -Cut/capped pipes were sticking up out of the floor on either side of the nurse's station office. There were four pipes, two on each side of the nurse's station door just below the handrails that residents were observed to use as they went down the halls. The pipes stuck out approximately an inch to an inch and a half from the wall as well as up from the floor. Residents were observed using the hand rails in the halls, and the pipes created a potential trip hazard. -Soiled, unpainted and chipped wall surfaces were observed in hallway 100 between rooms 106, 107 and 108. The length of the wall was covered with chipped paint, and streaked with dried reddish/brown and black drips running down the wall There were additionally several soiled unpainted plaster spots on the wall. III. Interviews The NHA and independent nurse consultant (INC) were interviewed on 2/21/22 at 1:54 p.m. The NHA said they had a list of several areas in the community which needed repairs. The list was supplied to the corporate consultant for guidance and they were working on a plan of repair. They had to prioritize the repair areas by severity of risk to the residents in the facility and had systematically been working on repairs over the last four months. The problem with maintaining repairs in the facility was that the building was old and even when things got repaired they tended to keep breaking. The facility had ordered supplies to repair the hallway handrails but there was an unknown delay in getting the supplies into the building. The maintenance assistant (MA) #1 was interviewed on 2/21/22 at 12:20 p.m. MA #1 said the maintenance department had a long list of repairs. Plastering and painting was a part of the list but broken toilets and safety hazards were a priority. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065152	A. Building B. Wing	02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Skilled Nursing and Rehabilitation	2612 W Cucharras St Colorado Springs, CO 80904

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The corporate maintenance director (CMD) was interviewed on 2/22/22 at 1:45 p.m. The CMD said he was just hired specifically to help this facility with maintenance repairs, and had a plan to fix and update many things in the facility. Repair plans came partly from staff who reported needed repairs and partly by maintenance observations. The CMD's expectation was to have the repair request completed within 72 hours of the request. Before he was able to start a full repair program, he had to complete required training to determine what the maintenance team could and could not do with maintenance areas. The CMD said the pipes sticking out of the floor in the 100 hallway used to be a part of a hallway heating unit. The unit was broken and in disrepair, so the heating unit was removed. The pipes were cut and capped to fulfill the last plan of corrective action in October of 2021. The CMD said he was told the plan was to remove the pipes once the weather warmed up. The CMD said parts for the current handrails were no longer available, but he had a plan to look into getting the end caps manufactured by a 3-D printer. In the interim they put some electrical tape on some of the handrails for safety.