STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. Building B. Wing	03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Health and Rehabilitation Center	1420 S 3rd Ave Sterling, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to ensure each resident had the right to formulate an advance directive for one (#19) of five residents reviewed out of 29 sample residents. Specifically, the facility failed to ensure Resident #19's advance directive was accurate, up-to-date and matched the physician's orders. Findings include: I. Facility policy and procedure The Advance Directive policy and procedure, last revised February 2017, provided by the corporate consultant (CC) on [DATE] at 3:00 p.m., revealed in pertinent part, If a resident has executed an advanced directive the facility must obtain a copy from the resident or the legal representative which is stored in the resident's medical record file. Nursing notifies the physician of the resident's or the legal representative's wishes, obtains orders as appropriate and enters the information in the electronic health record. The facility must document in a prominent part of the resident's clinical record whether the resident has issued an advanced directive. Decisions or instructions made by a resident's legal representative are only valid if they are consistent with the restrictions or specific instructions that the resident included in his or her advance directive. Similarly, a do not resuscitate (DNR) order that conflicts with a resident's wishes, as stated in an advance directive, may not be valid. II. Resident #19's status Resident #19, age 82, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included dementia with behavioral disturbance. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident required the extensive assistance of one to two people for his activities of daily living (ADLs). (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Record review The medical orders for scope of treatment (MOST) form revealed the resident wanted cardiopulmonary resuscitation (CPR) attempted if he did not have a pulse and was not breathing. It indicated this form was signed by the resident on [DATE] and was last reviewed by the MDS coordinator on [DATE]. A [DATE] physician telephone order revealed an order for social services to ensure the resident's MOST form was consistent with the resident's living will. It indicated if it was inconsistent, a new MOST form needed to be completed to align with the living will and to have the power of attorney (POA) sign due to the resident's lack of capacity. The care plan, last revised [DATE], revealed the resident was a Full Code and his goal was to have his wishes and advance directives honored as desired through the next review. Interventions included: -Specific wishes include: CPR, full treatment, no artificial nutrition; -Review advance directive and end of life requests with resident, family and the interdisciplinary team (IDT) periodically to ensure they are current and provide education as needed; and -Notify the physician for potential changes or needs for treatment changes. The [DATE] CPO revealed the resident had orders to Do Not Resuscitate (DNR), ordered [DATE]. -This did not match with the resident's MOST form. IV. Staff interviews The certified medication aide (CMA) was interviewed on [DATE] at 12:15 p.m. She said she would look in the electronic health record, to see if a resident was a DNR or not. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:30 p.m. She said if she needed to know if a resident was a DNR or not, she would go to the hard chart and look at the MOST form. The corporate consultant (CC) and the director of nursing (DON) were interviewed on [DATE] at 6:24 p.m. They said upon admission, the nurse should go over the MOST form with the resident or resident's representative and determine if the resident is a full code or a DNR, then they should contact the physician and get orders to match. They said the MOST form should be reviewed quarterly. They said they needed to have clarification to determine what code status Resident #19 was.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on observations, record review and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public in two out of two units. Specifically, the facility failed to: -Ensure multiple resident rooms throughout the facility were free from drywall damage and missing paint; -Ensure the carpeting throughout the facility was free from stains; -Ensure one hallway wall was completed and without potential hazards (sharp plastic molding to the corner); and -Ensure the one of two nurses station was attached to the wall. Findings include: I. Facility policies and procedures The Preventive Maintenance Program policy and procedure, last revised December 2010, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: A basic preventive maintenance program results in cleaner, safer and more efficient operations with fewer deficiencies and emergency repairs. Schedule: A successful preventative maintenance system is dependent on a routine schedule. Some preventative maintenance tasks are performed weekly while others are conducted monthly, quarterly, semi-annually, or annually. Touch-up painting: -Touch-up painting is a part of the preventive maintenance program, and is essential for extending the useful life of the physical plant. Each facility is required to develop a touch-up painting schedule that, over time, will address the painting needs of the entire building. The Physical Plant Interior Maintenance policy and procedure, last revised March 2008, was provided by the CC on 3/29/21 at 3:00 p.m. and read in pertinent part: All interior areas of the building are inspected within a one-month period to ensure proper condition and function. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interior maintenance of the physical plant is an essential function of the preventive maintenance program to assure employee and resident safety. II. Observations Two environmental tours of the facility were conducted: on 3/23/21 at 4:45 p.m., and on 3/25/21 at 10:00 a. m. with the facility maintenance service director (MSD). The observations of resident rooms, bathrooms, hallways and nurses stations revealed: room [ROOM NUMBER] bedroom: The wall behind the head of the residents bed had the paint removed to the drywall with large scratches in the drywall. room [ROOM NUMBER] bedroom: The wall behind the head of the residents bed had a large area where the paint had been removed. room [ROOM NUMBER]: bedroom: One of the bedroom walls had a large area of missing paint where the bed had been. The area had a recline in front of the damage. room [ROOM NUMBER] bathroom: The heater had large areas of scraped off paint on the heater. Common hallways with carpeting all with brown and black stains in varying sizes. The threshold between carpet and tile areas was cracked and missing in small chunks. The nurses station on the back hallway had come off the wall and was supported by a cabinet at one end. The area not easily