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	10/27/2021

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 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** 20287 Based on observations, record review and interviews, the facility failed to honor preferences of two (#13 and #49) of two residents reviewed for choices out of 42 sample residents. Specifically, the facility failed to: -Honor Resident #13's request for beer and provide an alternative when his request could not be honored; and -Honor Resident #49's request for coffee or provide an alternative beverage of her choice. Findings include: I. Resident #13 A. Resident status Resident #13, age 77, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPOs), diagnoses included cardiac arrhythmia, tobacco use, and alcohol abuse. The 7/16/21 minimum data set (MDS) assessment showed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of seven out of 15. The resident required extensive assistance with activities of daily living. B. Observations On 10/20/21 at 10:30 a.m., the resident was observed to ask for a beer. The resident was told by certified nurse aide (CNA) #4 that he could not have a beer. The resident was not provided any alternatives to his request. He looked upset as he wheeled himself away quickly, muttering something under his breath which could not be understood. On 10/22/21 at 10:51 a.m., the resident asked licensed practical nurse (LPN) #3 for a beer. The LPN said that he could not have a beer at this time. He was not offered any other alternative. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/21 at 5:15 p.m., the resident was observed to come out of his room and asked an unidentified CNA for a beer. The CNA responded he did not have any more. The resident became upset and used foul language toward the CNA. The resident wheeled himself away quickly, muttering under his breath. The resident was not offered any alternative or any explanation why, when he was denied his request. C. Record review The October 2021 CPO showed a physician's order that the resident could have one to two alcoholic beers a day, ordered on 9/25/2020. The care plan, which was updated 3/25/21, identified the resident was at risk for nutritional and hydration needs. The intervention was he could have one to two beers a day as ordered. -The care plan failed to address how to respond if the resident's request was denied due to the physician-ordered limit, any resulting behavior or frequent requests, and any alternatives which could be provided. D. Staff interviews LPN #3 was interviewed on 10/26/21 at 9:33 a.m. The LPN said that the resident was allowed to have only two beers a day. The LPN said that he could not have any more. The LPN said that she knew he became upset when he could not have another one. The LPN said the physician order was to have two beers a day. The time of day did not matter when he could receive the beer. The LPN said that they never looked into offering a non-alcoholic beer or other alternatives. The LPN said a non-alcoholic beer would be a good alternative for Resident #13. The social service assistant (SSA) was interviewed on 10/27/21 12:15 p.m. The SSA said she was aware the resident asked for a beer and could become upset if he did not receive it. She said an alternative beverage should be offered, if he had already consumed the two beers that day. She had not looked into any other alternatives to the beer, such as non-alcoholic beer. II. Resident #49 A. Resident status Resident #49, under age 60, was admitted on [DATE]. According to the October 2021 CPO, diagnoses included other special mental disorders, depressive episodes, gastroesophageal reflux disease and alcohol dependence. The 10/1/21 minimum data set (MDS) assessment showed the resident had severe cognitive impairment with a BIMS score of six out of 15. The resident required extensive assistance with activities of daily living. B. Observations (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/20/21 at 9:44 a.m., the resident walked out of her room and asked for a cup of coffee. CNA #4 was observed to tell the resident, No, you know what the deal is. The CNA said she could have a cup of coffee at lunch. The resident walked away from the CNA disappointed. The resident was not offered any alternative or explanation as to the reason she could not receive any coffee. On 10/22/21 at 9:24 a.m. the resident asked CNA #4 for a cup of coffee. The CNA told her she could not have any more coffee until lunch time. The resident said okay as she walked away disappointed. The resident was not offered any alternative or explanation as to the reason for no coffee. On 10/25/21 at 9:57 a.m., the resident left her room and asked for a cup of coffee. LPN #3 said there was not any upstairs and that she would get it in about 30 minutes. The resident was not offered any alternatives. The resident was not provided an explanation as to the reason for no coffee. C. Record review The October 2021 CPO showed an order, dated 11/18/2020, for decaffeinated coffee with meals. There was no physician order for limiting the resident's coffee or caffeine. The care plan, revised on 3/22/21, identified the resident had gastroesophageal reflux disease (GERD) related to years of inappropriate diet and diagnosis of morbid obesity. Pertinent interventions included to encourage the resident to avoid alcohol, smoking, coffee (even decaffeinated), fatty foods, chocolate, citrus juice, [NAME], and tomato products, and encourage a bland diet. -Although the care plan identified GERD, it was identical to other residents' care plans for the same diagnosis, and it was not individualized. D. Interviews The resident was interviewed on 10/22/21 at 9:24 a.m. The resident said she liked coffee and she did not know why she could not have any coffee when she asked. She said it made her angry when she was denied a cup of coffee. LPN #3 was interviewed on 10/26/21 at 9:33 a.m. The LPN confirmed the resident did like coffee a lot. She said that she got diarrhea if she drank too much, so they limited the resident's coffee. She said that it was not care planned, and there was nothing documented in the medical record that the resident had diarrhea when she drank coffee. She said when she told the resident she could not have any coffee, it was not untrue, as the kitchen did not send up any coffee other than at meal times. The SSA was interviewed on 10/27/21 at 12:15 p.m. The SSA was not aware that the resident became upset when she did not receive coffee. She said that the resident should receive an alternative.

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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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. 38503 Based on observation, record review and interview the facility failed to ensure that residents had reasonable access to send and receive mail during the routine United States Postal Service hours of operation. Specifically, the facility failed to ensure residents' personal mail was delivered timely on all days Monday through Saturday. Findings include: I. Facility policy and procedure The Mail and Electronic Communication policy, undated, was provided by the regional director of operation (RDO) on 11/4/21 at 3:24 p.m. It documented, in pertinent part, Mail and packages will be delivered to the residents each day mail is received from outside delivery services or to the facility ' s post office box (including Saturday deliveries). II. Resident interview and observation The resident council president (#51) was interviewed on 10/26/21 11:48 a.m. She said residents did not have mail delivered routinely since the end of March 2021 including weekends. She said the problem was not with the post office delivering it rather, the facility not delivering it when it arrived to the residents. She presented a letter which the post office postmarked on 9/20/21 and she wrote the date the facility gave the letter to her dated 10/11/21. She said the facility did not deliver mail on weekends. III. Staff interview and observation The social service director (SSD) was interviewed on 10/26/21 at 12:45 p.m. She said the mailman delivered mail and placed it in a box outside of her office. The box outside of her office was observed with a large stack of mail. She said the activity staff delivered the mail every day including on Saturdays. IV. Additional staff interviews The activity director (AD) was interviewed on 10/26/21 at 12:15 p.m. He said his department stopped delivering the mail to the residents about three months prior. He said they had too many obligations so he handed off mail delivery to the social services department. Receptionist (RPT) #1 was interviewed on 10/26/21 at 12:35 p.m. She said anyone who worked the front desk would give the mail to the social services department or the business office to sort. She said on the weekends they would lock up the mail for safety in the business office to be sorted the following Monday. (continued on next page)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The regional director of operations (RDO) was interviewed on 10/26/21 at 12:55 p.m. He said the residents had a right to receive their mail. He said he was made aware mail was not consistently delivered to the residents including on Saturdays. He said now that it was brought to his attention he would get it fixed. He said all mail had been locked on the weekends in the business office to keep everything safe until it was sorted on the following Monday. He said moving forward the activity department would deliver the mail again Monday through Saturday. 43135

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on record review and interviews, the facility failed to notify the primary physician for one (#24) of two residents out of 42 sample residents. Specifically, the facility failed to notify the provider of when Resident #24 was not administered her ordered medication. Cross-reference F760 for significant medication error I. Resident status Resident #24, under age 60, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included atherosclerotic heart disease, paroxysmal atrial fibrillation, bipolar disorder with depression and post traumatic stress disorder (PTSD). The 8/26/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required one to two person assistance with all activities of daily living (ADLs) and was independent for locomotion. The MDS reported antipsychotics were received on a routine basis. II. Record review Review of Resident #24's progress notes from July and August 2021 revealed her Lamotrigine tablet 25 milligrams (MG) for depressed mood and passive death wish related to bipolar disorder were not delivered by the pharmacy and not available for the resident from 7/26/21 through 8/11/21. -However, per the medication administration record (below) the resident missed her medication from 7/23/21 through 8/11/21. The progress notes did not reveal the physician was notified. Review of Resident #24's medical administration record (MAR) for July and August 2021 revealed the resident missed 13 doses of her Lamotrigine tablets 25 mg from 7/23/21 through 8/11/21. -The MAR and progress notes (above) conflicted on how many days the residents' medication was missed. The progress note on 8/8/21 at 10:14 a.m. revealed the resident stated to a certified nurse aide (CNA) that she wanted to commit suicide. The nurse was notified and removed objects that could be harmful from her room and placed her on 15 minute checks. -There was no evidence the physician was notified of the resident's suicidal ideations. The progress note on 8/11/21 at 12:22 p.m. revealed the resident stated she wanted to harm herself with her comb. The comb was removed from her room and a crisis mental health team was notified. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The progress note on 8/11/21 at 3:05 p.m. revealed the resident stated she would cut herself and bleed out. The manager on duty was notified and she was placed on 15 minute checks. The physician was notified and provided an order to send the resident to the hospital. Resident # 24's care plan, revised on 7/26/21, stated she would seek out staff when experiencing suicidal ideation through the next review date. The care plan was updated on 10/14/21 and revealed the resident was started on Abilify for her bipolar disorder. III. Staff interview The regional clinical resource (RCR) and director of nursing (DON) were interviewed on 10/27/21 at 4:45 p. m. The DON said in August 2021 they discovered the nurses did not understand how to order and track the delivery of medications ordered through their pharmacy. She said there were multiple medications that were not delivered and missed doses for multiple residents. She said she provided education to the nurses on how to properly order and track the delivery of medications. She said the education also included notifying the physician every time a medication was not given or not available. The RCR stated that the facility now works with a local pharmacy as a back up when medications are not available through their mail pharmacy. She said the nurses were educated on how to contact the DON when a medication is not available or delayed and the DON has the ability to order the medication through the local pharmacy for a one time order for emergencies. The RCR said the physician should be notified when a medication is not available or when a medication is not given.

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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** 20287 Based on interviews and record review, the facility failed to ensure two (#9 and #51) of four out of 42 sample residents were kept free from neglect and abuse. The facility failed to ensure Resident #9 was not neglected by staff on 6/8//21 by providing the care and services the resident required to maintain the highest practicable well-being. Resident #9 was left on the toilet commode for more than eight hours which resulted in the resident being fearful. During the time she was left on the commode, she cried with endless frustration and fear. She was tired and wanted to sleep, but stayed awake due to her position on the commode. She was uncomfortable, could not shift her legs and her bottom hurt. She describe the experience as torture and she was sore after being left on on the commode. In addition, Resident #51 had a resident to resident altercation with Resident #27 which resulted in having hair pulled and an episode of being choked. Findings include: I. Facility policy The Abuse Prevention Program policy, dated 11/17/17, was received from the nursing home administrator (NHA) on 10/18/21 at p.m., read in pertinent parts, Our residents have the right to be free from abuse, neglect, misappropriation of property, corporal punishment and involuntary seclusion. II. Resident #9 A. Resident status Resident #9, age was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO) diagnoses included hemiplegia and hemiparesis (muscle weakness, paralysis), following other nontraumatic intracranial hemorrhage (brain bleed) affecting left dominant side. The minimum data set (MDS) assessment dated , 7/30/21 documented the resident had no cognitive impairments with a score of 15 out of 15 for the brief interview for mental status (BIMS). The resident required extensive assistance with transfers and mobility and activities of daily living. B. Resident interview (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The resident was interviewed on 10/25/21 at 11:27 a.m. The resident said on 6/8/21 she was assisted onto the commode at 10:20 p.m. She said when she called for help at 10:30 p.m., she said she did not panic at first, because she knew she had to wait at times. She said she kept hitting her call light and began to use the metal wheelchair break to hit it against the metal of the wheelchair. She said when it was 11:00 p.m. and 11:30 p.m. she was concerned. At midnight, she said she became convinced that a certified nurse aide was not coming, but she thought a night nurse would check on her being new to the facility. She said at 1:00 a.m. , and 2:00 a.m., she said she tried several times to get up, but she was unable to do it. She said she had visions of lying on the floor without help. She said she cried endlessly with frustration and fear. She said she was uncomfortable and could shift her legs. She said her bottom was hurting. She said by 4:00 a.m., she was tired and wanted to sleep, but because of her position she had to force herself to stay awake. By 5:00 a.m., she hoped the day shift would come and help her. She said she continued to press the call button and make noise when she heard people in the hallway. However, no staff came. She said the longest hour was 5:00 a.m. to 6:00 a.m., she said she became frustrated every time she heard someone in the hallway. She said at 7:10 a.m., the door opened and she was assisted off the commode. She said she was sore and tired but alive. The resident said she was disappointed that no one checked on her, and that she lived through 8.5 hours of torture. She said if one person would have checked on her, it would have made a big difference. Resident #9 said an investigation was completed, the police were called and the nursing home administrator told her it would never happen again. C. Record review The care plan last revised on 8/5/21 identified the resident had an activities of daily living (ADL) self-care performance deficit related to CVA (cerebral vascular accident, stroke). Pertinent care interventions included, occupational therapist to work with the resident with bed mobility and toilet transfers. An investigation was requested on 10/26/21 at approximately 11:00 a.m. from the regional director of operations regarding the incident on 6/28/21, however the investigation was not provided (see regional clinical resource interview below). D. Interviews The director of nurses (DON) was interviewed on 10/27/21 at approximately 5:00 p.m. The DON confirmed the incident did occur as Resident #9 stated. She said a brand new CNA came on shift and assisted the resident on the commode and proceeded onto her assignment. The CNA helped with the shift change and the CNA did not check on the resident as it was not her assigned resident. She then went home and the one who was assigned never went and checked. The CNA was turned into the board of nursing and terminated. She said all staff training was completed, on answering call lights, and checking on residents. The DON said the resident had said she did not want to be checked on at night, however, the DON said the CNA/nurse should peek inside the room quietly to check on the resident. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The DON said the room had a portable air conditioner which was loud, and that was why no staff could hear the banging. The regional clinical resource (RCR) was interviewed on 10/27/21 at approximately 5:00 p.m. The RCR said an investigation was completed, however, she was unable to locate the investigation as there was a change in leadership. III. Resident-to-resident altercation between Resident #51 and Resident #27 A. Resident #51 1. Resident status Resident #51, age 55 was admitted on [DATE]. According to the October 2021 CPO diagnoses included peripheral vascular disease, diabetes, muscle weakness and dysphagia (swallowing difficulty). The MDS assessment dated [DATE] showed the resident had no cognitive impairments with a score of 15 out of 15 for the brief interview for mental status (BIMS). The resident required supervision with activities of daily living. 2. Record review On 8/29/21 the progress note showed Resident #51 was choked in the hall by Resident #27. The note documented the resident felt an arm around her neck. She screamed and the Resident #27 was removed. No injury occured. The 9/29/21 incident report showed Resident #51 had her hair pulled by Resident #27. The two residents were separated. B. Resident #27 1. Resident status Resident #27, age was admitted on [DATE]. According to the October 2021 diagnosis included, dementia with behaviors. The minimum data set (MDS) assessment dated [DATE] showed the resident had severe cognitive impairments with a score of three out of 15 on the BIMS. The resident ambulated and required limited assistance with activities of daily living. 2. Record review (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The progress note dated 8/29/21 documented the resident walked up to another resident and attempted to choke the resident. Resident #51 said he came up from behind and got a hold of her neck, Resident #51 then screamed right away and this resident let go after about four seconds. RN assessment completed, no noted apparent injuries on either resident. This resident walked back to his room immediately after the incident. Residents do not report any fears or feeling threatened. Both have been separated and they reside in different areas in the building. Abuse coordinator notified, all responsible parties notified. Staff will continue to monitor them for safety. resident unable to state what happened and why he did it. law enforcement notified. residents remain in line of sight of staff for safety. The care plan identified the resident had dementia with behaviors and had a history of combative with cares, and inappropriately touching others. Pertinent interventions included, to redirect the resident, provide activities of interest. The October 2021 CPO showed Rispeidone 0.5 mg twice a day was started on 9/8/21. C. Interview The DON was interviewed on 10/27/21 at approximately 5:00 p.m. The DON said Resident #27 has had resident to resident altercations. She said the resident was on one-to-one staff supervision. She said the physician had changed his medications and added the Risperidone, which has had an improvement in his behaviors. She said they were actively seeking placement in a secured all male unit, however unable to find placement at this time. The DON said the resident was consistently monitored for behaviors and would need to be redirected.