accessible to the residents and no residents were seen during survey 3/23-3/29/21 in that area. The nurses station was tipped at an angle which was unusable. There was no signage indicating to staff or residents not to use or enter the area near the broken nurses station. The wall across from the damaged nurses station was sheetrock that had not been finished and had only been painted over. There was a large vertical crack in the middle of the wall. The corner of the wall was protected by clear plastic molding which was pulling away from the wall and had sharp exposed top and waist height (no residents were seen in that area during survey 3/23-3/29/21). III. Staff interviews The MSD was interviewed on 3/25/21 at 10:00 a.m. during the second environmental tour. He said he was aware of the wall and paint damage behind multiple resident rooms as well as the missing paint on the bathroom heater vents. He said he had tried different things like bumpers on the bed and nothing seemed to help. The MSD said he needed to do a walk through and determine all of the rooms with paint and wall damage, and paint the damaged areas more often. The MSD said the carpeting in the facility was old and did not have any backing which made it difficult to clean. The MSD said the carpeting had just been cleaned Monday (3/22/21), and it did not matter how much they cleaned it the stains were not able to be removed. He said the nurses station had broken about a year ago, and he had the supplies to fix it, but he had just not found a good opportunity to block off the nurses station. The MSD said it was on his list of projects to complete. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MSD said there had been a leak in the shower room a while ago, and the wall across from the nurses station had been damaged, he said it had not been completed properly and was something he needed to look into fixing. The nursing home administrator (NHA) was interviewed on 3/25/21 at approximately 4:00 p.m. She said maintenance projects should be completed as needed throughout the facility. The NHA did not provide a timeframe for completion of any of the above mentioned environmental concerns. Licensed practical nurse (LPN) #2 was interviewed 3/29/21 at 10:30a.m. She said the clear plastic molding that was pulling away from the wall, the facility had placed a towel over it to ensure would not be an accident hazard for any resident. She said that the nurse station desk was not used by anyone and residents never entered that area. IV. Facility follow-up LPN #2 was interviewed on 4/8/21 at 5:00 p.m. She said the nurses station desk was removed from the area and the area was empty.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observation, record review and interviews, the facility failed to ensure two (#19 and #7) of the 29 sample residents were free from restraints and had the least restrictive alternative for the least amount of time and documented ongoing re-evaluation of the need for the restraint. Specifically, the facility failed to: -Have a consent with the risks and benefits for wander guard use for Resident #19; -Ensure Resident #7, who had severe cognitive impairment, did not sign their own consent for a wander guard; -Ensure Residents #19 and #7 were being monitored for elopement behavior to warrant the continued use of wander guards; and, -Re-evaluate the need for the wander guard for Resident #19. Findings include: I. Facility policy and procedure The Elopement Management policy and procedure, last revised July 2017, provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m., revealed in pertinent part, If the resident is identified to be at risk for elopement, interventions are developed and implemented in accordance with the care plan. Care plan interventions may include the placement of a signaling device. If a signaling device is determined to be an appropriate safety device, the facility is to: -Notify the resident and/or the resident representative of the need for its use; -Document the intervention in the resident's record; -The signaling device will be replaced if it is missing or fails to function; and -The licensed nurse will notify the attending physic of the implementation of the signaling device. Signaling devices should be placed on the resident, not on a wheelchair, geri-chair, walker, merry-walker, etc. Only one device should be placed to avoid malfunction of the device. II. Resident #19 A. Resident status Resident #19, age 82, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included dementia with behavioral disturbances. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/30/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident required the extensive assistance of one to two people for his activities of daily living (ADLs). The resident wandered four to six days during the assessment period. Wander/elopement alarm was not coded as being used. B. Observation On 3/24/21 at 2:28 p.m. the resident was sitting in his wheelchair in the hallway next to the medication cart. The wander guard alarm was on the back of the resident's wheelchair and the date on the wander guard was to be used by 1/6/21. C. Record review The March 2021 CPO revealed the following orders: -Ensure wander guard is in place every shift, last revised 8/18/2020; -Change wander guard every 90 days, last revised 8/18/2020; -Check alarm device via electronic machine every day, last revised 8/18/2020. The care plan, last revised 6/22/2020, revealed the resident was an elopement risk/wanderer related to adjustment to nursing home, disoriented to place, impaired safety awareness and has a history of attempts to leave the facility unattended. Interventions included: -Frequent checks as indicated for elopement behavior; -Check placement and function of safety monitoring device every shift; -Observe location at regular and frequent intervals. Document wander behavior and attempted diversional interventions; -Offer emotional and psychological support; -Offer snacks as diversion; -[NAME] resident to environment; -Reorient/validate and redirect resident as needed; and, -Wander guard in place. No consent with the risks and benefits for the use of a wander guard was found in the resident's record. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 4/9/2020 nursing note the interdisciplinary team (IDT) met for the resident's quarterly review. It indicated the resident was at risk for elopement, had wander guard interventions in place and the resident had no elopement attempts since the last review. A 5/28/2020 nursing note the IDT met for resident's annual review. It indicated the resident was at high risk for elopement, had wander guard intervention in place and the resident had no elopement attempts since the last review. -Review of the record on 3/26/21 revealed the IDT did not meet again for any reviews since 5/28/2020. The 7/7/2020 elopement risk assessment revealed the resident was at risk with a score of 12 due to the resident verbalizing a desire or plan to leave the facility unauthorized/unsupervised and was mobile with a device (wheelchair). According to the assessment, if a resident has verbalized to leave the facility and could self-propel, the resident was automatically considered at risk and no further assessment was required. -Review of the record revealed no documentation of the resident verbalizing a desire to leave the facility or any attempts of the resident trying to leave the facility. The 10/7/2020 elopement risk assessment revealed no risk was identified with a score of 11. According to the assessment, a score of 0-11 is low risk and 12 or higher is at risk. The 12/18/2020 elopement risk assessment revealed no risk was identified with a score of 7. According to the December 2020 treatment administration record (TAR), the wander guard was replaced on 12/28/2020. The 1/7/21 elopement risk assessment revealed no risk was identified with a score of 7. The 1/29/21 elopement risk assessment revealed the resident was at risk with a score of 12 due to the resident verbalizing a desire to leave the facility unauthorized/unsupervised. -Review of the record revealed no documentation of the resident verbalizing a desire to leave the facility or any attempts of the resident trying to leave the facility. D. Staff interviews The nursing home administrator (NHA), the director of nursing (DON) and the corporate consultant (CC) were interviewed on 3/25/21 at 3:44 p.m. They said elopement risks were being done quarterly on Resident #19 and should reflect that the resident was a high risk for wandering because he frequently went to the doors to try and get out. They agreed that this behavior had not been documented in the resident's record but should have been to show the on-going need for the wander guard. Certified nurse aide (CNA) #1 was interviewed on 3/16/21. She said Resident #19 had a wander guard on his wheelchair because he was not able to ambulate and was only able to get around in his wheelchair. She said in the evenings, he used to go around to the doors and try and get out but had not done it in several months. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social work consultant (SWC) was interviewed on 3/28/21 at 3:04 p.m. She said usually the social worker at the facility should do the elopement assessment and ensure it was care planned. She said the use of a wander guard should be reassessed at least quarterly to determine if the use of the wander guard was still necessary. The MDS coordinator was interviewed on 3/29/21 at 1:11 p.m. She said Resident #19 frequently went to the facility doors to get out of them and would say he wanted to leave. She said these behaviors should have been documented by the nursing staff and other staff in the progress notes. She said she coded wandering on the MDS based on her personal observations of the resident trying to go out the doors. She said the MDS should have been coded with the wander guard also and a new MDS would be done. The DON and the CC were interviewed on 3/29/21 at 6:24 p.m. The DON said the wander guard should be checked for placement every shift and function daily. She said the facility should re-evaluate the need for a wander guard at least quarterly. She said to do this, the IDT team would review the progress notes and see if there were any behaviors documented that warranted the continued use of the wander guard. She said Resident #19 was observed to frequently go to the doors in the evening to get out and the staff should have been documenting this. 39261 III. Resident #7 A. Resident status Resident #7, under the age of 60, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included fibromyalgia, anxiety disorder, altered mental status, major depressive disorder, obsessive-compulsive disorder and insomnia. The 1/1/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief mental status (BIMS) score of nine out of 15. She did not have any rejections of care. The resident wandered one to three days during the review period. She required two person assistance with bed mobility, transfering, walking, toilet use, and personal hygiene. She required one person physical assistance with bed mobility, walking in her room and in the corridor, dressing, toilet use and personal hygiene, she was independent with eating. The resident did not have the wanderguard at the time of the MDS assessment. B. Record review At 12:22 a.m. on 3/10/21 a nursing progress note documented the following: Resident went outside via courtyard door and walked around building pulling on door by dining area. At 3:11 a.m. on 3/10/21 a nursing progress note documented the following: Resident has been exhibiting wandering behaviors. I put a wander guard on (the) resident's left ankle. Patient tolerated without complications. There is room between the skin and the braclet (sic). Skin checks will be done. The 3/10/21 Elopement Risk Assessment documented the following: (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was mobile with a device, she verbalized desire or a plan to leave the facility unauthorized/unsupervised. The resident scored a 12 on the elopement risk, meaning that she was identified as at risk for elopement. A 3/11/21 Physician order documented the following physician order: Device alarm: visually check alarm to the left ankle every shift. The wanderguard care plan, initiated 3/11/21, documented the resident had a wanderguard and wandered inside the building frequently with no particular destination in mind. The care plan identified the resident had wandered outside and walked around the building. The resident was also noted to wander through offices and open refrigerators. The goal was for the resident not attempting to leave the building or property through the next review. The pertinent interventions included the fact the resident was easily redirectable, and to redirect her in a calm manner when she is wandering. Other interventions included placing a wanderguard on the resident to alert staff that she has left the building. The 3/10/21 Physical Restraint Consent form documented the resident had the following restraint: wanderguard to target the specific behavior of wandering. The consent form documented the following less restrictive, alternative non-restraint approaches had proven to be ineffective: redirection. The Physical Restraint Consent acknowledgement was signed by the resident on 3/10/21. -The resident's spouse was listed as her emergency contact, and was active in decision making regarding her care in the facility. He was not notified of the use of the wander guard being used, risks and the least restrictive interventions tried for the resident's wandering. A 3/29/21 review of the resident's medical revealed no additional documentation of the resident exhibiting wandering or exit seeking behaviors. C. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 3/24/21 at 10:38 a.m. She said she was the nurse who had requested the order for the resident's wanderguard. She said she had come on for her day nursing shift and learned Resident #7 had been outside, and she thought it would be best for the resident's safety to get an order for the wanderguard. The LPN said she did not recall calling the husband to obtain consent, but if she had she said she would have documented the verbal consent in a nursing progress note. The LPN reviewed the residents record and stated she could not locate any documentation regarding the husband providing consent. The LPN said she was not documenting the resident's continued wandering/exit seeking behavior. She said she simply knew the resident and her behaviors. The LPN reviewed the resident record and said there were only two documented wandering progress notes for the resident. She said the only wandering/exit seeking documentation was on 12/28/2020 and 3/10/21. The LPN said that was not an accurate representation of how the resident was observed wandering in the facility. The LPN said she had not seen the resident exit seeking and that was a behavior she exhibited more on the night nursing shift (10:00 p.m. to 6:00 a.m.). (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social work consultant (SWC) was interviewed on 3/29/21 at approximately 4:00 p.m. She said if staff were not documenting a behavior as occurring, it made it difficult to assess interventions to determine if they were working. She said specifically in regards to wanderguards, if the facility was not documenting wandering or more importantly exit seeking behavior, when assessments were reviewed it made it difficult to justify the continued use of the wanderguard. The SWC consultant said it was best practice to document the behavior to determine if the staff were using the correct intervention. The SWC said she would want consent for a wanderguard, which could either be a verbal understanding or a signed consent. She said if a resident had been identified as needing a wanderguard, the resident should not be signing or giving their own consent.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations, record review and staff interviews, the facility failed to maintain accurate minimum data set (MDS) assessment for one (#19) resident out of 29 sample residents. Specifically, the facility failed to identify the use of a wander/elopement alarm for Resident #19. Findings include: I.Resident status Resident #19, age 82, was admitted on [DATE]. According to the March computerized physician orders (CPO), diagnoses included dementia with behavioral disturbances. The 1/30/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident required the extensive assistance of one to two people for his activities of daily living (ADLs). The resident wandered four to six days during the assessment period. Wander/elopement alarm was not coded as being used. II. Observation On 3/24/21 at 2:28 p.m. the resident was sitting in his wheelchair in the hallway next to the medication cart. The wander guard alarm was on the back of the resident ' s wheelchair and the date on the wander guard was to be used by 1/6/21. III. Record review The March 2021 CPO revealed the following orders: -Ensure wander guard is in place every shift, last revised 8/18/2020; -Change wander guard every 90 days, last revised 8/18/2020; -Check alarm device via electronic machine every day, last revised 8/18/2020. The care plan, last revised 6/22/2020, revealed the resident was an elopement risk/wanderer related to adjustment to nursing home, disoriented to place, impaired safety awareness and has a history of attempts to leave the facility unattended. Interventions included: -Frequent checks as indicated for elopement behavior; -Check placement and function of safety monitoring device every shift; (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe location at regular and frequent intervals. Document wander behavior and attempted diversional interventions; -Offer emotional and psychological support; -Offer snacks as diversion; -Orient resident to environment; -Reorient/validate and redirect resident as needed; and -Wander guard in place. Review of all the MDS assessments previously submitted to the state reveal the use of a wander/elopement alarm was not coded. IV. Staff interviews The MDS coordinator was interviewed on 3/29/21 at 1:11 p.m. She said had been doing the MDS assessments at the facility for three years. She said she completed all parts of the MDS assessment except for the therapies section and activities section. She said in order to complete the assessment she did her own observations and interviews, reviewed nursing documentation in progress notes and monthly summaries. She said she knew of two residents that currently had wander guard alarms on. She said the wander guard should be coded on the MDS assessment. She said the wander guard not being coded for Resident #19 was an oversight and she would submit a new assessment right away. The corporate consultant (CC) and director of nursing (DON) were interviewed on 3/29/21 at 6:24 p.m. They confirmed Resident #19 had a wander guard alarm on and agreed the wander guard should be identified on the MDS assessment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and interviews, the facility failed to ensure the comprehensive care plans for three (#39, #13 and #142) of three out of 29 sample residents were reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Specifically, the facility failed to ensure: -Timely care conferences were conducted with Resident #39; -Residents #39 had care plans specific to participation in the restorative nursing program; -Resident #13's transfer status was updated on their care plan; and, -Resident #142's care plan was updated with the resident's hydration preferences. Findings include: I. Facility policies and procedures The Comprehensive Care Plan policy and procedure, last revised November 2017, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: The facility will develop a comprehensive person-centered care plan that identifies each resident's medical, nursing, mental, and psychosocial needs within seven days after the completion of the comprehensive assessment . The plan includes measurable objectives and timetables agreed to by the resident to meet such objectives. -The care plan is reviewed on an ongoing basis and revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, the care plan is updated with each comprehensive and quarterly assessment in accordance with Resident Assessment Instrument (RAI) requirements. The Care Plan Conferences policy and procedure, last revised November 2017, was provided by the CC on 3/29/21 at 3:00 p.m. and read in pertinent part: The interdisciplinary team, in conjunction with the resident and/or the resident representative, will develop the plan of care based on the comprehensive assessment. The care plan conference is held to identify resident needs and establish obtainable goals. -Since the comprehensive care plan must be developed within seven days of the completion of the comprehensive assessment, care plan conferences are held: at intervals every 90 days thereafter; with any subsequent completed assessments, and when there is a change in resident status or condition. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The following individuals must be involved in the development of the care plan: resident, resident representative, attending physician, registered nurse responsible for the resident, resident care specialist (certified nurse aide), and a member of food service. II. Failure to have timely care conferences for Resident #39 A. Resident #39 status Resident #39, age 74, was admitted on [DATE]. According to the Mach 2021 computerized physician orders (CPO), diagnoses included nondisplaced fracture of the medial malleolus right tibia, reduced mobility, other abnormalities of gait and mobility, and muscle weakness. The 3/12/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief mental status (BIMS) score of 15 out of 15. She was independent in all activities of daily living (ADLs) except for dressing and personal hygiene in which she required one person physical assistance. She did not have any behaviors or rejections of care. B. Resident interview Resident #39 was interviewed on 3/23/21 at 3:32 p.m. She said she had been in the facility for a few years. She said the facility had been hit or miss when it came to having care conferences, and in the past year only one or two staff members attended the care conferences. The resident said it would be helpful if other people would attend the meetings if she had questions. C. Record review A review of the resident's medical record revealed the following care conference notes for the resident for 2020 to current: 11/12/2020 Care conference note documented a care conference was held with the social service director (SSD), the minimum data set coordinator (MDSC), and the activity director (AD). 6/18/2020 Care conference note documented a care conference was held with the SSD, MDSC and AD. No other care care conferences were documented in the resident's medical record. D. Staff interviews The AD was interviewed on 3/29/21 at 1:05 p.m. She said there had been a lack of care conferences in the facility during the past year. She said it had been quite a while since the interdisciplinary team (IDT) participated in care conferences, and typically it was just her and the SSD, and occasionally the MDSC. The MDSC was interviewed on 3/29/21 at 1:38 p.m. She said care conferences should follow the MDS calendar, and the IDT should be participating along with the resident and/or their representative. The MDSC said care conferences were not happening in the past year on a regular basis. She said when they were happening it was typically the AD and the SSD attending the care conferences. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 3/29/21 at 6:08 p.m. She said care conferences should be happening in accordance with the MDS schedule and as needed or requested by residents or their families. The DON said the IDT needed to attend the care conferences, and the care conference needed to be documented in the resident's medical record. III. Failure to ensure Resident #39 had a restorative care plan A, Record review On 3/29/21 at 10:00 a.m. Resident #39 care plan was reviewed. There was no restorative care plan for the resident. (Cross reference F688, restorative program). B. Staff interviews The DON was interviewed on 3/29/21 at 6:08 p.m. She said if a resident had a restorative program, that program needed to be care planned. The DON said the care plan was important to know what the goals and interventions were for each resident. IV. Failure to ensure Resident #13's ADL care plan was updated A. Resident status Resident #13, age less than 65, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included cerebral palsy. The 1/12/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident required extensive assistance of one person for bed mobility and locomotion on the unit and the extensive assistance of two people for transfers, dressing, toilet use and personal hygiene. B. Record review The fall care plan, last revised 3/11/2020, revealed the following interventions: -Full body lift for all transfers; and, -The resident is able to squat pivot transfer with two staff. These were initiated on 1/15/2020 and revised 3/11/2020. The activity of daily living (ADL) care plan, last revised 12/15/2020, revealed the following interventions: -Requires extensive assistance of one to two staff for transfers, last revised 12/15/2020; and -Requires extensive assistance of one to two staff for toilet use, last revised 8/18/2020. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A 2/4/21 in-house communication form from the rehab program manager (RPM) revealed the resident had a change in transfers. It indicated the resident may use the sit to stand lift to assist with toileting tasks. A 2/5/21 progress note revealed the RPM assessed the resident for use of the sit to stand lift to assist with toileting tasks. It indicated the resident demonstrated good body mechanics and the staff were released to use the lift for toileting tasks only. The residents care plan was not updated with this information. V. Failure to ensure Resident #142 hydration care plan was updated. A. Resident status Resident #142, age 74, was admitted [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included diabetes, gastro-esophageal reflux disease (GERD) and cognitive communication deficit. The 12/30/2020 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 of one to two staff members for his activities of daily living (ADLs) except he was independent with set up assistance only for eating. The resident did not have any signs or symptoms of a possible swallowing disorder however he was on a mechanically altered diet. B. Resident observations and interview On 3/23/21 at 4:27 p.m. the resident was lying in bed. He had an empty Coke can on the table in front of him. On 3/24/21 at 5:22 p.m. the resident was lying in bed. He had an empty Coke can sitting on the table in front of him. On 3/25/21 at 10:01 a.m. the resident was lying in bed with his head under the covers. He had an empty Coke can sitting on the table in front of him. C. Record review The March 2021 CPO revealed the following orders: -Dysphagia diet-pureed texture, nectar consistency liquids, ordered 4/7/2020; and -May have non-thickened Coke two times a week for pleasure, ordered 10/31/19. The nutrition care plan, last revised 6/27/19, revealed the following interventions: -Provide diet as ordered, with pureed texture and nectar liquids, which offers adequate calories and protein for estimated needs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Encourage fluids with and between meals, last revised 5/17/19; and, -Provide and encourage fluids of choice with each encounter, last revised 5/21/19. The care plan did not include the resident's ability to have a non-thickened Coke two times a week for pleasure. VI. Staff interviews The rehabilitation program manager (RPM) was interviewed on 3/24/21 at 6:12 p.m. She said a resident's transfer ability should be care planned. She said it was the MDS coordinators responsibility to update the care plan with any changes. Certified nurse aide (CNA) #1 was interviewed on 3/26/21 at 1:22 p.m. She said the CNAs used the kardex (a way to communicate important information about how to take care of a resident) to know what type of care to provide for each resident. She said the kardex was not updated with the resident's current information. She said she was not sure who was responsible for updating the kardex. She said she had been present when therapy evaluated Resident #13 for his lift use so she knew that he was cleared to use the lift for toileting needs but was unable to find it on the resident's kardex. She said knew Resident #142 could have a non-thickened coke and she thought it was care planned once a day or once a shift but could not remember for sure and she was unable to find it on the resident's kardex. The MDS coordinator was interviewed on 3/29/21 at 1:11 p.m. She said it was her responsibility to update the resident's care plans. She said she came in early in the morning to review the 24 hour report in the electronic health record system and get updates in the morning meeting then she would update the care plan after the meeting. She said when updating the care plan, if she puts the CNA as the responsible party, then it would populate onto the kardex for the CNAs to see. She said she did not realize Resident #142's coke was not on the care plan or kardex. She agreed Resident #13's transfer status needed to be updated on his care plan and kardex. 37661

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for three (#34, #35, and #18) of three residents reviewed of 29 sample residents. Specifically, the facility failed to: -Ensure Resident #34, #35 and #18 received assistance with showers as scheduled; and -Ensure facial hair was removed for Resident #34, #35 and #18. Findings include: I. Facility policy and procedure The Routine Resident Care policy and procedure, last revised 9/11, provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m., revealed in pertinent part, Residents receive the necessary assistance to maintain food grooming and person/oral hygiene. Showers, tub baths, and/or shampoos are scheduled at least twice weekly and more often as needed. Daily personal hygiene minimally includes assisting or encouraging residents with washing their faces and hands, combing their hair each morning and brushing their teeth and or providing denture care. II. Resident #34 Resident #34, age 87, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included vascular dementia with behavioral disturbance, depression, polyosteoarthritis (multiple joints affected with pain), unspecified lack of coordination and need for assistance with personal care. The 3/2/21 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of two out of 15. She required the supervision of one person for personal hygiene and was totally dependent on one person for bathing. A. Resident observations and interviews On 3/23/21 at 4:36 p.m. the resident was sitting on her bed. Her hair was greasy and she had long facial hair covering her chin. On 3/24/21 at 2:40 p.m. the resident was sitting in a chair in her room. Her hair was greasy and she had long facial hair covering her chin. She said the hair on her chin really bothered her and if the facility would let her have a razor she would take care of it herself. She said she wished they would do it at least every other day. She said she would like to have showers at least twice a week but they didn't do them so she just washed up at the sink. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The nursing home administrator (NHA) was standing in the hallway outside the resident's door. She was notified of the resident's desire to have her facial hair removed. The NHA said she would have it done right away. B. Record review Review of the response history for the task of bathing for January 2021 revealed the resident received assistance with a shower four out of nine opportunities it was scheduled to be done. There were no signed refusals for the month. Review of the response history for the task of bathing for February 2021 revealed the resident received assistance with a shower six out of eight opportunities it was scheduled to be done. There were no signed refusals for the month. Review of the response history for the task of bathing from 3/1-3/24/21 revealed the resident received assistance with a shower five out of seven opportunities it was scheduled to be done. There were several other times documented that the resident had performed the task independently with no supervision or the supervision of one person. Interviews with staff revealed this was done when the resident washed herself at the sink in her room. It did not include a shower. There were no signed refusals for the month. The care plan, last revised 11/6/19, revealed the resident had an ADL self-care performance deficit related to confusion and dementia. Interventions included: -Provide cuing with tasks as needed; and -Requires limited assistance of one staff for bathing/showering. III. Resident #35 Resident #35, age 93, was admitted [DATE]. According to the March 2021 CPO, diagnoses included congestive heart failure (CHF), generalized muscle weakness, lack of coordination, abnormalities of gait and mobility and need for assistance with personal care. The 3/2/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 13 out of 15. She required supervision with the assistance of one person for personal care and was totally dependent on one person for bathing. A. Resident observations and interviews On 3/23/21 at 4:36 p.m. the resident was sitting in her wheelchair in her room. Her hair was greasy and she had long facial hair covering her chin. On 3/24/21 at 2:40 p.m. the resident was sitting in her wheelchair in her room. Her hair was greasy and she had long facial hair covering her chin. She said she needed assistance from the staff with bathing and with removing her facial hair. She said if she could get the hair removed during her showers, that would be often enough for her but she did not always get help with her showers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review Review of the response history for the task of bathing for January 2021 revealed the resident received assistance with a shower three out of nine opportunities it was scheduled to be done. The resident had two signed refusals for the month. Review of the response history for the task of bathing for February 2021 revealed the resident received assistance with a shower four out of eight opportunities it was scheduled to be done. There were no signed refusals for the month. Review of the response history for the task of bathing from 3/1-3/24/21 revealed the resident received assistance with a shower three out of seven opportunities it was scheduled to be done. There were no signed refusals for the month. The care plan, last revised 1/7/2020, revealed the resident had an ADL self-care performance deficit and preferred to be involved in her daily care and bathing. Interventions included: -She preferred her showers two times a week on Monday and Friday; and -Requires supervision to limited assistance of one staff member for bathing/showering. IV. Resident #18 Resident #18, age 56, was admitted [DATE]. According to the March 2021 CPO, diagnoses included end stage renal disease with dependence on dialysis, generalized muscle weakness and need for assistance with personal care. The 1/28/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. She required the extensive assistance of two people for personal care and was dependent on two people for bathing. A. Resident observations and interview On 3/24/21 at 9:11 a.m. the resident was lying in bed. She had long facial hair covering her chin and cheeks. The resident had body odor. On 3/26/21 at 9:56 a.m. the resident was lying in bed. She had a significant amount of long facial hair covering her chin and cheeks. The resident said she wished the staff would remove it more often, especially before she left the facility to go to dialysis. She said it was embarrassing to her. The resident had strong body odor. B. Record review Review of the response history for the task of bathing for January 2021 revealed the resident received assistance with a shower two out of eight opportunities it was scheduled to be done. There were no signed refusals for the month. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the response history for the task of bathing for February 2021 revealed the resident received assistance with a shower three out of eight opportunities it was scheduled to be done. She had two signed refusals for the month. Review of the response history for the task of bathing from 3/1-3/25/21 revealed the resident received assistance with a shower six out of nine opportunities it was scheduled to be done. There were no signed refusals for the month. The care plan, last revised 11/3/2020, revealed the resident had an ADL self-care performance deficit due to increased lethargy/decreased interaction. Interventions included: -Provide cuing with tasks as needed, -Requires extensive assistance of one to two staff for bathing/showering; and -Requires extensive assistance from one person for personal hygiene. V. Staff interviews The NHA was interviewed on 3/24/21 at 3:55 p.m. She said she was going to have a CNA assist Resident #34 to have her facial hair removed right away. She said it should be done with the resident's shower and any other time it was needed or requested by the resident. Certified nurse aide (CNA) #1 was interviewed on 3/26/21 at 1:22 p.m. She said the CNA working the floor was responsible for doing their own showers. She said sometimes it was very difficult to get showers done daily if they did not have enough help. She said if a resident refused their shower, she would tell the nurse and have the resident sign a refusal form. She said the refusal forms then went to the director of nursing (DON). She said facial hair on females should be removed as often as needed to keep the resident's face free from hair. CNA #2 was interviewed on 3/29/21 at 12:09 p.m. She said the facility used to have a shower aide but now they were responsible for bathing the residents on the hall they were assigned. She said showers were offered to the residents two to three times a week depending on their preference. She said they did not always have the time to get the showers done if they were short handed. She said if a resident refused their shower, then she would go back later and ask them again. If they still refused, then she would have them sign a refusal form. She said facial hair, whether on a man or woman, should be removed during their shower. She said Resident #18 was supposed to be showered every morning before she went to dialysis. The director of nursing (DON) was interviewed on 3/29/21 at 6:24 p.m. She said showers should be offered to the resident's twice a week or depending on the resident's preference. She said the CNAs were responsible for providing scheduled showers to the resident's they were assigned to that day. She said if a resident refused their shower, the CNA should notify the nurse and fill out a refusal form that was signed by the resident, CNA and the nurse. She said facial hair should be removed per the resident's preference.

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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** 37661 Based on observations, record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for two (#18 and #32) residents out of 29 sample residents. Specifically, the facility failed to: -Ensure nursing staff followed physician orders for wound care for Resident #18; and -Monitor existing bruises for Resident #32. Findings include: I. Following physician orders A. Facility policy and procedure The Physician Orders policy and procedure, last revised 11/17, provided by the corporate consultant on 3/29/21 at 3:00 p.m., revealed in pertinent part, After noting an order, the receiving licensed nurse enters the order into the electronic health record (EHR) and ensures it is active in the electronic administration record as appropriate. B. Resident status Resident #18, age less than 65, was admitted [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included open wound of the abdominal wall. The 1/28/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required extensive assistance of one to two people for her activities of daily living (ADL). The assessment did not include the resident's open wound to her abdominal wall. C. Observations On 3/24/21 at 4:00 p.m. licensed practical nurse (LPN) #2 was observed removing an undated dressing off the left lower quadrant of Resident #18's abdomen. She then removed a small brown dressing from inside the wound bed. The wound was approximately 2.5 centimeters (cm) in length by 1.5 cm in width with approximately 0.3 cm depth. The wound bed was pink and the surrounding skin was pink. There was a small amount of yellow drainage around the edges of the wound. The nurse did not cleanse the wound. She applied zinc oxide cream to the wound with her gloved finger and left the wound open to air. LPN #2 said she checked the physician order prior to entering the room. D. Record review The March 2021 CPO revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 2/25/21 orders were obtained to cleanse the wound to the right lower abdomen with wound cleanser, pat dry and apply zinc oxide to the wound and leave open to air daily until healed. This order was discontinued on 3/22/21. -On 3/22/21 orders were obtained for wound care for the abdominal fold dehiscence wound to cleanse with wound cleanser, apply silver alginate and cover with a secondary foam dressing every night shift. The March 2021 treatment administration record (TAR) revealed the order for the zinc oxide was discontinued on 3/22/21 and the order for the wound care obtained on 3/22/21 for the silver alginate was not scheduled to start on the TAR until 3/27/21 instead of on the day it was ordered. This transcription error meant the resident would not receive any treatment to the area for five days. This error was corrected on 3/25/21 