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on interviews and record review, the facility failed to timely and thoroughly investigate an allegation of verbal abuse for one (#5) of five residents reviewed out of 42 sample residents. Specifically, the facility failed to timely investigate an allegation of verbal abuse reported by Resident #5. Findings include: I. Facility policy The Protection of Residents During Abuse Investigations policy, dated 11/17/17, was received from the nursing home administrator (NHA) on 10/18/21 at 6:13 p.m. It read in pertinent part, Our facility will protect residents from harm during investigations of abuse. During the abuse investigation, employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended until the finding of the investigation have been reviewed by the NHA. (The facility will conduct) timely and thorough investigations of all reports and allegations of abuse, and the implementation of changes to prevent future occurrences of abuse. II. Resident #5 status Resident #5, age 63, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included generalized anxiety disorder, post traumatic stress disorder, and history of falling. The 7/15/21 minimum data set (MDS) assessment showed the resident had no cognitive impairments with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision with activities of daily living. III. Resident interview Resident #5 was interviewed on 10/18/21 at 3:34 p.m. The resident said that a few weeks ago, the maintenance director (MTD) raised his voice at her. She said that she told the regional plant operator. She said the MTD was busy trying to fix a water break, and told him her heat was not working. When the MTD came to the room, he was angry and he raised his voice. She said that she reported it to the regional plant operator. IV. Record review The resident's medical record failed to show any information about the allegation. The facility had no written report or investigation in regards to the allegation. V. Interviews (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #3 was interviewed on 10/26/21 9:33 a.m. LPN #3 said Resident #5 did report to her the allegation of verbal abuse. She said that the resident had already completed a grievance report so she did not do anything further. She confirmed that the regional plant supervisor was informed. LPN #3 said Resident #5 said it made her feel uncomfortable. She said the resident reported the maintenance director (MTD) had yelled at her and he later had come back and apologized that he was frustrated over another situation. The regional plant supervisor was interviewed on 10/27/21 at approximately 3:00 p.m. The regional plant supervisor said he did not speak with Resident #5 and therefore did not receive any allegations of abuse. He also had not been interviewed about an abuse investigation. The clinical resource (CR) was interviewed on 10/27/21 at approximately 3:30 p.m. The CR said that after reviewing all the grievance forms and also any investigations with Resident #5, she determined an investigation had not been completed. She said all allegations of abuse needed to be investigated. She was provided information that the resident's therapist was in the room at the time, when the MTD conversed with the resident. The CR said LPN #3 should have spoken with the abuse coordinator in order to ensure all allegations were reported. The CR was interviewed a second time on 10/27/21 at approximately 6:00 p.m. The CR said she did get in touch with the resident's therapist. She said the therapist confirmed the MTD was flustered when he spoke with the resident. However, the therapist said the MTD did not raise his voice and she did not see anything which was alarming and cause for concern.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to refer two (#53 and #33) of 16 residents reviewed out of 42 sample residents to the appropriate state-designated authority for level II preadmission screening and resident review (PASRR) evaluation and determination for services. Specifically, the facility failed to ensure that residents with a known psychological disorder were properly assessed on the PASRR level I screen to gain and maintain their highest practicable medical, emotional and psychosocial well-being. Findings include: I. Facility policy and procedure The PASRR policy was requested from the interim nursing home administrator/director of nursing (INHA/DON) on 10/20/21. However, the INHA said they did not have one. II. Resident #53 A. Resident status Resident #53, age 63, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease and schizophrenia The 9/14/21 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status score of eight out of 15. He required no setup or physical assistance with bed mobility, transfers, and toilet use. Personal hygiene required one person's physical assistance. According to the 9/14/21 admission MDS, the resident had no rejection of care or other behaviors. He was coded as having a diagnosis of schizophrenia. He was identified as not being evaluated for a PASRR level II. B. Record review Record review findings revealed no evidence that a preadmission screening and resident review (PASRR) level I or II was completed. Documentation was requested on 10/21/21 at 12:35 p.m. from the interim nursing home administrator/director of nursing (INHA/DON) of a PASRR assessment for Resident #53. The INHA checked on the request and said per the regional clinical resource (RCR) it was not submitted, but they were doing it now. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan revealed that the resident had impaired cognitive function/dementia or impaired thought processes related to chronic mental illness, initiated on 9/29/21. Interventions included administering medications as ordered and monitoring/documentation for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. Communicate with the resident/family/caregivers regarding the resident's capabilities and needs. -There was no mention of a PASRR assessment in the progress notes. C. Staff interviews The social services assistant (SSA) was interviewed on 10/27/21 at 12:18 p.m. She said that two regional social services directors came in to help train her on 9/25/21 with the PASRR process. She said there was not anyone there before to do the PASRRs because the other director left around 8/15/21 and she was alone. The SSA said she had worked alone since the middle of August and she was working diligently to get them done. She said she was not shown the PASRR process until 9/25/21. She said she was hired and then the social services director left five days later. D. Facility follow-up The facility provided documentation that they began initiation of PASRR level 1 screening for Resident #53 on 10/21/21 at 1:41 p.m., during the survey. 42193 III. Resident #33 A. Resident status Resident #33, under age 60, was admitted on [DATE]. The October 2021 CPO included diagnoses of diabetes, schizophrenia, Parkinson's disease and cognitive communication deficit. According to the 8/31/21 minimum data set (MDS), the resident was cognitively intact with a brief interview of mental status (BIMS) score of 15 out of 15. He required supervision with dressing, personal hygiene, toileting and bathing. The MDS included diagnoses of schizophrenia and bipolar disorder without dementia. The 8/31/21 MDS indicated the resident had these diagnoses on admission to the facility. B. Record review Physicians orders dated 10/20/21 included Quetiapine Fumarate (Seroquel, antipsychotic), 200 mg, give one tablet by mouth at bedtime for schizophrenia, and Risperedone (antipsychotic), give one 4 mg tablet three times per day for schizophrenia. The care plan initiated on 10/14/21 indicated that Resident #33 was taking multiple antipsychotic medications although it did not indicate the diagnoses for these medications. There was no mention of a PASRR I or PASRR II in the care plan. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 10/20/21 indicated that a level I PASRR had been done on this day and the resident required a level II PASRR evaluation. This evaluation request was submitted on 10/20/21, during the survey. C. Staff interview The social service director (SSD) was interviewed on 10/20/21 at 11:00 a.m. She said that the PASRR I and PASRR II screening for Resident #33 had not been completed and that she had submitted the level I today, and requested a screening for a level II PASRR due to the diagnosis of schizophrenia.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on observations, interviews and record review, the facility failed to provide activities for one (#37) of two residents reviewed out of 42 sample residents, and failed to provide evening activities for the residents who resided in the facility. Specifically, the facility failed to: -Ensure activities were provided for Resident #37 as care planned, for psychosocial well-being and fall prevention; and, -Ensure evening activities were offered and provided to residents. Findings include: I. Facility policy and procedures The Activity Program policy, revised August 2006, was provided by the regional director of operations (RDO) on 10/26/21 at 9:30 a.m. It read in pertinent part: The activity program consists of individual, small and large group activities that are designed to meet the needs and interests of each resident. The facility will offer at least one evening activity per week depending on population needs. II. Resident #37 A. Resident status Resident #37, age 69, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included dysarthria following unspecified cerebrovascular disease, secondary Parkinsonism, repeated falls, difficulty walking and dementia. The 9/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. The resident required extensive assistance with all activities of daily living and was totally dependent on staff for transfers and toileting. -The MDS did not reflect use of a chair restraint, however Resident #37 did have a wheelchair seat belt in place. The MDS documented two or more falls with no injury and two or more falls with injury since the previous MDS assessment on 7/5/21. The resident received hospice care. B. Observations Resident #37 was observed on 10/20/21 multiple times throughout the day sitting in his chair in the hallway with no interaction from staff: -At 9:29 a.m. he was sitting in the hallway outside of the nurses' station; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:03 a.m. he was sitting in the same spot in the hallway. Staff did not offer an activity or visit during observation; -At 11:00 a.m. he was observed in the same location in his wheelchair; -At 2:37 p.m. he was observed sitting in his wheelchair in the hallway. He was fiddling with his hair and was not engaged in an organized activity; -At 2:49 p.m. he was sitting in the same location next to the nurses' station fiddling with his hair. He was not engaged in an activity or staff engagement. Licensed practical nurse (LPN) #1 asked Resident #37 to stop playing with his hair but did not offer an activity or something for him to do. Resident #37 was observed on 10/21/21 from 9:00 a.m. until 1:15 p.m during continuous observation sitting in his wheelchair outside the nurses' station without staff engagement or activity offered. On 10/21/21 at 11:00 a.m. the activity staff walked by Resident #37 and did not offer an activity or a visit. The activity staff was observed offering other residents visits and snacks. On 10/21/21 at 4:50 p.m. Resident #37 was observed sitting in his wheelchair outside of the nurses' station undressing. LPN #5 was observed walking by the resident three times and did not offer assistance or engage with him. On 10/25/21 at 11:34 a.m. the rehabilitation service director (RSD) was observed sitting with Resident #37 listening to music. He was sitting at the table in the hallway tapping his fingers to the beat of the music. The RSD sat with him for 20 minutes. He tapped his fingers and [NAME] some of the words to the song. On 10/26/21 at 11:26 a.m. the RSD was observed sitting with Resident #37 listening to music. He was tapping his fingers to the beat of the music and singing. On 10/26/21 at 11:30 a.m. activity assistant (AA) #1 was observed pushing an activity cart down the hall offering art projects to the other residents. She walked by Resident #37 and did not offer him anything from the cart. On 10/27/21 at 9:35 a.m. Resident #37 was observed sitting in the hallway holding a piece of paper. He tore a piece of the paper off and dropped it on the floor. The resident leaned forward in his wheelchair to pick up the paper on the floor. LPN #1 was in the hallway as well as the regional clinical support (RCS) within proximity of the resident. The resident observed falling forward. LPN #1 and RCS were alerted and assisted the resident. Staff picked up the paper on the floor. C. Record review Review of the resident's progress notes on 10/25/21 revealed the resident had multiple falls since his initial admission. The most recent falls were noted on: -8/16/21 -9/4/21 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-9/13/21 -10/4/21 -10/22/21 The 10/3/21 quarterly activity assessment reported the resident was interested in music, pets, snack cart, socializing, outside activities and entertainment. The 10/5/21 comprehensive care plan revealed the resident had approximately 45 interventions in place to prevent falls. The most recent intervention added on 9/14/21 read to encourage one to one activities. Review of the resident's activity participation log dated 10/20/21 revealed four social visits were provided under the one to one documentation for the past 30 days. D. Staff interviews The RSD was interviewed on 10/25/21 at 11:40 a.m. She said Resident #37 was not on therapy services. She said she tried to visit with him when she could because he enjoyed music and wanted to improve his quality of life. She said he was a musician. She said he did have a history of falls and had a velcro seat belt he was able to remove. She said he was able to lock and unlock his wheelchair brakes. She said the staff kept him in the hallway because he was a fall risk. AA #1 was interviewed on 10/26/21 at 11:35 a.m. She said she was new to the facility. She said Resident #37 was not on a regular one to one activity schedule. She said he did not participate in independent activities or join group activities. She said she would visit with him when she could. She said he would benefit from more one to one visits because of his history of falls. The director of nursing (DON) and the RCS were interviewed on 10/27/21 at 4:45 p.m. The DON said Resident #37 had a history of falls and was on hospice. She said the interdisciplinary team (IDT) reviewed his falls and looked for a pattern. She said they had implemented multiple interventions and updated his care plan. She said his falls started to pick up more recently and hospice was adjusting his medications for terminal agitation. The RCS said the care plan identified one to one visits to address his history of falling. She said since his most recent fall on 10/22/21 staff had increased their visits with him and she thought that had helped. She said the care plan identified one to one visits prior to his most recent fall. She acknowledged that the staff were not providing the increased one to one visits until after his most recent fall. 43135 III. Evening activities offered and provided to residents A. Record review The facility activity calendars for August, September, and October 2021 were provided on 10/26/21 by the interim nursing home administrator (INHA). It was reviewed on 10/26/21 at 10:25 a.m. and revealed there were no weekly group evening activities offered on the resident's activity calendars. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interviews Resident #51 was interviewed on 10/26/21 at 11:00 a.m. She said the facility did not have any evening activities. She said she would attend if an evening group was offered. Resident #5 was interviewed on 10/26/21 at 2:35 p.m. She said the facility did not have any evening activities. She said the monthly activity calendar did not have any evening activities listed on it. She said she was unsure if she would or would not attend an evening activity if it was offered. C. Staff interview The activity director (AD) was interviewed on 10/26/21 at 12:10 p.m. He said he did not have any evening activities listed on the monthly calendar. He said he listed on the resident's calendars weekly manicures that were offered on Mondays at 5:30 p.m. He said the activity was mostly participated by only a few women. He said he knew most residents did not attend this event. He said the manicures were really one-on-one visits with a few women who participated. He said he had hoped by having on the calendar the 5:30 p.m. event it would count as the required evening group activity per week. He said he knew there was a requirement to have one evening activity per week. He said he knew the manicures were not an evening activity that was offered to everyone. He said he knew that 5:30 p.m. was not considered an evening activity time. He said he would fix the situation the next time he wrote the facility calendars for December 2021 and he would add one evening group per week.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on record review, observation and interviews, the facility failed to ensure one (#42) of one reviewed out of 42 sample residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan. Specifically, the facility failed to identify and provide treatment for an open wound and scratches on Resident #42's posterior back shoulder. Findings include: I. Facility policy The Wound Care policy, dated 11/1/17, was provided by the regional clinical resource (RCR) on 10/26/21 at 11:30 a.m. It documented in pertinent part, to verify there was a physician order for treatment, and review the resident's care plan to assess for any special needs. The following information should be recorded in the resident's medical record: -The type of wound care given; -The date and time the wound care was given; -The name and title of the individuals performing the wound care; -Any change in the resident's condition; -All assessment data (i.e., wound bed color, size, drainage etc.) obtained when inspecting the wound; -How the resident tolerated the procedure; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and the reason(s) why; and -The signature and title of the person recording the data. II. Resident #42 A. Resident status Resident #42, age 72, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO) diagnoses included, chronic obstructive pulmonary disease, insomnia, and dependent on supplemental oxygen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimum data assessment (MDS) dated [DATE] assessment showed the resident had a score of 14 out of 15 on the brief interview for mental status. The resident required extensive assistance with mobility. The resident required limited assistance with personal hygiene. The resident. The resident did not have any skin issues, and she had skin ointments applied. B. Observations On 10/27/21 at 10:14 a.m.,the resident was sitting in an overstuffed lounge chair. She said she had a sore on her shoulder (left) and then she pulled the top of the elastic dress down to reveal the top of her shoulder. It was on the posterior of her shoulder she had a quarter size open area and also another scratch further down. The wound was irregular in shape, scabbed and bleeding at its edges and the surrounding skin was red. She said her skin itched and a cream was put on her shoulders, legs and arms, but the nurses did not always do it. The resident's nails were jagged and about 1/4 to half inch long. The resident's left index finger was jagged. She said they had not cut her nails for a while. C. Record review The October 2021 CPO showed an order for Triamcinolone Acetonide Cream 0.1 % to be applied on arms, legs and abdomen two times a day for skin irritation. The order also indicated it may be applied to other areas that itch/scratch present. -The medical record showed no indication that the resident had open areas. The care plan last updated 4/22/21 identified the resident had a self care deficit. Pertinent interventions were to complete skin inspection daily, for reddened skin, scratches, open areas, and bruises, report to the nurse. -The last skin assessment completed on 10/21/21 showed no open areas. The 10/27/21 progress note documented (during survey), residents skin was assessed by the director of nurses (DON) and noted to have scratches to anterior shoulders, and shearing to the right buttock. The note documented the resident had a cream. The physician was notified of the scratches. Continued barrier cream for shearing on buttocks. The note incorrectly said anterior, as it was posterior. The October 2021 MAR showed theTriamcinolone Acetonide Cream 0.1 % was being applied twice daily. D. Staff interview The director of nurses (DON) was interviewed on 10/27/21 at 11:00 a.m. The DON said skin assessments were completed weekly, however, needed to be completed whenever there was an open area or a skin condition which needed to be followed. The DON said open skin wounds needed to be followed in order to track the healing. The DON acknowledged when the cream was applied to the resident's back then the skin assessment should have been completed to include the wounds. The regional clinical resource (RCR) was interviewed on 10/27/21 at approximately 4:00 p.m. The RCR said the medical record was updated to include the wounds on her back shoulder. She said orders were obtained and the physician was notified.

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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** 38503 Based on observation, record review, and staff interviews, the facility failed to ensure two (#38 and #41) of two out of 42 sample residents received care consistent with professional standards of practice to promote healing of pressure injuries. Resident #41 was admitted to the facility on [DATE] with an unstageable pressure ulcer to her sacrum and remained at risk for pressure ulcer development due to her diagnoses of Alzheimer's disease, protein-calorie malnutrition, acute respiratory failure with hypoxia, muscle wasting and atrophy, and muscle weakness. The facility failed to timely implement sufficient measures to minimize her risks. The facility failed timely implement treatment orders for Resident #41's pressure injury, which was a delay in treatment over eight days (a treatment order was not obtained until 6/16/21). Resident #41's wounds were not assessed, monitored or evaluated consistently to include size, tissue types, evidence of undermining (the destruction of tissue or ulceration extending under the skin edges/margins so that the pressure ulcer is larger at its base that at the skin's surface), tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound), exudate (fluid that has been forced out of tissue or capillaries because of inflammation or injury), and odor. Due to the facility failures, Resident #41's pressure injury was documented as a stage 4 on 6/30/21 by the wound physician. Furthermore, Resident #38's coccyx stage 3 pressure ulcer was not consistently assessed and monitored to include size, stage, tissue types, evidence of undermining, tunneling, exudate and odor. According to the minimum data set (MDS) assessment documented the resident had a stage 2 pressure ulcer on 10/1/21, which then worsened to a stage 3 pressure ulcer on 10/4/21 (see record review below). In addition, there was no documentation of a collaborative interdisciplinary (IDT) review of Resident #38 or #41's wound to indicate if the resident's wounds were improving or worsening. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference Guide, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, from http://www.npuap.org (11/1/21): Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. (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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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, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). II. Facility policy (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Wound Care policy was provided by the regional clinical resource (RCR) on 10/26/21 at 11:30 a.m. It documented in pertinent part, to verify there was a physician order for treatment, and review the resident's care plan to assess for any special needs. The following information should be recorded in the resident's medical record: -The type of wound care given; -The date and time the wound care was given; -The name and title of the individuals performing the wound care; -Any change in the resident's condition; -All assessment data (i.e., wound bed color, size, drainage etc.) obtained when inspecting the wound; -How the resident tolerated the procedure; -Any problems or complaints made by the resident related to the procedure; -If the resident refused the treatment and the reason(s) why; and -The signature and title of the person recording the data. III. Resident #41 A. Resident status Resident #41, age 79, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Alzheimer's disease, protein-calorie malnutrition, acute respiratory failure with hypoxia, muscle wasting and atrophy, and muscle weakness. The 6/11/21 minimum data set (MDS) assessment revealed Resident #41 was severely cognitively impaired with a brief interview for mental status (BIMS) score of two out of 15. She required extensive two-person assistance with all activities of daily living (ADLs) and was always incontinent of bowel and bladder. -She had one unstageable pressure injury over a bony prominence. She had a pressure reducing device for her chair and bed. She was not on a turning/repositioning program. She was receiving pressure ulcer/injury care, contradictory to record review (see below). The 9/24/21 MDS documented she received hospice services. B. Delay in obtaining treatment orders 1. Baseline care plan (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The baseline care plan, initiated on 6/7/21, was incomplete and it documented the resident did not have current skin integrity issues or history of integrity issues. 2. The skin/incontinence care plan, initiated on 6/27/21, documented Resident #41 had an unstageable pressure ulcer to her sacrum related to caloric malnutrition and the wound was unavoidable. Interventions included to follow facility policies/protocols for the prevention/treatment of skin breakdown, provide supplements as ordered to promote healing, provide analgesics for pain management, provide pressure relieving/reducing mattress, pillows, sheepskin padding to protect skin; and monitor/document location, size and treatment of skin injury, report abnormalities, failure to heal, signs and symptoms of infection or maceration to the physician. 3. CPO Review of the June 2021 CPO revealed upon admission Resident #41 did not have treatment orders for her sacral wound. On 6/16/21 treatment orders were obtained, and read, Medihoney (treatment which supports removal of necrotic tissue) on eschar of wound q (every) shift every day and night shift for unstageable sacral ulcer. Additionally, the CPO documented an order to admit the resident to hospice on 6/22/21. C. Failure to assess, monitor and evaluate the wound consistently Review of Resident #41's record revealed her sacral ulcer was not consistently monitored to include size, tissue types, evidence of undermining, tunneling, exudate and odor. 1. Admission assessment The 6/8/21 nursing assessment documented Resident #41 had an open area on her coccyx, which had no drainage or presence of odor. Treatment included to clean the area with normal saline and opti-foam (absorbent dressing) was applied. 2. Braden scales (tools used for predicting pressure ulcer development, score of 15-18 is at risk, score of 13-14 is moderate risk, score of 10-12 is high risk and score of nine or below is very high risk) -The 6/7/21 Braden scale documented Resident #41 was at high risk (score=10) for pressure ulcer development. -The 6/14/21 Braden scale documented Resident #41 was at moderate risk (score=14) for pressure ulcer development. -The 6/21/21 Braden scale documented Resident #41 was at high risk (score=11) for pressure ulcer development. -The 6/28/21 Braden scale documented Resident #41 was at moderate risk (score=13) for pressure ulcer development. 3. Skilled nursing notes (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of skilled nursing notes from 6/8/21 to 6/15/21 revealed staff documented Resident #41 had a sacral wound and physician ordered treatment was not obtained during this time period. Documentation revealed, in pertinent part, the following. -On 6/8/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing change performed every shift to open area on coccyx. -On 6/9/21 it was documented Resident #41 had a necrotic decubitus to her coccyx. -On 6/10/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing changed performed every shift to open area on coccyx. -On 6/11/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing change performed every shift to open area on coccyx. -On 6/12/21 at 9:34 a.m. it was documented Resident #41 had an open necrotic wound to her sacrum, dressing changed performed every shift to open area on coccyx. -On 6/12/21 at 6:40 p.m. it was documented Resident #41 had an unstageable decubitus with eschar (necrotic tissue) to her sacrum, foam dressing applied. -On 6/13/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing change performed every shift to open area on coccyx. -On 6/14/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing changed performed every shift to open area on coccyx. -On 6/15/21 it was documented Resident #41 had an open necrotic wound to her sacrum, dressing changed performed every shift to open area on coccyx. Although skilled documentation indicated treatment was performed, specific treatment was not indicated to promote healing, orders were not obtained from the physician until 6/16/21 and the sacral ulcer was not consistently monitored to include size, tissue types, evidence of undermining, tunneling, exudate and odor. -There was no documentation in the record that an IDT review was completed to identify if the resident's wounds were improving or deteriorating. 4. Wound physician notes and interview The initial consult wound dated 6/30/21 documented Resident #41 had a stage 4 sacral/coccyx wound. It measured 4.9 cm (centimeters) x (by) 6 cm x 3.9 cm depth, with 3 cm of undermining at 12 o'clock. The wound had moderate exudate, with 80% granular tissue, 20% slough and erythema (redness to skin that results from capillary congestion) to the periwound. The wound physician continued to assess the resident's wounds through 8/4/21. It was documented no change under wound progression and transfer care (to hospice) under wound status. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The wound physician was interviewed on 10/27/21 at 10:44 a.m. He said he had been rounding at the facility since 2019. He said Resident #41 had stage 3 to stage 4 wound with nonviable tissue. He said the facility had already taken measures to offload/reposition the resident and they had started Medihoney treatment management. He and the facility talked with the resident's son regarding management of the wound. He said the goal would be to try to heal the wound, but the concern was the resident was declining and then was placed on hospice care. He said hospice took over and started to manage the wound (starting 8/4/21) so he no longer assessed the resident's wound. D. Wound observation On 10/26/21 at 12:07 p.m. licensed practical nurse (LPN) #1 was observed providing wound care to Resident #41. Resident #41 was lying in bed on an alternating air mattress, bunny boots in place to her bilateral heels, and she had a high back wheelchair with gel cushion. LPN #1 and certified nurse aides (CNAs) #10 and #11 performed hand hygiene. CNAs #10 and #11 provided incontinence care to Resident #41 and positioned her on her left side. LPN #1 donned gloves and removed the dressing from Resident #41's sacrum, doffed her gloves, performed hand hygiene, donned clean gloves and cleansed the area with wound cleanser. There was a moderate amount of serosanguineous drainage to the wound; the wound bed was pink with scattered areas of slough; the surrounding skin was pink; undermining was present; there were no signs and symptoms of infection or signs and symptoms of pain during the treatment. LPN #1 doffed her gloves, performed hand hygiene, donned clean gloves and packed the wound with calcium alginate (dressing for heavily exuding wounds) and covered it with a Mepilix (absorbent) dressing. E. Staff interview LPN #1 was interviewed on 10/27/21 at 8:33 a.m. She said there was a wound physician who completed weekly wound rounds for residents with wounds. She said when a resident was admitted to the facility a registered nurse would assess the resident's wounds and obtain treatment orders from the physician. She said the hospice nurse completed weekly assessments of residents with wounds. F. Weekly wound documentation provided by hospice Resident #41's sacral ulcer was not consistently monitored to include size, tissue types, evidence of undermining, tunneling, exudate and odor until admitted to hospice on 6/22/21, and even then weekly monitoring was not consistent (see below). Review of the documentation revealed weekly assessments were not consistently completed from 8/4/21 to 10/25/21. -Specifically, Resident #41 was assessed by the hospice nurse and wound treatment was provided. However, Resident #41's sacral ulcer was monitored to include size, tissue types, evidence of undermining, tunneling, exudate and odor only four times, on 9/13/21, 10/12/21, 10/18/21 and 10/25/21, over the 12 week period. The 9/13/21 hospice note documented Resident #41 had an unstageable wound to her medial buttock. The wound had 75% granular tissue, less than 25% slough and less than 25% eschar. The wound edges were intact, periwound was ping and it measured 5.7 cm x 6.2 cm x 3.4 cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 10/12/21 hospice note documented Resident #41 had a stage 4 pressure injury. The right buttock wound had 15% slough and 85% granulation tissue. The wound edges were rolled, periwound had erythema and it measured 4.5 cm x 3.5 cm x 0.9 cm depth with 2.6 cm of undermining at five o'clock, 0.5 cm at 12 o'clock and 4.2 cm from one to three o'clock. Wound #2 to Resident #41's left buttock had a tunnel at eight o'clock measuring eight cm. The 10/18/21 hospice note documented Resident #41 had a stage 4 wound to her coccyx. The wound (wound #1) measured 4.4 cm x 5 cm x 0.3 cm depth. There was undermining which measured 2.6 cm at five o'clock, 0.5 cm at 12 o'clock, 4.2 cm at one to three o'clock and 2.4 cm at one to four o'clock. Wound #2 to Resident #41's left buttock had a tunnel at eight o'clock measuring eight cm. The 10/25/21 hospice note documented Resident #41 had an unstageable wound to her right buttock/coccyx. The wound (wound #1) measured 4.5 cm x 5 cm x 0.8 cm depth. There was tunneling at nine o'clock which measure 2.8 cm and 4.0 cm. There was undermining which measured 2.5 at five o'clock, 0.5 cm at 12 o'clock, 4.2 cm from one to three o'clock, 2.4 cm from one to four o'clock and 1.8 cm at eight o'clock. Wound #2 to Resident #41's left buttock had a tunnel at eight o'clock measuring eight cm. IV. Resident #38 A. Resident status Resident #38, age less than 60, was admitted on [DATE] and readmitted on [DATE]. According to the October 2021 CPO, diagnoses included multiple sclerosis, quadriplegia, acute respiratory failure, protein calorie-malnutrition, dysphagia, gastroparesis, major depressive disorder, and other mental and behavioral disorders. The 10/1/21 MDS assessment revealed Resident #38 was cognitively intact with a BIMS score of 14 out of 15. She required two-person assistance with most ADLs. She was always incontinent of bowel and bladder. She received hospice services. She had one stage 2 pressure injury over a bony prominence. She had a pressure reducing device for her chair and bed. She was not on a turning/repositioning program. She was receiving pressure ulcer/injury care. B. Failure to assess, monitor and evaluate the wound consistently 1. Care plan The skin care plan, initiated 8/27/2020 and revised on 9/28/21, revealed Resident #38 had an open area to her coccyx. Interventions included to apply dressing as ordered. Resident #38 had an air mattress, needed assistance with peri-care and hygiene, monitoring skin for signs and symptoms of irritation related to incontinent episodes, and encouraging hydration/nutrition to promote healthier skin. 2. Braden scales The 9/10/21 Braden scale documented Resident #38 was at moderate risk (score=13) for pressure ulcer development. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 10/1/21 Braden scale documented Resident #38 was at moderate risk (score=13) for pressure ulcer development. 3. Progress note The 9/10/21 at 6:28 p.m. nursing note documented Resident #38 had an open area to her coccyx which measured 0.5 x 0.7 cm. The wound was cleansed with normal saline, and a dry dressing was applied by hospice and the physician was notified. -There was no documentation of Resident #38's coccyx ulcer to include stage, tissue types, evidence of undermining, tunneling, exudate and odor when it was first identified. -Additionally, review of progress notes from 9/11/21 to 10/25/21 revealed no further documentation of Resident #38's wound to include stage, size, tissue type, evidence of undermining, tunneling, exudate or odor. 4. CPO The September 2021 CPO revealed an order dated 9/11/21 which read to cleanse open area to coccyx with normal saline, pat dry, then apply 3 (three) x 3 foam dressing, and to entire reddened peri-wound area apply calmoseptine (barrier) cream one time a day for wound care. -It did not include the stage of the wound. 5. Weekly summary The 9/11/21 weekly summary documented the resident had a pressure injury. It read, in pertinent part, the resident had a coccyx wound with current treatment orders in place and hospice was aware. -It did not include the stage of the wound. C. Staff interview Registered nurse (RN) #1 was interviewed on 10/27/21 at 8:49 a.m. She said the RN was responsible for assessing wounds and obtaining a physician order for treatment. She said hospice managed Resident #38's wounds and would document their findings during their visits. D. Hospice notes Review of 9/10/21 hospice notes revealed Resident #38 had an open area to her right buttock the size of my pointer finger nail. Calmoseptine cream was applied and covered with 3 x 3 foam dressing daily. -It did not include the stage of the wound. -Resident #38's wound was not assessed again to include size, tissue type, evidence of undermining, tunneling, exudate or odor until 9/20/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Additionally, there was no assessment of Resident #38's wound to include tissue type, evidence of undermining, tunneling, exudate or odor for the hospice visit on 9/20/21. It documented the resident had a superficial open area to her coccyx measuring 2.2 cm x 3.1 cm, apply calmoseptine cream with a foam dressing every shift. -It did not include the stage of the wound. Resident #38's wound was not staged until 10/4/21, when it was documented Resident #38 had a stage 3 pressure ulcer to her coccyx. The 9/29/21 hospice note documented wound care was performed cleansed area with normal saline applied Medihoney with foam dressing. The 10/4/21 hospice note documented Resident #38 wound care was performed. Resident #38's wound was a stage 3 pressure ulcer. It measured 3 x 2 x 1.5 cm depth, tunneling 2.6 cm at 3 o'clock and undermining 0. 8 cm at 12 o'clock to 9 o'clock. -There was no documentation in the record that an IDT review was completed to identify if the resident's wounds were improving or deteriorating. V. Administrative interviews The director of nursing (DON) and regional clinical resource (RCR) were interviewed on 10/27/21 at 4:53 p. m. The DON said Resident #41 and Resident #41's husband were admitted at the same time and they shared a room. She said Resident #41's husband was very controlling and would not let staff provide care. Eventually they were able to convince him to let staff provide care, a week or so went by and he allowed staff to provide consistent care. She said during the admission process registered nurses were responsible for assessing and treating resident's wounds. They said they were not aware of hospice's inconsistent documentation of characteristics of wounds and measurements, but they should had completed house audits of wounds to ensure things were not missed. They acknowledged the facility staff were not assessing resident wounds and missed monitoring and obtaining treatments orders for Residents #41 and #38. The RCR said the facility was ultimately responsible and they planned to start training to include assessment of causation of wounds, obtaining orders, monitoring and implementation of interventions for pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observation, record review, and interviews, the facility failed to ensure residents were as free from accident hazards as possible and that one (#40) of six out of 42 sample residents received adequate supervision. Specifically, the facility failed to ensure: -Resident #40 had interventions in place to keep him safe from wandering; and, -The environment was safe without sharp objects in the resident areas. Findings include: I. Elopement A. Facility policy The Risk for Wandering Protocol was received on 10/25/21 from the regional clinical nurse consultant. The policy read in pertinent part, a wander assessment was to be completed when current behavior of demonstrated wandering was identified. If the resident was at risk for elopement, then staff must proceed with the following: complete an evaluation of at risk for elopement, after consent for the wander guard, place the wander guard on resident. Place an order for monitoring of wander guard which included location and placement, update the care plan if no wander guard was present, then place the resident on 15 minute checks. The wander guard was to be evaluated within seven days to ensure it was still needed. B. Resident #40 status Resident #40, age 65, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Parkinson's disease, and dementia with Lewy bodies. The minimum data assessment (MDS) assessment, dated 9/23/21, showed the resident had a score of 15 out of 15 on the brief interview for mental status. The resident required supervision with activities of daily living. The MDS did not code the resident as wandering. C. Observations On 10/22/21 at approximately 11:00 a.m., the resident was observed sitting outside with other residents. No staff were in the near vicinity. On 10/25/21 at 11:34 a.m., the resident was in his room. The resident was asked if he wore a wander guard bracelet. The resident said no. His wrists did not show any wander guard bracelet. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/25/21 at 12:09 p.m., licensed practical nurse (LPN) #3 was observed to look for the wander guard bracelet on Resident #40. The resident showed her his wrists, and she looked at his ankles, and he had no wander guard bracelet on. The LPN said she could not remember the last time she saw the bracelet on the resident. On 10/25/21 at 12:32 p.m., LPN #3 returned to the floor with a wander guard bracelet for Resident #40. D. Record review The October 2021 CPO included an order to check placement and function of wander guard each shift. Replace if the wander guard was not functioning. If one was not available, place the resident on 15 minute checks. The progress note dated 9/21/21 documented the resident was on elopement monitoring for an episode of elopement. The resident left the floor without the staff's knowledge and went outside. He then took off toward the back of the building. The resident told the nurse he would come back inside, and became confused on which door led back inside. Another resident who was also outside assisted him back to the 2nd floor. The care plan identified the resident was at risk for elopement related to history of elopement attempts prior to admission. The care plan was initiated on 11/20/2020 and revised on 3/3/21. Pertinent interventions included to distract resident from wandering by offering pleasant diversions, such as food, structured activities, books and television. The care plan documented quarterly and as needed elopement assessments were to be completed. -The care plan failed to show the wander guard bracelet was utilized. The last elopement assessment was completed on 5/15/21. There was not an assessment for the resident's 9/21/21 elopement. The elopement assessment documented the resident had a moderate risk for elopement, and the resident had a diagnosis of dementia and was newly admitted to the facility. E. Interviews Licensed practical nurse (LPN) #3 was interviewed on 10/25/21 at 12:09 p.m. LPN #3 said that the resident wore a wander guard bracelet. She said that he had left the building and had gotten confused on what door to come back into. She said that he would also leave to go to the store. She said the receptionist knew to notify her if he was going outside. The October 2021 medication administration record (MAR) was reviewed with LPN #3. LPN #3 had worked the previous two days, and she verified she had initialed off that the bracelet was on the resident, however, she had stated she could not remember the last time she saw the bracelet on the resident. Receptionist #2 was interviewed on 10/25/21 at 2:55 p.m. The receptionist said the wander guard was placed on the front door. She said when a resident who had a wander guard came near, it would lock the door. She said Resident #40 did not have a wander guard and he went outside regularly. She said she did not notify the nurse when he went outside. She was not aware she had to. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social service director (SSD) was interviewed on 10/25/21 at 2:10 p.m. The SSD said that the resident's cognitive status has deteriorated. She said she had just completed the BIMS, as a significant change in condition MDS was being completed. She said he was now moderately cognitively impaired. The clinical nurse consultant (CNC) was interviewed on 10/25/21 at 2:50 p.m. The CNC said an elopement assessment needed to be completed after an episode of elopement. She also said the wander guard placement and function needed to be checked daily. 44997 II. Accident hazards A. Observation Two environmental tours of the facility were conducted on 10/20/21 at 3:15 p.m. and on 10/27/21 at 9:45 a.m. Handrails on the 100 hall were observed to have the end caps missing. Due to the end cap missing on two sections, it had sharp edges, which were exposed. A broken radiator on the 100 hall creating a tripping hazard (cross-reference F921 for safe environment). B. Staff interview The maintenance director (MTD) was interviewed on 10/27/21 at 2:44 p.m. He said there were three hand rails on the first floor that were missing the end caps. He said the hand rails were sharp on the ends and he would order new caps or new handrails if the caps were not available. He said there was also a floor radiator on the first floor near the nurses' station that was missing some parts. He said the frame that was left attached to the wall was sharp and a tripping hazard for the residents. He said he would talk to his supervisor to see if they were replacing the missing parts or if he could remove the radiator frame to remove the hazard.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review, and interviews; the facility failed to maintain acceptable parameters of nutritional status for two (#40 and #43) of five residents reviewed for nutrition out of 42 sample residents. The facility failed to ensure Resident #40 was assessed in a timely manner by a registered dietitian (RD) and interventions were implemented to address his weight loss. The resident was not provided supervision and encouragement with eating, including offering alternatives for meals when meals were not eaten. Due to the facility's failures, Resident #40 sustained a 27.8 lb weight loss from 3/5/21 to 10/13/21, which was 15.0% considered a significant weight loss. Furthermore, Resident #43 was not provided assistance with eating, nor offered alternatives to meals when his meal intake was inadequate. The facility failed to consistently monitor and assess the resident's nutritional status with him being at nutritional risk. The resident's comprehensive care plan was not updated with interventions/strategies to address his nutritional status. Due to the facility's failures, Resident #43 sustained a weight loss of 17.8 lbs from 8/6/21 to 10/13/21, which was 13.26% considered significant weight loss. Findings include: I. Resident #40 A. Resident status Resident #40, age 65, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Parkinson's disease, and dementia with Lewy bodies. The minimum data assessment (MDS) assessment, dated 9/23/21, showed the resident had a score of 15 out of 15 on the brief interview for mental status. The resident required supervision with activities of daily living and supervision with eating. The MDS showed the resident was 5'8 feet tall and weighed 162 pounds. B. Observations Resident #40 received his meal on 10/25/21 at 12:20 p.m. The meal did not include the fortified potatoes or the fortified pudding (see record review below). Certified nurse aide (CNA) #11 dropped off his tray and left the room. He was served 240 cc of juice. -At 12:33 p.m., the resident brought his tray out of his room and placed it on the cart in the hallway, the resident had only eaten bites of the meal. -At 12:44 p.m., the CNA #11 picked up the tray and scraped the food off of the plate. The CNA did not approach the resident and ask if he wanted an alternative. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-At 5:12 p.m., the resident received his meal of a grilled cheese, rice, carrots/broccoli and mandarin oranges. The resident received 240 cc of orange juice. The resident did not receive the fortified potatoes or the fortified pudding. -At 5:18 p.m., the resident brought his tray back out to the cart. The resident ate half of the grilled cheese sandwich. The social service director (SSD) told the resident he did not eat much. She asked if he was hungry, but he did not reply. He was not offered any alternative to his meal. 10/26/21 -At 5:45 p.m., the resident was served his tray. He was served fish, rice, roll and a vegetable. The fish was not mechanical soft as the diet order instructed (see record review below). Licensed practical nurse (LPN) #3 was notified of the wrong meal texture. The LPN #3 told the resident she would get him another meal. The tray ticket also requested fruit, which he did not receive. -At 5:51 p.m., the resident received the replacement tray. He was now served the mechanical soft ham, with rice, peas and two bowls of cantaloupe. The door was closed by the SSD after he was served. -At 6:00 p.m., the resident brought his tray out of his room and placed it on the cart. The resident ate only bites of food. There was no staff near when he brought his tray out to the hallway and therefore was not offered any alternative to his meal. D. Record review The October 2021 physician's order read mechanical soft diet. Review of the resident's weights were as follows: 3/5/21 185 lbs 4/11/21 181.4 lbs 5/3/21 183 lbs 6/8/21 175 lbs 7/2/21 169.8 lbs 8/2/21 168.4 lbs 9/2/21 164.6 lbs 10/4/21 158.6 lbs 10/13/21 157.2 lbs, weight loss of 27.8 lbs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The resident had significant weight loss between 3/5/21 and 10/13/21 of 27.8 lbs, which was 15.0% weight loss. The RD note dated 8/22/21 documented the resident had a 10.7% weight loss within 180 days. The Medpass supplement was increased to 120 cc three times a day for nutrition support. The note documented that the resident's intakes were variable and he required supervision with his meals. -The facility failed to have a registered dietitian (RD) assess the resident until 8/22/21 when he had suffered a 10.7% weight loss. The resident's meal preferences were not evaluated. The dietary note dated 10/7/21 was assessed by the RD and had a 12.2% weight loss from 4/11/21 to 10/6/21. His current weight was 159.2 pounds with a usual body weight of 170 pounds. The Medpass (nutritional supplement) was increased on 9/28/21 to four times a day. The note documented that the resident had a swallowing eval which showed a decreased swallowing difficulty. The resident required 1809-2171 kcal/day. The RD added power (fortified) potatoes and fortified pudding twice daily with lunch and dinner for additional calories and protein. He was also added to weekly weights for close monitoring. The October 2021 medication administration record (MAR) showed the resident was consuming 100% of the Medpass four times a day. The care plan last updated 10/6/21 identified the resident was at nutrition/hydration risk related to Parkinson's disease, and dementia. Pertinent approaches included, encourage good meal intakes and offer substitutes for uneaten food, fortified pudding and potatoes. The meal ticket was reviewed on 10/26/21 at 5:30 p.m., it did not include the fortified potatoes or fortified pudding to be served at lunch and dinner meals as indicated in his care plan and an intervention for the resident's significant weight loss. C. Fortified foods Observations of the tray line in the kitchen on 10/26/21 at 4:50 p.m., showed no fortified potatoes on the tray line and no fortified pudding on the tray line. Resident #40 did not receive the fortified potatoes or the fortified pudding on 10/26/21 at 5:51 p.m. The dietary manager was interviewed on 10/27/21 at 8:20 a.m. She confirmed the fortified potatoes were not on the tray line, but they were on the stove top. She said the fortified potatoes and the fortified pudding needed to make it on the plate, regardless of where the potatoes were being held. She said the potatoes were fortified with butter and half and half. She said she would provide education to the dietary staff about ensuring the potatoes and pudding were served to the residents. D. Staff interview The SSD was interviewed on 10/25/21 at 5:25 p.m. The SSD said she was worried about Resident #40 as he was declining in health and cognitive status. She said she worried he was not eating. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The registered dietitian (RD) was interviewed on 10/27/21at 2:24 p.m. The RD said the facility did not have an RD until late August 2021. She said when she assessed the resident she put into place the fortified pudding and the power potatoes for extra calories. She said he had experienced a significant weight loss at 12.2%. She said an alternative should always be offered when he did not eat his meal. The director of nurses (DON) was interviewed on 10/27/21 at approximately 5:00 p.m. The DON said the resident did suffer a significant weight loss. She said the resident was now placed on the nutrition at risk committee, and also on weekly weights. She said they went a period of time without a RD. She said the resident snacked when he was down visiting with his friends. She said if the resident ate less than 50% of his meal, then he should always be offered an alternative. She said the kitchen was available for alternative meals. She said they would begin tracking the snacks he ate while downstairs. He fed himself, but did require encouragement and cueing to eat. 42193 II. Resident #43 A. Resident status Resident #43, age 72, was admitted on [DATE] and readmitted from hospital 10/2/21. According to the October 2021 computerized physicians orders (CPO), diagnoses included acute respiratory failure, adult failure to thrive, diabetes and weight loss. The 10/7/21 minimum data set (MDS) indicated the resident was mildly cognitively impaired with a brief interview for mental status (BIMS) score of 14 out of 15. He required extensive assistance with toileting, bathing, dressing and personal hygiene; he was an independent eater. The resident had experienced over ten percent weight loss in the past six months and was not on a physician prescribed weight loss regimen. B. Meal observations 10/25/21 -At 5:15 p.m. Resident #43's dinner meal was served to him. The plate contained double portions of the meal. Observations of the resident's meal continued until 5:45 p.m. The resident did not eat any of his evening meal. He did not receive any encouragement or assistance from the staff with eating. -At 5:50 p.m. certified nurse aide (CNA) #8 took the plate from Resident #43. It was full of food. He was not offered an alternative. 10/26/21 -At 12:15 p.m. Resident #43 was served the lunch meal. Observations from 12:15 p.m. to 12:45 p.m. indicated the resident did not eat any of his food. He was not offered an alternative. C. Resident interview (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #43 was interviewed on 10/26/21 at 12:45 p.m. He said the lunch meal was very bad and he did not eat any of it. He said he was not offered an alternative. E. Record Review Resident weights were as follows: 8/6/21 134.2 lbs 9/7/21 133.2 lbs 9/11/21 133.0 lbs 10/4/21 124.2 lbs, returned from hospital on 10/2/21 10/7/21 119.6 lbs 10/12/21 117.4 lbs 10/13/21 116.4 lbs, a weight loss of 17.8 lbs. The resident lost weight from 8/6/21 to 10/13/21 of 17.8 lbs which was 13.26%, which indicated significant weight loss that was not prescribed. The dietary quarterly assessment dated [DATE] indicated that Resident #43 was an independent eater and would let his dietary needs be known. It revealed that the resident consumed 50 percent to 75 percent of his meals. A dietary note added on 10/7/21 (five days after the resident returned from hospital) indicated Resident #43 had triggered significant weight loss of 6.8% from 9/7/21 to 10/4/21. A possible error was suspected due to a reported good appetite. It was suggested by the RD for the resident to be weighed again. -However, there was no follow-up from the RD to determine if the weight was an error. The resident's meal preferences or intake were not reviewed. The resident's supplement was increased from two times a day to three times a day, but the percentage the resident was consuming was not indicated. The medication administration record (MAR) for October 2021 indicated an order for one carton of Glucerna shake two times daily started 9/29/21 and discontinued on 10/7/21. According to the MAR from 10/1-10/7/21, the resident refused the supplement three times. The October 2021 MAR indicated an order for one carton of Glucerna shake three times daily started on 10/7/21. This order was discontinued on 10/25/21. According to the MAR from 10/7/21-10/25/21, the resident refused the supplement three times. The amount eaten history record from 10/14/21 to 10/24/21 indicated Resident #43 ate 25 percent to 50 percent of his meals for eight of 16 meals, he ate 76 percent to 100 percent of his meals for six out of 16 meals. On the other days he ate 50 percent to 75 percent of his meals. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-According to meal observations above on 10/25/21 and 10/26/21, the resident did not consume any of his meal nor was he offered an alternative meal. A dietary note added on 10/20/21 revealed that Resident #43 had been informed of his weight loss by the RD and was asked why he thought he had lost weight. He replied, I do not know, I guess I am not hungry. The RD increased the supplement drink from two times per day to three times per day. -However, the resident's supplement order was already increased on 10/7/21 to three times a day. The resident's meal preferences, supplement and meal intake were not reviewed. A new order for one carton of Glucerna shake four times daily was started on 10/25/21 (this order was written during the survey). The nutrition care plan, updated on 10/25/21 (during survey), revealed Resident #43 experienced additional weight loss for one week. It did have an update of the orders for the Glucerna shake which started on 10/7/21 for one carton two times daily. The next update was on 10/17/21 for one shake three times daily and the last update was 10/25/21 for one shake four times daily. -The resident did have a comprehensive care plan that included strategies/interventions for his nutritional needs.There was one update from 10/25/21 (during survey) which included the increase of the Glucerna shake from three times daily to four times daily. -Although the RD ordered a supplement, it was not documented how much the resident was consuming. In addition, the resident's meal preferences were not evaluated nor was the resident offered meal alternatives when he did not eat his meals (see observations above). The resident had diagnoses of failure to thrive, diabetes and weight loss, which placed him at nutritional risk. The facility failed to monitor and assess the resident with ongoing weight loss. D. Staff interviews CNA #8 was interviewed on 10/25/21 at 6:00 p.m. She said that Resident #43 ate nothing all day today which was normal for him. She said the staff gave the resident a sandwich every evening because he was diabetic. She said he ate the sandwich half of the time. She said the staff did not help the resident eat because he ate on his own. She said they did not encourage him to eat and he was offered nothing else to eat except for the sandwich in the evening. The assistant director of nursing (ADON) was interviewed on 10/26/21 at 12:45 p.m. He said Resident #43 would become angry if the staff tried to encourage him to eat or help him to eat. He said the resident would not go to the dining room and prefered to stay in his room for meals. He said he did not realize the resident had not been offered alternatives to the meals. He said he would offer one to him today and encourage the staff to do so in the future. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The registered dietitian consultant (RD) was interviewed on 10/21/21 at 10:36 a.m. She said Resident #43 came back from the hospital on 10/2/21 and that was when she did an initial assessment on him, which was the dietary note entered into the medical record on 10/7/21. She said the interventions she used were to order fortified drinks for the resident and also to serve him a double portion of food at mealtimes. She said the resident was offered snacks at snack time which he usually ate. She said the resident was getting weighed weekly. She said she observed the resident at one meal but did not indicate which one. She said he ate all of his food.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38503 Based on observations, interviews, and record review, the facility failed to monitor and manage pain for one (#15) of two residents reviewed for pain out of 42 sample residents. The facility failed to: -Adequately assess and treat Resident #15's pain; -Update Resident #15's pain care plan timely; -Ensure Resident #15's tolerable pain level was assessed and attained; and, -Ensure non-pharmacological approaches were identified and attempted to assist with alleviating the resident's pain. As a result of these failures, Resident #15's pain was not adequately managed or relieved. Routine and as-needed (PRN) pain medication was not given, which contributed to the resident experiencing unrelieved back pain that she described as steady and deep, at a level eight (severe on a pain scale of 0-10) per interview and observation. During October 2021, the resident experienced moderate to severe pain at level four to seven on 13 occasions per facility documentation. Cross-reference F755, failure to ensure medications were available to residents. Findings include: I. Facility policy The Pain policy was provided by the clinical resource (CR) on 10/26/21. It read, in pertinent part, Assess the resident's pain and consequences of pain at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. Pharmacological interventions may be prescribed to manage pain. Strategies that may be employed when establishing the medication regimen include: combining long-acting medications with PRNs (as-needed medications) for breakthrough pain. II. Resident status Resident #15, age 86, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included chronic pain, muscle spasm of back, sciatica, neuropathy, and other intervertebral disc disorders. The 7/30/21 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. It documented the resident was on a scheduled pain medication regimen and did not receive any pain medications as needed (PRN). It was documented the resident's worst pain level was four out of 10 in the past five days and pain did not interfere with her sleep or daily activities. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A. Pain management plan The pain care plan, initiated 3/8/17 and revised on 2/24/21, revealed Resident #15 had chronic osteoarthritis. Interventions included to administer analgesia (Percocet) per physician orders, apply Biofreeze Gel 4% topically to joints every four hours as needed for arthritis pain and evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Offer non-pharmacological interventions (taking a nap in the afternoon, listening to music and reading a book) and notify the physician if interventions are unsuccessful or if current complaint is a significant change from the resident's past experience of pain. B. Failure to assess and manage Resident #15's pain 1. Assessments The pain assessment dated [DATE] documented Resident #15 had moderate pain (level=5 out of 10) to her left hip, right hip and sacrum. Increased activity made her pain worse and Percocet helped manage her pain. The pain interview dated 10/9/21 documented Resident #15 had occasional mild to moderate pain (level=4 out of 10), and scheduled and as needed Percocet provided effective pain management. -The pain assessment did not document the resident's preferred/tolerated level of pain, or specific non-pharmacological measures that helped the resident's pain. 2. CPO The October 2021 CPO included an order for the resident's pain to be evaluated every shift starting on 7/28/21, using a pain scale of 0-10 with 0 being no pain, 1-3 being mild pain, 4-6 being moderate pain, and 7-10 being severe pain. The October 2021 CPO and recent physician telephone orders revealed current orders for pain control included: -Lidocaine cream 4% applied to lower back as needed for pain with a start date of 5/21/21; -Meloxicam tablet 7.5 milligrams (mg) every morning for neck osteoarthritis with a start date of 5/17/21; -Gabapentin capsule 100 mg three times a day for chronic pain with a start date of 9/18/21; -Percocet tablet 5-325 mg every six hours for pain with a start date of 12/14/2020; and, -Percocet tablet 5-325 mg every six hours as needed for moderate pain with a start date of 12/14/2020. 3. Observation and interview (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 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #15 was observed on 10/20/21 at 9:30 a.m. Resident #15 was at the nurses station and she grimaced and cried out it hurts! while she pointed to her back. She was observed to ask licensed practical nurse (LPN) #4 for something to manage the pain since the facility did not have her Percocet. The nurse responded that she could give the resident Tylenol. Resident #15 was observed on 10/20/21 at 10:01 am. Resident #15 was in bed and told LPN #4 her pain was at an eight out of 10. Resident #15 said her pain was steady and deep. She was observed groaning and grimacing. 4. Pain level summary Review of the pain level summary revealed it was documented Resident #15 had a zero pain level on 10/20/21 at 6:58 a.m., 9:20 a.m., 12:29 p.m., 7:33 p.m., and 11:06 p.m., contradictory to the observation (see above). According to the pain level summary from 10/1 to 10/20/21, the resident's pain level was documented 13 times at level four to seven out of 10. Her pain was documented five times at two to three out of 10, and 50 times at zero out of 10. 5. Medication administration record (MAR) Review of the October 2021 MAR revealed the resident had not received several of her routine or PRN (as needed) doses of Percocet on 10/18/21, 10/19/21 and 10/20/21; it was documented numeric code 10 (see progress notes). Resident #15 missed a total of six routine doses, three on 10/18/21, two on 10/19/21 and one on 10/20/21. -In addition to pain medication being missed, review of the MAR revealed Resident #15 was not provided non-pharmacological interventions on 10/18/21, 10/19/21 and 10/20/21 as per the care plan. -Tylenol 500 mg (milligram) give two tablets was ordered on 10/20/21 at 9:44 a.m. (one time order) and given at 11:18 a.m.; however it was not documented as effective or ineffective and no further intervention was documented. 6. Progress notes Review of progress notes from 10/18/21 to 10/20/21 revealed staff documented the following: -On 10/18/21 at 5:38 a.m. Percocet tablet 5-325 mg waiting to be delivered from hospice pharmacy; -On 10/18/21 at 6:41 a.m. Percocet tablet 5-325 mg waiting delivery from pharmacy; -On 10/19/21 at 12:18 a.m. Percocet tablet 5-325 mg waiting to be delivered by hospice; -On 10/19/21 at 12:19 a.m. Percocet tablet 5-325 mg waiting to be delivered by hospice; -On 10/20/21 at 1:33 a.m. Percocet tablet 5-325 mg waiting to be delivered from pharmacy; and, -On 10/20/21 at 1:34 a.m. Percocet tablet 5-325 mg waiting to be delivered from pharmacy. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-There was no further documentation in the progress notes related to pain management due to medication not being available or non-pharmacological interventions being provided. -There was no evidence the resident's physician was notified of her moderate to severe pain levels, and that her pain medication was unavailable until 10/20/21 (during survey). 7. Nurse practitioner (NP) note The 10/15/21 NP note documented Resident #15 was a recent hospice graduate (she graduated from hospice on 9/29/21). III. Interviews LPN #4 was interviewed on 10/20/21 at 9:52 a.m. She said Percocet was not ordered from the pharmacy and there must have been a miscommunication. She said she knew the resident needed Percocet, but it was not sent to the pharmacy, but she would give the resident Tylenol to manage her pain. She said Tylenol was not the same as Percocet. She said the physician was notified today of the error. The director of nursing (DON) and regional clinical resource (RCR) were interviewed on 10/27/21 at 5:01 p. m. They said the facility did have an emergency kit available for pain medication, antibiotics, insulin and various other medications. They said they contracted with backup pharmacies to obtain medications if unavailable. They talked to the pharmacist about the medication being unavailable in quality assurance (QA), and they were investigating on their end why medications were not being delivered from the pharmacy. The RCR said they planned to re-educate staff to ensure medication was received from the pharmacy, how to access from the emergency kit and exhaust every option to ensure the residents had their medications. The DON said when a resident requested pain medication the licensed nurses needed to assess the resident's pain level and administer pain medication, if the resident did not have pain medication available, the physician should be notified. She said when she learned Resident #15 had not received her pain medication, the nurse was terminated. 41172

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on record review and interviews, the facility failed to ensure four (#24, #36, #15 and #40) of eight residents reviewed for medication administration out of 42 sample residents had physician-ordered medications available for administration. Specifically, the facility failed to: -Ensure Resident #24 received Lamotrigine, prescribed to treat depressed mood and passive death wish related to bipolar disorder. The medication was not available, and Resident #24 missed 13 doses. The facility further failed to: -Administer 14 doses of Maxitrol ointment, prescribed to treat Resident #36's inflammatory eye condition; -Administer Percocet, prescribed for pain management for Resident #15; and -Apply seven Rivastigmine patches, prescribed to treat Resident #40's hallucinations. Residents #24, #36, #15 and #40 had run out of these medications. Cross-reference F580, physician notification; F697, pain management; and F760, significant medication errors. Findings include: I. Facility policy The Provider Pharmacy Requirements policy, reviewed September 2018, was provided by the regional director of operations (RDO) on 11/4/21 at 12:12 p.m. It documented, in pertinent part, Regular and reliable pharmaceutical services are available to provide residents with prescription and non-prescription medications, services, and related equipment and supplies . -The provider pharmacy maintains all current pharmacy licenses and registrations required by state and federal laws, regulations, nursing care center policies and procedures, community standards of practice and professional standards of practice. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to assisting the nursing care center, as necessary, in determining the appropriate acquisition, receipt, dispensing and administration of all medications and biologicals to meet the medication needs of the residents and the nursing care center .Providing routine and timely pharmacy service per contractual agreement and emergency pharmacy service 24 hours per day, seven days per week. II. Resident #24 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #24, under age 60, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included antherosclerotic heart disease, paroxysmal atrial fibrillation, bipolar disorder with depression and post traumatic stress disorder (PTSD). The 8/26/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required one to two person assistance with all activities of daily living (ADLs) and was independent for locomotion. The MDS reported antipsychotics were received on a routine basis. B. Record review Review of resident #24's progress notes from July and August 2021 revealed her Lamotrigine tablet 25 milligrams (MG) for depressed mood and passive death wish related to bipolar disorder were not delivered by the pharmacy and not available for the resident from 7/26/21 through 8/11/21. The progress notes did not reveal the physician was notified (cross-reference F580 and F760). Review of resident #24's medication administration record (MAR) for July and August 2021 revealed the resident missed 13 doses of her Lamotrigine tablets 25 mg from 7/23/21 through 8/11/21. C. Staff interview The regional clinical resource (RCR) and director of nursing (DON) were interviewed on 10/27/21 at 4:45 p. m. The DON said in August 2021 they discovered the nurses did not understand how to order and track the delivery of medications ordered through their pharmacy. She said there were multiple medications that were not delivered and missed doses for multiple residents. She said she provided education to the nurses on how to properly order and track the delivery of medications. She said the education also included notifying the physician every time a medication was not given or not available. The RCR stated that the company now works with a local pharmacy as a back-up when medications are not available through their mail pharmacy. She said the nurses were educated on how to contact the DON when a medication was not available or delayed and the DON has the ability to order the medication through the local pharmacy for a one time order for emergencies. III. Resident #36 A. Resident status Resident #36, age 66, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, history of falls and major depressive disorder. The 7/3/21 minimum data set (MDS) assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required supervision to one person assistance with all activities of daily living (ADLs). The MDS reported impaired and limited vision. B. Record review (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident #36's progress notes from September and October 2021 revealed her Maxitrol ointment for her left eye, to be administered two times a day for chalazion (inflammatory lump in the oil gland of the eyelid), was not delivered and administered according to physician orders. The progress notes did not reveal the physician was notified (cross-reference F580 and F760). Resident #36's progress note dated 9/15/21 at 7:18 p.m. revealed maxitrol ointment to be administered two times daily for chalazion was ordered and pending arrival from the pharmacy. The resident #36's progress note dated 9/22/21 at 8:29 a.m. revealed the maxitrol ointment was on order and unable to be administered. Resident #36's progress note dated 9/29/21 at 8:19 a.m. revealed the maxitrol ointment was on order and unable to be administered. Resident #36's progress note dated 10/10/21 at 8:49 a.m. revealed the resident stated she no longer used the maxitrol ointment. Resident #36's progress note dated 10/18/21 at 7:14 p.m. revealed the resident declined the maxitrol ointment to be administered. Resident #36's progress note dated 10/19/21 revealed the maxitrol ointment was on order and unable to be administered. Review of Resident #36's medical administration record (MAR) for September and October 2021 revealed the resident missed 14 doses of her maxitrol ointment from 9/15/21 through 10/25/21. C. Staff interview The regional clinical resource (RCR) and director of nursing (DON) were interviewed on 10/27/21 at 4:45 p.m. The DON said she did an inservice for all of the nurses that covered medication ordering and tracking of the medications. The DON said either a registered nurse (RN) or a licensed practical nurse (LPN) could order the medications from the pharmacy. She said the inservice was done in August and she would provide another education to the current staff on medication administration, ordering and documentation. 38503 IV. Resident #15 A. Resident status Resident #15, age 86, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included chronic pain, muscle spasm of back, sciatica, neuropathy, and other intervertebral disc disorders. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/30/21 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. It documented the resident was on a scheduled pain medication regimen and did not receive any pain medications as needed (PRN). It was documented the resident's worst pain level was four out of 10 in the past five days and pain did not interfere with her sleep or daily activities. B. Record review Review of progress notes from 10/18/21 to 10/20/21 revealed staff documented the following: -On 10/18/21 at 5:38 a.m. Percocet tablet 5-325 mg waiting to be delivered from hospice pharmacy; -On 10/18/21 at 6:41 a.m. Percocet tablet 5-325 mg waiting delivery from pharmacy; -On 10/19/21 at 12:18 a.m. Percocet tablet 5-325 mg waiting to be delivered by hospice; -On 10/19/21 at 12:19 a.m. Percocet tablet 5-325 mg waiting to be delivered by hospice; -On 10/20/21 at 1:33 a.m. Percocet tablet 5-325 mg waiting to be delivered from pharmacy; and -On 10/20/21 at 1:34 a.m. Percocet tablet 5-325 mg waiting to be delivered from pharmacy. Review of the October 2021 MAR revealed the resident had not received several of her routine or PRN (as needed) doses of Percocet on 10/18/21, 10/19/21 and 10/20/21; it was documented numeric code 10 (see progress notes). Resident #15 missed a total of six routine doses, three on 10/18/21, two on 10/19/21 and one on 10/20/21. (Cross-reference F697, failure to manage the resident's pain.) 20287 V. Resident #40 Resident status Resident #40, age 65, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Parkinson ' s disease, dementia, and psychotic disorder with hallucinations. The 9/23/21 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. It indicated the resident did not have hallucinations or delusions and did not have behaviors including resistance to care. B. Record Review The October 2021 CPO included the following: -Rivastigmine patch (a cognition enhancing medication; stopping suddenly may cause mental/behavioral changes) 24 hour, 4.6 milligrams per hour. Apply one patch transdermally one time a day for hallucinations and remove per schedule, with a start date of 9/15/21. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The October medication administration record (MAR) revealed the following: -Rivastigmine patch was not administered from 10/15-10/20/21. The MAR documented see progress note. -Rivastigmine patch was administered in the evening on 10/21/21. The nursing progress notes revealed the following: -The 10/15/21 progress note indicated the patch was not administered due to Resident #40 not completing lower dosage. -The 10/16/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/17/21 progress note did not indicate a reason the patch was not administered. -The 10/18/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/19/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/20/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/21/21 progress note indicated the patch was not administered due to patch not on Resident #40 did not receive the medication seven times throughout seven days. There was no evidence the physician was notified that the resident did not receive the medication. (Cross-reference F760). The care plan, last updated on 3/3/21, indicated Resident #40 was at risk for pacing, worrying, and hallucinations related to his diagnoses. Interventions included administration of medications as ordered and support and reassurance of safety at times of hallucinations. C. Interview The director of nurses was interviewed on 10/27/21 at 11:00 a.m. The DON reviewed the record and confirmed the resident did not receive his scheduled Rivastgmine patch. The DON said all licensed nurses were responsible for ordering the medications. She said she had conducted recent training which instructed the nurses to order the medications as early as 10 days prior to running out, then fax the request to the pharmacy. When the pharmacy delivered medications, the nurse was to review the received medications and compare them to the sheet faxed. She said if medication was not received, then they needed to call the pharmacy and track the whereabouts.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on record review and interviews, the facility failed to ensure three (#24, #36 and #40) of eight residents reviewed for medication administration out of 42 sample residents were free from significant medication errors. Resident #24 was not given 13 doses of Lamotrigine, prescribed to treat depressed mood and passive death wish related to bipolar disorder. The medication was not available, the facility did not ensure the medication was reordered timely, and the resident's physician was not notified the resident had missed this medication. These failures contributed to Resident #24's hospitalization after a mental breakdown and self-injurious behavior. The facility further failed to: -Administer 14 doses of Maxitrol ointment, prescribed to treat Resident #36's inflammatory eye condition; and -Apply seven Rivastigmine patches, prescribed to treat Resident #40's hallucinations. Findings include: I. Facility policy and procedure The Medication Administration policy, dated 2007, provided by the regional director of operations (RDO) on 10/27/21, read in pertinent part: Medications shall be administered in a safe and timely manner. Medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified. II. Resident #24 A. Resident status Resident #24, under age 60, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included antherosclerotic heart disease, paroxysmal atrial fibrillation, bipolar disorder with depression and post traumatic stress disorder (PTSD). The 8/26/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required one to two person assistance with all activities of daily living (ADLs) and was independent for locomotion. The MDS reported antipsychotics were received on a routine basis. B. Record review (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #24's progress notes from July and August 2021 revealed her Lamotrigine tablet 25 milligrams (mg) for depressed mood and passive death wish related to bipolar disorder were not delivered by the pharmacy and not available for the resident from 7/26/21 through 8/11/21 (cross-reference F755). The progress notes did not reveal the physician was notified (cross-reference F580). Review of Resident #24's medication administration record (MAR) for July and August 2021 revealed the resident missed 13 doses of her Lamotrigine tablets 25 mg from 7/23/21 through 8/11/21. The progress note on 8/8/21 at 10:14 a.m. revealed the resident stated to a certified nurse aide (CNA) that she wanted to commit suicide. The nurse was notified and removed objects that could be harmful from her room and placed her on 15 minute checks. The progress note on 8/11/21 at 12:22 p.m. revealed the resident stated she wanted to harm herself with her comb. The comb was removed from her room and a crisis mental health team was notified. The progress note on 8/11/21 at 3:05 p.m. revealed the resident stated she would cut herself and bleed out. The manager on duty was notified and she was placed on 15 minute checks. The physician was notified and provided an order to send the resident to the hospital. The progress note on 8/12/21 at 5:14 p.m. was a late entry that revealed the resident was sent out to the hospital for psychiatric evaluation. The resident stated she planned to kill herself. She was picked up by ambulance on 8/11/21 at 9:30 p.m. The progress note on 8/17/21 at 5:00 p.m. revealed the resident returned from the hospital with self-inflicted bruises on her right upper arm, left leg and stomach. The progress note on 8/18/21 at 4:32 p.m. revealed the monthly medication regimen review was completed. The hospital admission paperwork dated 8/12/21 noted chief complaints as suicidal history and bipolar schizophrenia. The report revealed the resident had a plan to use an aluminum can to cut her wrists open. She confirmed increasing family related stress and she did not like her nursing facility due to understaffing. The psychiatric evaluation revealed her mood as depressed with withdrawn behavior. The resident had suicidal ideation that included a plan. She stated she wished she would fall asleep and not wake up. The resident stated after discussion she was motivated to live for her son and needed help from the facility to stay in compliance. C. Staff interview (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The regional clinical resource (RCR) and director of nursing (DON) were interviewed on 10/27/21 at 4:45 p. m. The DON said in August 2021 they discovered the nurses did not understand how to order and track the delivery of medications ordered through their pharmacy. She said there were multiple medications that were not delivered and missed doses for multiple residents. She said she provided education to the nurses on how to properly order and track the delivery of medications. She said the education also included notifying the physician every time a medication was not given or not available. The RCR stated that the company now works with a local pharmacy as a back up when medications were not available through their mail pharmacy. She said the nurses were educated on how to contact the DON when a medication was not available or delayed and the DON has the ability to order the medication through the local pharmacy for a one time order for emergencies. The RCR said the physician should be notified when a medication was not available or when a medication was not given. The RCR said the multiple missed doses of Lamotrigine may have contributed to the mental break and hospitalization of Resident #24. D. Facility follow-up Record review revealed that after the resident's hospitalization on [DATE] and when she returned to the facility on [DATE], her medications were changed, mental health services were provided, and her psychosocial condition was improving. III. Resident #36 A. Resident status Resident #36, age 66, was initially admitted on [DATE] and readmitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, history of falls and major depressive disorder. The 7/3/21 minimum data set (MDS) assessment the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. She required supervision to one person assistance with all activities of daily living (ADLs). The MDS reported impaired and limited vision. B. Record review Review of Resident #36's progress notes from September and October 2021 revealed her Maxitrol ointment for her left eye to be administered two times a day for Chalazion (inflammatory lump in the oil gland of the eyelid) was not delivered and administered according to physician orders. The progress notes did not reveal the physician was notified (cross-reference F580). Resident #36's progress note dated 9/15/21 at 7:18 p.m. revealed Maxitrol ointment to be administered two times daily for Chalazion was ordered and pending arrival from the pharmacy (cross-reference F755). Resident #36's note dated 9/22/21 at 8:29 a.m. revealed the Maxitrol ointment was on order and unable to be administered. Resident #36's progress note dated 9/29/21 at 8:19 a.m. revealed the Maxitrol ointment was on order and unable to be administered. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Resident #36's progress note dated 10/10/21 at 8:49 a.m. revealed the resident stated she no longer used the Maxitrol ointment. Resident #36's progress note dated 10/18/21 at 7:14 p.m. revealed the resident declined the Maxitrol ointment to be administered. Resident #36's progress note dated 10/19/21 revealed the Maxitrol ointment was on order and unable to be administered. Review of Resident #36's medical administration record (MAR) for September and October 2021 revealed the resident missed 14 doses of the Maxitrol ointment from 9/15/21 through 10/25/21. Resident #36's care plan, revised on 10/9/21, revealed the resident was visually impaired with nuclear cataracts with a benign neoplasm of the left eye. C. Staff interview The regional clinical resource (RCR) and director of nursing (DON) were interviewed on 10/27/21 at 4:45 p. m. The DON said she did an inservice for all of the nurses that covered medication ordering and tracking of the medications. The DON said either a registered nurse (RN) or a licensed practical nurse (LPN) could order the medications from the pharmacy. She said the inservice was done in August (2021) and she would provide another education to the current staff on medication administration, ordering and documentation. 20287 IV. Resident #40 A. Resident status Resident #40, age 65, was admitted on [DATE]. According to the October 2021 computerized physician orders (CPO), diagnoses included Parkinson's disease, dementia, and psychotic disorder with hallucinations. The 9/23/21 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. It indicated the resident did not have hallucinations or delusions and did not have behaviors including resistance to care. B. Record Review The October 2021 CPO included the following: -Rivastigmine patch (a cognition enhancing medication; stopping suddenly may cause mental/behavioral changes) 24 hour, 4.6 milligrams per hour. Apply one patch transdermally one time a day for hallucinations and remove per schedule, with a start date of 9/15/21. The October medication administration record (MAR) revealed the following: (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Rivastigmine patch was not administered from 10/15-10/20/21. The MAR documented see progress note. -Rivastigmine patch was administered in the evening on 10/21/21. The nursing progress notes revealed the following: -The 10/15/21 progress note indicated the patch was not administered due to Resident #40 not completing lower dosage. -The 10/16/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/17/21 progress note did not indicate a reason the patch was not administered. -The 10/18/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/19/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/20/21 progress note indicated the patch was not administered due to awaiting delivery from the pharmacy. -The 10/21/21 progress note indicated the patch was not administered due to patch not on Resident #40 did not receive the medication seven times throughout seven days. There was no evidence the physician was notified that the resident did not receive the medication. The care plan, last updated on 3/3/21, indicated Resident #40 was at risk for pacing, worrying, and hallucinations related to his diagnoses. Interventions included administration of medications as ordered and support and reassurance of safety at times of hallucinations. C. Interview The director of nurses was interviewed on 10/27/21 at 11:00 a.m. The DON reviewed the record and confirmed the resident did not receive his scheduled Rivastgmine patch. The DON said all licensed nurses were responsible for ordering the medications. She said she had conducted recent training which instructed the nurses to order the medications as early as 10 days prior to running out, then fax the request to the pharmacy. When the pharmacy delivered medications, the nurse was to review the received medications and compare them to the sheet faxed. She said if medication was not received, then they needed to call the pharmacy and track the whereabouts.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, record review, and interviews, the facility failed to ensure all medications and biologicals were properly stored in two of three medication carts. Specifically, the facility failed to: -Remove expired insulin timely from the back hall medication cart, which had the potential for Residents #43 and #46 to receive expired insulin; -Remove undated insulin from the back hall and second floor medication carts, which had the potential for Residents #43 and #49 to receive expired insulin; and -Ensure the medication cart on the first floor remained locked and secured when left unattended. Findings include: I. Facility policy and procedure The Storage of Medications policy and procedure, dated April 2007, was provided by the regional clinical nurse (RCR) on 10/25/21 and included the following guidance: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. II. Professional references A. According to NovoLog Highlights of Prescribing Information (dated 1/14/15) instructions for use, retrieved from https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020986s080lbl.pdf on 11/2/21, in pertinent part: After initial use a vial may be kept at temperatures below 86 degrees Fahrenheit for up to 28 days. B. According to Lantus Prescribing Information (dated 1/20/21) instructions for use, retrieved from https://products.sanofi.us/lantus/lantus.html on 11/2/21, multi-dose vials were good for 28 days from the date they were opened. C. According to NovoLog Getting Started on NovoLog FlexPen (dated 2/2015) instructions for use, retrieved from https://www.novomedlink.com/content/dam/novonordisk/novomedlink/resources/generaldocuments/NovoLog%20FlexPen%20IFU%20PDF_LOCKED.pdf on 11/2/21, in pertinent part: Once in use, NovoLog FlexPen must be kept at room temperature below 86 degrees Fahrenheit for up to 28 days. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. According to Victoza Important Safety Information (dated 2/2021), retrieved from https://www.victoza.com/faq/Using-the-Victoza-Pen.html?modal=isi&&utm_source=google&utm_medium=cpc&utm_term=%2Bvictoza%20%2Bpens&utm_campaign=1+BMM+Brand+Pen+Injection&utm_content=Pen+Injection_-mkwid-sYpANxdtH_dc-pcrid-413157645299-pkw-%2Bvictoza%20%2Bpens-pmt-b-&gclid=Cj0KCQjw5oiMBhDtARIsAJi0qk0qroygIbmb3aKihYpdoDTkNGTI_oCETMFS0CcrY80wpyIRWAtlwAsaAmgyEALw_wcB&gclsrc=aw.ds on 11/3/21: If the pen was stored outside of the refrigerator, it should be thrown away within 30 days. E. According to the Humalog Purpose and Safety Summary (dated 1/2020), retrieved from https://www.humalog.com/u100?gclsrc=aw.ds&gclid=Cj0KCQjw5oiMBhDtARIsAJi0qk2X0-VfHkHfd97yrPUBpddFCxr8VhUWSQbhzxGzEUEedDstCLr6ruYaAqRPEALw_wcB on 11/3/21: Store opened vials in the refrigerator or at room temperature below 86 F (30 C) for up to 28 days. Keep vials away from heat and out of direct light. Throw away all opened vials after 28 days of use, even if there is insulin left in the vial. III. Observations and staff interviews On 10/20/21 at 9:38 a.m., the back hall medication cart was inspected with licensed practical nurse (LPN) #1, and the following items were found: -A vial of Novolog insulin was dated as opened on 9/16/21 (34 days prior), and was expired. LPN #1 said she did not know how long the insulin was good for after it had been opened. -A vial of Lantus insulin was dated as opened on 6/15/21 (97 days prior), and was expired. LPN #1 said the insulin was no longer good and should not be used. -An opened, in use [NAME] Novolog pen had no date on the pen or the package to indicate when it was opened and first used. LPN #1 said the insulin pen should not be used when they did not know when it had been opened. The LPN explained the facility's previous infection preventionist used to inspect the carts for expired and undated items in the past and was not aware of who was inspecting them now. On 10/20/21 at 9:45 a.m., the second floor medication cart was inspected with LPN #4, and the following items were found: -An opened, in use Victoza insulin pen had no date on the pen or the package to indicate when it was opened and first used. -An opened, in use Humalog insulin vial had no date on the vial or box to indicate when it was opened and first used. -An opened, in use Humalog insulin vial was dated as opened on 9/16/21 (34 days prior), and expired. LPN #4 said she did not know how long the insulin was good for after it was opened, and said they did not have a list from the pharmacy that would provide them with that information. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/21/21 at 9:21 a.m., the medication cart on the first floor was being used by LPN #5 to distribute medications to residents. He left the cart unattended, the keys remained in the lock for the narcotic drawer, and the drawer was open. There were residents present in the rooms directly across from the open medication cart. The director of nursing (DON) was found and shown the open narcotic drawer. She confirmed there were narcotics in the open drawer that were accessible to anyone who passed by. LPN #5 returned to the cart while the DON was there and told the DON that he had never left the drawer open like that before. The DON said the medication cart should always be locked and the keys removed when it was left unattended. IV. DON and RCR interviews The DON and RCR were interviewed on 10/27/21 at 5:01 p.m. The DON said the facility nursing staff had been routinely cleaning the medication carts on a monthly basis to ensure items were not outdated. She said when they were made aware of the expired medications during the survey, they immediately removed all undated and expired medications from the carts. The DON said the pharmacist came to the facility on a quarterly basis to check the carts for expired medications and, moving forward, would review the medication storage policy and procedures with the nurses. 20287

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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. 43950 Based on observation, interview, and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, the facility failed to: -Ensure dishwasher temperatures were at sanitary level per Ecolab plaque recommendations which stated minimum wash/rinse temperature of 120 degrees Fahrenheit (F), however facility dishwasher was at 100-105 degrees F; -Maintain snack refrigerators used for resident snacks on two of two nurse units with proper temperatures to prevent foodborne illness, with a broken seal on the refrigerator, without temperature logs or cleaning logs; and, -Ensure ice coolers and scoops were cleaned and sanitized. These failures had the potential to cause foodborne illness among residents and staff who eat food prepared in the facility's kitchen. Findings include: I. Facility policies and procedures The Food Receiving and Storage policy and procedure, revised October 2017, was provided by the regional director of operations (RDO) on 10/27/21 at 10:44 a.m. It read in pertinent part, .Refrigerated foods must be stored below 41 degrees fahrenheit (F) unless otherwise specified by law .Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements .Food items and snacks on the nursing units must be maintained as indicated below: All food items to be kept below 41 degrees F must be placed in the refrigerator located at the nurses ' station and labeled with a 'use by' date. Refrigerators must have working thermometers and be monitored for temperature according to the state-specific guidelines. The Refrigerator Cleaning policy and procedure, revised 3/28/19, was provided by the regional director of operations (RDO) on 10/27/21 at 10:44 a.m. It read in pertinent part, All refrigerators will be cleaned, and documentation maintained to assure optimal conditions for refrigerated food supplies. Kitchen and kitchenette refrigerators are the responsibility of the dietary department .All refrigerators will be cleaned and documented on a cleaning record. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dishwasher Machine Use policy and procedure, revised March 2010, was provided by the regional director of operations (RDO) on 10/27/21 at 10:44 a.m. It read in pertinent part, .The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and record the results in a facility approved log. The operator will monitor the gauge frequently during the dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. The supervisor will check the calibration of the gauge weekly by: Running a secondary thermometer through the machine to compare temperatures; or Using commercial temperature strips following manufacturer ' s instructions. If hot water temperatures or chemical sanitation concentration do not meet requirements, cease use of the dishwashing machine immediately until temperatures or parts-per-million are adjusted. The Refrigerator and Freezers policy and procedure, revised December 2014, was provided by the regional director of operations (RDO) on 10/27/21 at 10:44 a.m. It read in pertinent part, This facility will ensure refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Acceptable temperature ranges are 35 degrees F to 40 degrees F for refrigerators and less than 0 degrees F for freezers. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures. Monthly tracking sheets will include time, temperature, initials, and action taken. The last column will be completed only if temperatures are not acceptable. Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and other damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled and followed. II. Dishwasher A. Observations and staff interviews On 10/18/21 at 10:06 a.m. the kitchen was observed. The dishwasher machine rinse temperature was 106 degrees F per the machine thermometer (the Ecolab plaque on the machine stated minimum wash/rinse temperature was 120 F). It was brought to the attention of the dishwasher and the corporate dietary consultant and she went to get maintenance. She said that maintenance was working in the area on the floor and had turned down the hot water but it would be brought up to 120 degrees F by maintenance. On 10/20/21 at 9:05 a.m. the dishwasher machine's final rinse temperature was 100-106 degrees F per the machine thermometer. The dietary service manager (DSM) said the dishwasher had been fixed, but would contact maintenance. Maintenance increased the temperature and it was at 120 degrees F by 9:51 a.m. The registered dietician consultant (RDC) said they would rewash all the dishes. The corporate maintenance consultant (CMC) said that a commercial cleaning equipment company was consulted yesterday concerning the possibility of a new dishwasher. On 10/20/21 at 11:15 a.m. the DSM said they decided to use paper plates for lunch because the dishwasher temperature kept fluctuating. She said maintenance went to buy a booster heater so increasing the water temperature would not affect the residents' water temperature. On 10/20/21 at 2:00 p.m. the RDC consultant said the CMC tried a water heater booster, however that did not work. The newest plan for the dishwasher was to turn up the water temperature but lower the temperature for the residents on the second floor. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The RDO was interviewed on 10/21/21 at 10:46 a.m. He said he checked for the facility dishwasher machine service records and he said he also requested Ecolab service records. He said the facility had no record of any maintenance visits. However, he said Ecolab claimed to come monthly for a service check and he was still waiting for that documentation. He said the facility would put in an order for a new dishwasher but it would not arrive for two months, so the plan meanwhile was to fix the water temperature and continue to use the current dishwasher. On 10/21/21 at 1:12 p.m. the dietary service aide (DSA #1) said that the dishwasher was still broken. Per observation, the dishwasher was not being used. She said they had used paper plates for lunch and had hand washed dishes. B. Record review The dish machine temperature and sanitizer log form for October 2021 was reviewed. It documented that the wash/final rinse temperature from 10/12-10/18/21 was 120 degrees F. The October record log started on 10/12/21. The 10/18/21 log for breakfast documented 120 degrees F, lunch documented 115 degrees F, and dinner 114 degrees F for final rinse temperatures. The 10/19/21 log for breakfast documented 110 degrees F, lunch documented 115 degrees F, and dinner 115 degrees F for final rinse temperatures. The 10/20/21 log for breakfast documented 120 degrees F for final rinse temperatures, and the lunch log documented that the dishwasher was being repaired. III. Refrigerators on nursing units A. Observations and staff interviews On 10/20/21 at 11:15 a.m. the DSM said the nursing unit refrigerators were stocked with resident snacks three times per day at 10:00 a.m., 2:00 p.m., and 7:00 p.m. On 10/20/21 at 2.30 p.m. the RDC observed the inspection of the nursing unit refrigerators. -The first floor nursing unit refrigerator did not have a thermometer in the freezer. The facility thermometer was moved to the freezer and read 18 degrees F, the surveyor thermometer read 21 degrees. The RDC said the freezer temperature should be 0 degrees F. The RDC said that the new DSM arrived on Monday 10/18/21 (first day of survey) and there was no temperature or cleaning log so she started one. -The second floor nursing unit refrigerator did not have any temperature or cleaning log. The refrigerator temperature was 50 degrees F and the freezer temperature was 10 degrees F per surveyor thermometer. The RDC acknowledged that both temperatures were out of compliance and said she would remove all food and resident snacks (sandwiches). The refrigerator also contained two opened Pepsis and undated/unlabeled Chinese food. The RDC discarded it and said she would discard the sandwiches. The seal on the refrigerator door was broken, brown in color and hanging on the ground. The maintenance director (MTD) said they would file a report in their system. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Certified nurse aide (CNA) #12, on the second floor, was interviewed on 10/20/21 at 3:58 p.m. She said she saw the second floor refrigerator had a broken seal but did not think much of it because a lot of things needed to be repaired in the facility. She said she went to the refrigerator for resident snacks only. She said the CNAs did not clean or check the temperatures. Licensed practical nurse (LPN) #1, on the first floor, was interviewed on 10/20/21 at 4:02 p.m. She said the kitchen staff cleaned the refrigerator and checked the temperatures for the refrigerators and did that when they brought the resident snacks to the refrigerator. The RDO was interviewed on 10/21/21 at 10:46 a.m. He said he was not sure what the plan was concerning the broken snack refrigerator on the second floor. He said he would check with maintenance concerning the broken seal. The MTD was interviewed on 10/21/21 at 3:50 p.m. He said he heard about the broken refrigerator seal on the second floor and would see if it could be repaired, otherwise the facility would order a new refrigerator The new DSM was interviewed on 10/21/21 at 3:53 p.m. She said when she first came on Monday 10/18/21 there was no log on the nursing unit refrigerator for temperature checks or cleaning. She said she started one on Monday for the refrigerator on the first floor. B. Record review The October 2021 first floor nursing unit refrigerator temperature log for the cooler and freezer was reviewed. It was blank from 10/1-10/17/21. The reference ranges at the bottom of the page documented the refrigerator temperature was 32-40 degrees F, and the freezer temperature was 0 degrees F. The 10/18/21 refrigerator temperature was documented as 31 degrees; the freezer temperature was not recorded. The 10/19/21 refrigerator temperature was documented as 33 degrees; the freezer temperature was not recorded. The 10/20/21 refrigerator temperature was documented as 32 degrees; the freezer temperature was recorded as two degrees F. The 10/21/21 refrigerator temperature was documented as 33 degrees; the freezer temperature was not recorded. IV. Ice Cooler A. Observations and staff interviews On 10/20/21 at 9:33 a.m., CNA #4 was observed to enter a room on the second floor. She removed an individual drinking jug from the room and used the scoop from the ice chest to fill the cup. As she filled the cup she touched the cup. The CNA then was observed to enter another room, and used the scoop to fill the thermal cup of another resident. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/21/21 at 11:48 a.m. the DSM was interviewed and she said the ice scoops were washed whenever they were brought to the kitchen. -LPN #1 said she was not sure how often the ice scoops were washed. On 10/25/21 at 10:57 a.m., a resident was in the hallway with his thermal cup, LPN #3 took the cup from the resident and filled it with the ice using the ice scoop and cooler of ice. The maintenance director (MTD) was interviewed on 10/27/21 at 2:00 p.m. The MTD said they did not have a cleaning schedule, they just cleaned the ice coolers when they were dirty. The registered dietician (RD) was interviewed on 10/27/21 at 2:30 p.m. The RD said that the ice coolers should be on a schedule and washed at least daily. V. Facility follow-up On 10/21/21 at 4:57 p.m. new refrigerators were observed on the first and second floor nursing units. -There was no log for monitoring temperature and cleaning on either refrigerator. Both of the refrigerators and freezers were not at proper temperature; however ice cream was in the freezer; and snacks of applesauce, soda, crackers, milk and other various snacks were in the refrigerators. The refrigerator temperatures were 48 degrees F per surveyor thermometer. CNA #10 was notified that the refrigerators were not up to proper temperatures and that there were no temperature logs on the refrigerators. -At 5:14 p.m. the dietary department was notified of the refrigerators, however cook #1 said the DSM was not in. -At 5:16 p.m. the interim nursing home administrator was notified about the two new refrigerators. She said the refrigerators should not be stocked with food when not at proper temperature. She acknowledged that there were no temperature logs on the refrigerators and acknowledged milk and other snacks were in the refrigerators. She said she would have the food removed.

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F 0867 Level of Harm - Actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 20287 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of life, quality of care. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program policy last revised March 2020 was received on 10/29/21 at 8:05 a.m., from the regional director of operations. The policy read in pertinent parts, The Administrator, whether a member of the QAPI Committee or not, is ultimately responsible for the QAPI Program, and for interpreting its results and findings to the governing body. The responsibilities of the QAPI Committee are to: Collect and analyze performance indicator data and other information; Identify, evaluate, monitor and improve facility systems and processes that support the delivery of care and services; Identify and help to resolve negative outcomes and/or care quality problems identified during the QAPI process; Utilize root cause analysis to help identify where identified problems point to underlying systemic problems; Help departments, consultants and ancillary services implement systems to correct potential and actual issues in quality of care; Establish benchmarks and goals by which to measure performance improvement; Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and Communicate all phases of the QAPI process to the Administrator and governing body through sharing meeting minutes, committee activities and results of QAPI activities. 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 F 692 Nutrition/hydration During an abbreviated survey on 11/17/2020, nutrition/hydration was cited at a G (harm) level. During the recertification survey on 10/27/21 nutrition/hydration was cited at a G level. 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 the recertification survey on 10/27/21 the facility was cited at an increase of scope and severity for abuse at a G (harm) level. (continued on next page)

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	065152	A. Building B. Wing	10/27/2021

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 0867 Level of Harm - Actual harm Residents Affected - Few	F880 infection control During an infection control focused survey the facility was cited at a E pattern level. During the recertification survey on 10/27/21 the facility was cited a L (immediate jeopardy) for not having an effective infection control program. III. Cross-referenced citations Cross-reference F600: The facility failed to protect residents after allegations of abuse. Cross-reference F610: The facility failed to thoroughly investigate allegations of resident verbal abuse. Cross-reference F692: The facility failed to ensure that residents timely interventions in order to prevent significant weight loss. Cross-reference F880: The facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of COVID-19. Cross-reference F886: The facility failed to have an effective program to test for COVID-19 residents, facility staff and individuals providing services to residents of the facility. IV. Interviews The regional director of operations (RDO) and clinical resource (CR) were interviewed on 10/27/21 at 6:33 p. m. The RDO said the QAPI committee met monthly with the interdisciplinary team attending. The RDO said the facility had had a lot of turnover in administration within the past year. He said he continued to have turnover in the department heads receiving two this past week. A new nursing home administrator was scheduled to start on 10/28/21. The previous NHA had resigned and vacated the position approximately three weeks prior. The RDO said the last QAPI he attended was in May or June 2021. He said the QAPI had an agenda which was followed. He said the QAPI was to be used to identify and solve problems within the facility. The RDO reviewed the minutes and said infection control was discussed every month, however, the facility had a change in the infection preventionist (IP) who vacated the position roughly two weeks prior to the survey. The facility had appointed the assistant director of nurses (ADON) as the IP, however, he had not received any training and he had not started the training for the certificate to be an IP. The CR was assisting with the infection preventionist. The RDO said the facility needed to ensure education and ensure the changes in local authority, and CDC were followed. The RDO said the NHA was responsible to follow up on any of the items which were identified to ensure performance improvement changes were put into place. The CR said significant weight loss and significant weight gains were discussed at each meeting. She said the providers were notified and the residents were placed on the nutrition at risk (NAR) meeting. The registered dietitian attended the NAR meeting. The RDO confirmed the facility was without a RD until late August. The RD was now ensuring all residents were being assessed. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The RDO said at every meeting abuse was discussed, the allegations and the risk management investigations were followed. The RDO said the staff need to identify what constitutes abuse and work together to fully investigate and prevent abuse.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases, and infections. Record review revealed the facility was in outbreak status as of 10/2/21, when a staff member tested positive for COVID-19. On 10/18/21, another staff member tested positive for COVID-19 and on 10/19/21, four residents tested positive for COVID-19. Observations, record review and staff interviews from 10/18/21-10/25/21 revealed multiple and repeated failures in the facility's infection control program, creating a situation for the likely transmission of highly infectious COVID-19 and placing all facility residents at risk of serious harm. Specifically: -The facility failed to follow outbreak testing guidance on 10/2/21 creating a situation for the likely transmission of highly infectious COVID-19 and routinely test unvaccinated staff prior to the start of their shift. Cross-reference F886L. -The facility failed to ensure staff properly wore personal protective equipment (PPE) throughout the facility, and when caring for residents in quarantine and cleaning their rooms. -The facility failed to ensure staff encouraged and assisted residents to wear masks, encouraged quarantined residents to remain in their rooms and residents to socially distance. -The facility failed to ensure staff followed proper hand hygiene procedures for themselves and for the residents. Findings include: I. The facility's COVID-19 status The facility had one confirmed positive case of COVID-19 in one staff member, certified nurse aide (CNA) #1 as of 10/2/21. CNA #1 was symptomatic. Another staff member tested positive on 10/18/21 with a point-of-care (POC) test, the results from the polymerase chain reaction test (PCR) test had not been received as of 10/25/21 As of 10/19/21, the facility had four COVID-19 positive residents. The facility placed eight residents on the first floor in quarantine as they were the roommates of the four residents who had tested positive. II. Immediate Jeopardy A. Findings of Immediate Jeopardy (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review revealed the facility was in outbreak status as of 10/2/21, when a staff member tested positive for COVID-19. On 10/18/21, another staff member tested positive for COVID-19 and on 10/19/21, four residents tested positive for COVID-19. Observations, record review and staff interviews from 10/18/21-10/25/21 revealed multiple and repeated failures in the facility's infection control program, including failed to follow outbreak testing guidance and routinely test unvaccinated staff, failure to properly and appropriately use PPE, failure to perform staff and resident hand hygiene, as well as wear masks, implement quarantine restrictions and ensure social distancing. The above failures created an immediate jeopardy situation that placed all facility residents at risk due to the likely transmission of highly infectious COVID-19. B. Facility notice of immediate jeopardy On 10/21/21 at 4:19 p.m., the nursing home administrator (NHA) was notified that the failures in the facility's infection control program created an immediate jeopardy situation that placed all residents in the facility at risk for serious harm (COVID-19). C. Facility plan to remove immediate jeopardy On 10/22/21 at 6:00 p.m. the NHA provided a plan to remove the immediate jeopardy. The plan read: 1. NHA or Designee will assign Department heads and mangers on duty will provide monitoring and ensure compliance with all staff through shift change to ensure immediate education and compliance with PPE and COVID. Outbreak mitigation guidance, Education was initiated 10/21/2021 and will (be) on going. 2. DON/ADON Post transmission-based precautions signs for current, positive and/or presumptive COVID-19 residents on 10/19/21. 3. The ICP ADON [name] [ICP from another facility) completed education and checkoffs with ADON and DON on 10/21/21. Director of Nursing (DON), Assistant Director of Nursing (ADON) or designee began in-servicing and competencies of staff 10/21/21 and will receive training at the beginning of each shift until all staff are educated. a. COVID-19 Outbreak b. Current residents who are identified as COVID-19 positive and/or presumptive c. Transmission-based Precautions: Droplet d. Hand Hygiene for staff and residents to include before and after meals, snack, beverages, personal cares, high touch surfaces, before and after smoking. e. When to utilize PPE and the correct PPE for Isolation and Quarantine rooms (i.e. N95, Gown, Face shield or goggles, gloves). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	f. How to don/doff PPE g. Cleaning/disinfecting of resident equipment (i.e. vital sign equipment-dispose of disinfectant wipe after one use). h. Offer/remind residents on hand hygiene, masking, and social distancing i. DON/ADON/Designee to Educate the staff difference between quarantine and isolation room by 10/25/21. j. Social Distancing and resident mask usage/encouragement k. Hand Hygiene Before and after meals, beverages/snacks, before and after smoking, personal care tasks and as indicated. l. All Residents should be encouraged to maintain appropriate social distancing. m. All staff to be immediately educated on encouraging and redirecting residents who are on isolation and quarantine to remain in rooms with the door closed. Education started 10/21/2021. n. DON/ADON to educate all staff on where to take meal breaks, store lunches and beverages. Education began 10/22/2021 and ongoing. 4. Training was provided to ADON/DON (name of IP) 10/22/21 on proper use of Line Listing submission and ongoing management. 5. DON, ADON or assigned IDT member will monitor every shift for adherence to hand hygiene for residents and staff, posting of signs for transmission-based precautions, use of PPE (donning/doffing; N95, face shield/goggles, gown, gloves), and cleaning/disinfecting of resident equipment until the facility is COVID-19free. 6. All residents who are currently on Isolation or Quarantine will be placed on 15 minute checks and redirected as needed. a. All staff will be educated that they are to frequently encourage Quarantine/Isolation guidelines. b. Staff will immediately be educated on ensuring they are encouraging and not forcing. c. Staff will be immediately educated on safety strategies if resident is unwilling to stay in room. i. Offering and placing Mask and Gown on resident not willing to stay in room. ii. Hand hygiene offered and assisting resident with HH. Offer to take resident outdoors for a few minutes to give them a break from their room. Offer open area where social distancing can be maintained (Basement/Day room if available). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. CDC and CMS Guidance on PPE when COVID-19 has been identified in the building According to the Centers for Medicare and Medicaid Services (CMS) directive COVID-19 Long-Term Care Facility Guidance April 2, 2020, retrieved on 10/23/21from https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf, If COVID-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of COVID-19 diagnosis or symptoms. According to the Centers for Disease Control (CDC) Key Strategies to Prepare for Coronavirus COVID-19 in Long Term Care Facilities, updated 9/10/21 read in pertinent part: If COVID-19 is identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: a N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown . According to the CDC guidance, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 9/10/21, retrieved on 10/23/21 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html: -PPE must be donned correctly before entering the patient area. - PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted. - Face masks should be extended under the chin. - Both your mouth and nose should be protected . 2. Observations revealed staff failed to properly wear PPE On 10/20/21 at 8:08 a.m., registered nurse (RN) #2 was observed to enter room [ROOM NUMBER]. The resident was in quarantine. The RN put a gown, gloves and eye protection on, however, she did not wear a N95 respirator mask, wearing instead a surgical mask. The RN was interviewed as she came out of the room. She said she was not educated that she needed to wear the N95 mask. On 10/20/21 at 9:53 a.m., housekeeper (HSK) #1 was observed to wear a surgical mask under a N95 respirator. HSK #1 was observed to enter an isolation room with the surgical mask under the N95 respirator, then left the isolation room and did not change his face mask. The HSK #1 was interviewed on 10/20/21 at 10:10 a.m. The HSK said that he was not aware that he could not wear the surgical mask under the respirator. He said he thought it provided more protection. On 10/20/21 at 2:35 p.m. licensed practical nurse (LPN) #2 was observed to wear her surgical mask under her chin. She was standing in the nurses' station eating a piece of pizza. There were two other staff members present at the nurses' station. Two residents were in the hallway, and within three feet of the unmasked LPN #2. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 10/20/21 at approximately 1:00 p.m., the receptionist (RPT) #1 was observed to conduct point of care (POC) testing with staff members. RPT #1 wore only a surgical mask; she was not wearing a N95 respirator. On 10/21/21 at approximately 4:00 p.m., an unidentified RPT was observed conducting the POC testing with staff members. The RPT wore only a surgical mask. 3. Interview confirmed improper use of PPE. The director of nurses (DON) was interviewed on 10/20/21 at 8:30 a.m. The DON said staff needed to wear the N95 mask, gown, and eye protection when they entered the isolation rooms. The unidentified RPT was interviewed on 10/21/21 at approximately 4:00 p.m. The RPT said she had just returned from vacation and she had not been instructed to wear a N95 mask. The DON, the assistant director of nurses (ADON), regional director of operations, and the regional clinical resource (CR) were interviewed on 10/20/21 at 2:39 p.m. The DON said she would ensure the receptionist used the proper mask of a N95. The clinical resource (CR) was interviewed on 10/27/21 at p.m. The CR said that throughout the pandemic, the facility had trained staff on how to properly wear PPE. She said surgical masks were not to be worn under the N95 respirator, especially when entering an isolation room. C. The facility failed to ensure staff encouraged and assisted residents to wear masks and wear them properly when outside their rooms, ensure staff implemented quarantine restrictions and ensure residents were socially distanced when in group. Professional references The CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes (updated 9/10/21), retrieved on 10/27/21 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, read in pertinent part, Remind residents to wear a cloth face covering (if tolerated) and perform hand hygiene. 1. Masks - Observations and staff interviews - absence of encouragement and use of masks by non-quarantined residents. 10/18/21: At 10:30 a.m. the second floor certified nurse aide (CNA) #4 and activities staff person were observed in the hallway. They did not encourage the following residents to wear a mask when out of their rooms. -Resident #40 and Resident #2, waiting in the hall, who were not wearing a mask. -Resident #13, propelling his wheelchair in the hall, who was not wearing a mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Resident #15, who came out of her room without a mask and spoke to CNA #4. The CNA did not encourage the resident to don a mask. -At 2:00 p.m., the NHA was observed getting in an elevator with an unidentified resident. The resident was not wearing a mask and no mask was offered or encouraged. -At 2:30 p.m. Resident #30 was observed in the second floor TV room, sitting close to another resident. Staff were in the room but did not encourage the residents to don a mask. 10/19/21: At 9:14 a.m., the following residents were not observed wearing masks on the first floor. Staff were present in the area. -Resident #23, observed in a wheelchair in the first floor hallway. He was not wearing a mask and he was not encouraged to wear one. -Resident #51, observed in the first floor hallway. She was not wearing a mask and she was not encouraged to wear one. -Resident #30, at 9:30 a.m., walking in the hallway on the second floor. He was not wearing a mask. Staff were present in the area; however, he was not encouraged to wear a mask. b. Interviews CNA #11 was interviewed on 10/19/21 at 10:13 a.m. Contrary to the observations above, she said staff do encourage the residents to wear masks outside their rooms, but they cannot force them to do so. She said the residents with dementia will fight the staff if they try to get them to wear a mask. She said she did not know of any interventions to use when a resident refused to wear a mask The activity assistant (AA) was interviewed on 10/19/21 at 12:52 p.m. She said that she conducted an exercise activity on 10/18/21 at 10:45 a.m. She said the residents did not wear masks and she did not encourage them to do so. She said that six residents attended the exercise activity after 2. Masks - Observations and staff interviews - absence of encouragement and use of masks by quarantined residents as well as absence of redirection to return to their rooms. a. See above; on 10/19/21 the facility had four residents test positive for COVID-19. The facility placed eight residents on isolation. Observations revealed the residents who were quarantined were out of their rooms without masks and were not redirected by staff to return to their rooms or to don a mask. 10/19/21: -At 9:14 a.m. Resident #22 was observed in the hallway outside of his room. The ADON saw him and asked the resident if he wanted help putting on a mask. The resident pulled a mask out of his pocket but did not put it on, and the ADON moved on to other tasks. Although quarantined, Resident #22 was not redirected to his room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-At 10:10 a.m. Resident #17, who was in quarantine, was observed getting on the first floor elevator. She was not wearing a mask. Staff were in the area, however, she was not encouraged to wear one. 10/20/21: -At 9:05 a.m. Resident #17 was observed roaming around the halls on the first floor in her wheelchair. Her mask was down below her nose. She was not redirected to return to her room or to pull up her mask over her nose. -At 10:04 a.m. Resident # 17 went into room [ROOM NUMBER]. This was a quarantine room. -At 12:59 p.m. Resident #17 was in the first floor lobby with her mask below her nose. Staff did not redirect her to go back to her room or to pull up her mask. 10/21/21: -At 10:59 a.m. Resident # 17 got off the elevator and entered the basement area to the main dining room. Her mask was below her nose. Three different staff members walked past the resident and did not encourage her to go back to her room or to pull up her mask. Although under quarantine, she was not encouraged or directed back to her room. -At 11:37 a.m. Resident # 17 sat at one of the tables in the dining room drinking a soda. Her mask was below her nose when she was not drinking. She was not encouraged by staff who were present to return to her room. -At 1:12 p.m. Resident #17 again was in the first floor lobby in her wheelchair. Her mask was below her nose. She was not redirected to return to her room or to pull up her mask, although staff were in the area. b. The infection preventionist (IP) was interviewed on 10/20/21 at 10:08 a.m. He said Resident #17 was supposed to be in her room since she was in quarantine. He said it was very difficult to keep her in her room because of her dementia. Contrary to multiple observations above, he said the staff were supposed to encourage her to stay in her room and to wear a mask when she came out of her room. 2. Observations and interviews - absence of social distancing On 10/18/21 at 3:00 p.m., a group activity was conducted in the basement by the piano. There were seven residents attending and none of the residents were wearing masks, even though the facility was in outbreak status for COVID-19. On 10/20/21 at approximately 3:00 p.m., four residents were outside smoking. The residents were not social distancing, and all of the residents, two of whom were not smoking, had their masks off. D. The facility failed to ensure staff followed proper hand hygiene procedures for themselves and for the residents. 1. CDC references and facility policy (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Centers for Disease Control (CDC) Hand Hygiene updated 5/17/2020, retrieved on 10/19/21 from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html, read in part: -Hand hygiene is an important part of the U.S. response to the international emergence of COVID-19. Practicing hand hygiene, which includes the use of alcohol-based hand rub (ABHR) or handwashing, is a simple yet effective way to prevent the spread of pathogens and infections in healthcare settings. CDC recommendations reflect this important role. -The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate SARS-CoV-2. -ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The facility Handwashing/Hand Hygiene policy and procedure (undated), was provided by the Regional Director of Operations on 10/26/21 at 9:00 a.m. It read in pertinent part, The facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) water for the following situations: . Before and after eating or handling food; Before and after assisting a resident with meals. 2. Handwashing - Observations and staff interviews - Staff and resident failures a. Staff not offering hand hygiene prior to serving residents their meals Lunch menu on 10/18/21 was thyme chicken, potatoes, broccoli, and bread rolls to be buttered and eaten with hands. i. First floor lunch observation -At 12:07 p.m. certified nurse aide (CNA #5) took a food tray to room [ROOM NUMBER]. She did not offer hand hygiene to the residents in this room. -At 12:09 p.m. CNA #11 delivered five food trays to the residents who were in the activity room. She did not offer hand hygiene to any of the residents. -At 12:12 p.m. CNA #5 delivered food trays to the residents in rooms #102 and #103. She did not offer hand hygiene to the residents. -At 12:24 p.m. CNA #5 delivered food trays to residents in rooms #104 to #107. She did not offer hand hygiene to the residents. -At 12:13 p.m. a lunch tray was delivered to Resident #23 in his room. There was no offer of hand hygiene. Resident #23 had fingerless gloves on which he uses to wheel his own wheelchair, touching the wheels. His gloves are brown and his hands are brown with dirt when the gloves are removed. There were no hand sanitizing wipes on his lunch tray. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-At 12:23 p.m., a lunch tray was served to Resident #46. Hand hygiene was not offered. -At 12:25 p.m., a lunch tray was served to Resident #58. Hand hygiene was not offered. ii. Second floor lunch observation -At 12:18 p.m. CNA #4 took a tray from the cart. She took the tray to Resident #14; hand hygiene was not offered to the resident. The tray was set down in front of the resident and CNA #4 went back to the cart and without performing hand hygiene, the CNA touched the next tray. -At 12:20 p.m. CNA #4 took a lunch tray to Resident #13. He had propelled himself into his room from the hallway; no hand hygiene was offered to the resident or encouraged. -At 12:21 p.m. CNA #4 went to the cart, got another lunch tray from the cart. She did not apply hand sanitizer before entering the resident's room. She took a lunch tray to Resident #19, and did not offer the resident hand hygiene. Without performing hand hygiene, CNA #4 went back to the cart and took the next tray. -At 12:23 p.m. CNA #4 took a lunch tray to Resident #5 without offering the resident hand hygiene. -At 12:25 p.m. CNA #4 took a lunch tray to Resident #6, without offering hand hygiene to the resident. -At 12:26 p.m. CNA #4 took a lunch tray to Resident #32, without offering hand hygiene to the resident. -At 12:28 p.m. CNA #4 took a lunch tray to Resident #49 without offering hand hygiene to the resident. -At 12:29 p.m. CNA #4 took a lunch tray to Resident #28 without offering hand hygiene to the resident. b. Staff not performing or offering hand hygiene or passing ice in a manner consistent with infection control. i. Hand hygiene -At 9:33 a.m. on 10/20/21, CNA #4 was observed to enter a room on the second floor. She filled a water cup up and then left the room. She did not sanitize her hands prior to entering another room. She then filled another water cup up without performing hand hygiene. -At 12:45 p.m., CNA #2 delivered a lunch tray to Resident #35 in her room. CNA #2 dropped off the tray and left without offering hand hygiene to the resident. -At 12:20 p.m., CNA #11 was observed to serve a tray to Resident #40. The CNA did not offer hand washing to the resident. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-At 12:27 p.m., CNA #11 passed the lunch tray to Resident #15. The CNA did not offer hand hygiene to the resident. The trays on the second floor continued to be passed out, and none of the residents were offered hand hygiene prior to eating the meal. The clinical resource (CR) was interviewed on 10/27/21 at 11:27 a.m. The CR said staff should offer hand hygiene in the form of hand sanitizer, hand wipes or the sink to wash hands to residents prior to serving their meal. ii. Ice On 10/20/21 at 9:33 a.m., CNA #4 was observed to enter a room on the second floor. She removed an individual drinking jug from the room and used the scoop from the ice chest to fill the cup. As she filled the cup she touched the cup. The CNA then was observed to enter another room, and used the scoop to fill the thermal cup of another resident. On 10/25/21 at 10:57 a.m., a resident was in the hallway with his thermal cup, LPN #3 took the cup from the resident and filled it with the ice using the ice scoop and cooler of ice. On 10/27/21 at 3:00 p.m., the CR was interviewed The CR said the residents were to receive ice water by filling up clean cups and then bringing the cup to the residents' rooms. 43950 44997 42193

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. 20287 Based on interviews and record review, the facility failed to test residents, facility staff, individuals providing services under arrangement and volunteers for COVID-19 which had the potential to affect all 59 residents residing in the facility at the time of the survey. Record review and interview revealed the facility failed to follow outbreak testing guidance when a staff member was symptomatic and had a positive POC (point-of-care) test on 10/2/21, creating a situation for the likely transmission of highly infectious COVID-19. Specifically, contrary to CMS and the local public health authority, the facility failed to test all staff following notification of an outbreak on 10/2/21, failed to properly handle test materials and perform timely follow up testing of residents as well as staff, and failed to prevent staff who refused testing from working in the facility. The facility failures beginning 10/2/21, created an immediate jeopardy situation, a situation that was preceded by the facility's failure to consistently test unvaccinated staff for the purpose of early detection of asymptomatic, pre-symptomatic and symptomatic staff. Findings include: I. Facility status COVID-19 positive staff and residents The facility had one confirmed positive case of COVID-19 in one staff member, certified nurse aide (CNA) #1 as of 10/2/21. CNA #1 was symptomatic. Another staff member tested positive on 10/18/21 with a point-of-care (POC) test, the results from the (PCR) test had not been received as of 10/25/21. As of 10/19/21, the facility had four COVID-19 positive residents. The facility placed eight residents on the first floor in quarantine as they were the roommates of the four residents who had tested positive. II. Immediate Jeopardy A. Findings of immediate jeopardy Record review and interview revealed the facility failed to follow outbreak testing requirements when a staff member was symptomatic and had a positive POC test for COVID-19 on 10/2/21. The facility did not test all staff from 10/3 through 10/7/21, did not properly handle test materials, did not timely conduct follow up testing, and did not prevent staff who refused to test from working their shift. The facility's failure to follow outbreak testing requirements created an immediate jeopardy situation due to the likelihood the facility's failures would lead to transmission of COVID-19. B. Facility notice of immediate jeopardy On 10/21/21 at 4:19 p.m., the nursing home administrator (NHA) was notified that the failures in the facility's infection control program and testing created an immediate jeopardy situation that placed all residents in the facility at risk for serious harm (COVID-19). (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	C. Plan to remove immediate jeopardy On 10/22/21 at 6:00 p.m., the regional director of operations (RDO) presented the following final plan to address the immediate jeopardy situation: 1. DON (Director of Nurses)/ADON (Assistant Director of Nurses)/DOR (Director of Operations) will Complete PCR testing of all residents. If any residents refuse testing, they will be quarantined for 14 days starting 10/22/2021. 2. ADON/DON/DOR will Complete PCR testing of all staff. Receptionist and or charge nurse will complete POC testing. If any staff refuse, they will be excluded from work for 14 days. a. DON/ADON/Charge Nurse/NHA (Nursing Home Administrator) have the authority to remove staff member from the facility if testing requirements are not met. b. Testing requirements and frequency will be based on CMS/CDC and local public health authority guidance starting 10/21/2021. c. Testing frequency and latest COVID-19 guidance for outbreak testing and Public Health recommendations will be monitored by DON/ADON weekly starting 10/22/21. 3. ADON/Designee will Identify any current, positive and/or presumptive COVID-19 residents in the facility via POC and PCR testing completed 10/21/2021. a. DON/ADON to ensure any staff member or resident identified as exposed or presumptive positive are immediately tested via POC and PCR testing. 4. Director of Nursing and Assistant Director of nursing have been educated by (name of IP) ICP on effective testing tracking, testing both POC and PCR, line listing expectations, competencies with checkoffs, policy procedures and protocols for COVID-19 completed 10/21/2021. 5. The Director of Nursing(DON), Assistant Director of Nursing(ADON) or designee will in-service 100% of staff on the below items. Education began 10/20/2021 and will be completed by 10/25/2021. a. COVID-19 surveillance and outbreak testing requirements. b. Staff Expectations of testing and outcome if testing is not performed. 6. DON, ADON or designee will ensure that residents testing requirements are completed and followed up daily for staff and residents starting 10/22/21. a. Identified testing tracking system established. i. All resident not in 90-day window of COVID-19 have POC testing added to EMAR effective 10/21/21 and will continue throughout break status. ii. ADON/DON to complete daily audit of results of resident and staff POC testing starting 10/22/21. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Test results obtained 10/18/21 revealed a staff member, unvaccinated (UV) #6, was positive for COVID-19. S/he had worked with CNA #1 in the 48 hours before the CNA was tested . Additional results on 10/19/21 revealed four residents were positive for COVID-19. The four residents were all living on the first floor and had been cared for by CNA #1 in the previous 48 hours that the CNA had worked. B. Failure to follow routine testing requirements prior to the identification of CNA #1's COVID-19 positive test, to ensure early detection of asymptomatic, pre-symptomatic and symptomatic COVID-19. Review of the facility's COVID-19 Testing Strategies and Cohorting policy, was received from the NHA on 10/21/21. The policy read in pertinent part, Routine SARS-CoV-2 diagnostic screening testing of SNF, HCP (health care provider), and response testing of SNF residents and HCP is essential to protect the vulnerable SNF population. Routine diagnostic screening testing at a minimum weekly cadence should continue for SNF HCP who are unvaccinated or partially vaccinated. SNF's should implement strategies to increase and maintain vaccination coverage among HCP as high as possible, including verifying vaccination status of new hirers, and offering education, listening sessions, counseling and vaccination at every opportunity, even to those HCP who have previously refused. Testing should continue to be performed for HCP with signs or symptoms consistent with COVID-19, regardless of their vaccination status. The policy did not include the procedure if the staff refused to be tested for COVID-19 with either the POC or the PCR test. Further, the policy was not consistent with CMS guidance, state guidance for residential care facilities and information the facility received from the local health department on 11/5/21. Specifically: According to Centers for Medicare and Medicaid Services (CMS) Ref: QSO-20-38-NH revised 9/10/21 read in pertinent part, Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested . Facilities should use their community transmission level as the trigger for staff testing frequency. State guidance, Comprehensive Mitigation for Residential Care Facilities, p. 26, found at https://cdphe.colorado.gov/health-facility-covid-19-response/residential-care-strike-team/guidance-by-facility-type reads that the facility should test all health care providers (HCP) using a rapid molecular or antigen test at the beginning of every shift and complete once weekly lab-based PCR testing based on a community level of transmission (of less than 10 percent). Consistent with CMS and state guidance above, the local public health authority told the facility on 11/5/21, to test unvaccinated staff prior to the beginning of each shift. Yet, record review and interview revealed the facility failed to do so and also allowed unvaccinated staff who refusing testing to work their shift. 1. On 10/19/21 the facility provided a list with six unvaccinated staff working in the facility. 2. The POC daily rapid test record was reviewed from 9/18/21 to 10/19/21. The record was compared to the staff schedule and it revealed the following unvaccinated staff did not have a POC test prior to their shift. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Unvaccinated staff (UV) #1 had a POC test prior to shift five times out of 13 opportunities from 10/1/21 to 10/19/21. -UV #2 had no POC tests prior to the shift out of nine opportunities from 10/1/21 to 10/19/21. -UV #3 had a POC test prior to shift seven times out of 12 opportunities from 10/1/21 to 10/19/21. -UV #4 had a POC test prior to shift nine times out of 13 opportunities from 10/1/21 to 10/19/21. -UV #5 had a POC test prior to shift 11 times out of 14 opportunities from 10/1/21 to 10/19/21. On 10/22/21 at 5:55 p.m., after the immediate jeopardy was called, the POC daily rapid test record was reviewed and it revealed the facility was testing all staff prior to their shift. Forty-three (43) tests were administered and were negative for COVD-19. However, seven of the test results did not have a result of either positive or negative. The RDO also reviewed the sheets and confirmed seven test results were missing. The RDO said the receptionist had been trained on how to perform and document the POC test on 10/21/21. He said he would provide further training. 3. Interviews confirmed the facility neither tested unvaccinated staff as required nor barred those who refused testing from working their shift. Receptionist (RPT) #1 was interviewed on 10/19/21 at 4:21 p.m. The RPT said she worked the front desk five days a week. She said she did not have a list of staff members who were vaccinated or unvaccinated. She said she would ask the staff members and then, if the staff member said they were not vaccinated, the staff member would perform a POC rapid test. She said the staff members test on their own and fill out form in book which she then signs. The DON, the ADON, and the regional clinical resource (CR), and RDO were interviewed on 10/20/21 at 2:39 p.m. The DON and ADON said some unvaccinated staff refused to come in to get tested . They said when that occurred, the staff member was not taken off of the schedule, but would allow the staff member to work without being tested . The RDO said they were not strict enough on following the policy for staff who refused testing and allowing them to work. He said he was not aware the unvaccinated staff were refusing to be tested .

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	10/27/2021

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	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 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: -Replace broken blinds in five out of seven resident rooms identified; -Replace broken radiator on the 100 hall creating a tripping hazard; -Replace missing handrail caps on three handrails on the 100 hall creating a hazard; and, -Ensure residents have bath towels and hand towels readily available. Findings include: I. Facility policy and procedure The Safety and Supervision of Residents policy, revised in July 2017, was provided by the regional director of operations (RDO) on 10/27/29. The policy read in pertinent part: The facility strives to make the environment as free from accident hazards as possible. -The facility takes an individualized, resident centered approach to safety. -The facility takes a facility oriented approach to safety. -The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. II. Observations Two environmental tours of the facility were conducted on 10/20/21 at 3:15 p.m. and on 10/27/21 at 9:45 a.m. Observations revealed: -room [ROOM NUMBER] had broken blinds; -room [ROOM NUMBER] had broken blinds and had to ask the staff for towels; -room [ROOM NUMBER] had broken blinds; -room [ROOM NUMBER] did not have towels in her room and had to ask the staff; (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	10/27/2021

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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	-room [ROOM NUMBER] had broken blinds; -room [ROOM NUMBER] did not have towels in her room and had to ask the staff; and, -room [ROOM NUMBER] had broken blinds and had to ask the staff for towels. Observations on the 100 hall revealed: -A broken radiator on the 100 hall creating a tripping hazard; and, -Missing handrail caps on three handrails on the 100 hall. III. Staff and resident interviews Resident #5 was interviewed on 10/27/21 at 11:00 a.m. She said she had to ask for wash clothes and bath towels when she needed them. She said there had been a couple of occasions where she could not take a shower because there were not enough towels. She said she would like to have a washcloth and hand towel in her room and did not want to ask the staff for them. An environmental tour of the facility was conducted on 10/27/21 at 2:44 p.m. with the maintenance director (MTD) and the above mentioned concerns were observed and discussed with the MTD. The MTD said there were a number of resident rooms with blinds that were broken. He said it was an ongoing problem. Residents break them regularly and it was difficult for him to keep up with the problem. He said he had conducted an audit but had not gotten around to reordering blinds. He observed seven out of eight rooms that had broken blinds on the tour. He observed the missing end caps on the handrails. He said there were three caps on the 100 hall that were missing with exposed sharp edges. He said the radiator on the 100 hall was broken and had not been replaced. The frame of the radiator was sharp and a trip hazard. He said he would either replace the radiator or remove it entirely. He said there are no towels provided to the residents daily but there were paper towel dispensers in each room. He said the residents need to ask for a washcloth, hand towel or bath towel. The regional clinical resource (RCS) was interviewed on 10/27/21 at 5:43 p.m. She said the MTD would order more bath towels for the facility. She said there should be enough hand and bath towels for all of the residents to use and the residents should not need to ask for a towel to use in the resident ' s room.