after the above observation was made. E. Staff interviews LPN #2 was interviewed on 3/24/21 at 4:22 p.m. She said she checked the physician orders before entering Resident #18's room and the orders were to apply zinc and leave it open to air. She said she must have missed that the order had been discontinued. LPN #1 was interviewed on 3/29/21 at 12:30 p.m. She said before doing any treatments, she would check the TAR to make sure she knew what the current treatment orders were. She said if an order had been discontinued, it would not show up on the current TAR. The director of nursing (DON) was interviewed on 3/29/21 at 6:24 p.m. She said the nurse should always look at the TAR and check the orders prior to providing any type of wound care. She said she expected the nurse to clean the wound prior to applying any type of medication or dressing. She said LPN #2 was being educated and education was being provided to the other nurses as well. 37166 II. Failure to complete skin assessments timely and monitor existing bruising for Resident #32 A. Facility policy and procedure The skin assessment policy was provided by the director of nursing (DON) on 3/29/21. The policy read: On admission residents are assessed for skin integrity. Residents admitted with skin impairment will have interventions implemented to promote healing and physician orders for treatment. B. Resident #32 status Resident #32, age less than 60, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included orthopedic aftercare, tibial fracture, edema, epilepsy, traumatic brain injury, and developmental disorder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/21/20 minimum data set (MDS) assessment revealed the resident was cognitively intact, her brief interview for mental status (BIMS) score of 13 out of 15. She required extensive assistance of two people with bed mobility and transfers. She was at risk for developing skin conditions and she was admitted with surgical wounds. C. Resident interview and observations The resident was interviewed on 3/23/21 at 3:57 p.m. She was sitting in the wheelchair, looking out the window. She said she was here because of this and pointed to her legs. The resident had dressings on both of her legs and large multicolored bruises on both of her forearms. The bruises extended from elbow to wrist on both hands. She said her hands were bruised by a dog who lived with her at home before she came to the facility. She said she wanted to go home. D. Record review According to the admission note on 12/22/2020, the resident arrived at the facility from the hospital after surgery on her tibia. Prior to the surgery she was residing at a group home. The skin assessment on admission revealed the resident had extensive bruising to both of her forearms. The bruises were not measured at the time of admission. All consecutive skin assessments after the admission mentioned the resident's wounds on both legs. Bruises were not included on the skin assessments. Review of the progress notes since admission revealed no mention of the bruising on both of the resident's arms. Review of the March 2021 CPO revealed no orders to monitor the bruising. Review of the treatment administration record (TAR) for March 2021 revealed no orders to monitor the bruising. The care plan, inticiated on 12/21/2020 documented monitor skin per facility protocol. E. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 3/28/21 at 4:45 p.m. She said she was familiar with the resident and had taken care of her for the last few weeks. She said she was aware of the bruises on her arms and looked at them every shift. She said she did not document the healing of the bruises. She said she probably should document that on the skin assessment with other skin conditions. She said she would ask the director of nursing (DON) where it should be documented. The DON was interviewed on 3/29/21 at 11:21 a.m. She said it was brought to her attention that bruises for Resident #32 were not documented on the skin assessments. She said she provided education to the nurses to document all skin issues including bruises on weekly skin assessments. In addition, all bruises should be monitored every shift on the TAR. She said she reviewed Resident #32's orders and would make changes to the record immediately.

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on observations, record review and interviews the facility failed to ensure one (#25) of three residents reviewed for ancillary services, such a podiatry services, out of 29 sample residents received proper foot care and treatment according to standards of practice. Specifically, the facility failed to ensure podiatry care was provided timely and as requested by Resident #25. Findings include: I. Facility policy The Podiatry Policy and Procedure was requested on 3/29/21, but was not provided by the facility. II. Resident status Resident #25, under the age of 87, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included bipolar disorder, essential hypertension, need for assistance with personal care, and muscle weakness. The 1/1/21 minimum data set (MDS) assessment revealed the resident was cognitive intact with a brief mental status (BIMS) score of 14 out of 15. She did not have any rejections of care or behaviors. She required one person assistance with bed mobility, transfering, walking, toilet use, and personal hygiene. She required one person physical assistance with bed mobility, locomotion on and of the unit, and personal hygiene. She required set-up assistance with transfers, walking, eating, and toilet use. III. Resident interview Resident #25 was interviewed on 3/23/21 at 4:17 p.m. She said her toenails had been really bothering her, and she finally had to make her own podiatry appointment because the facility staff were not assisting her. The resident said her toenails were digging into the sides of her other toes and not only was it painful, it was making it difficult to walk. IV. Record review A 1/27/2020 Social Service Progress note documented the following: Resident #25 has stated that she would like to see the visiting podiatrist when he is here on 2/11/2020. A 2/4/2020 Social Service Progress note documented the following: Resident #25 is scheduled to see the podiatrist on 2/11/2020. No other ancillary needs at this time. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/29/21 review of the resident's medical revealed no additional documentation regarding the resident receiving podiatry services from January 2020 to March 2021. V. Staff interviews The social work consultant (SWC) was interviewed on 3/28/21 at 2:56 p.m. She said she was in the facility on a part time basis and in her role she was working on completing new admission social services assessments, and also working with residents who were discharging. She said the responsibility of podiatry care was currently the responsibility of the nursing department and she was unaware of the last time podiatry services had been provided. She said the podiatry provider should be in the facility at least every 90 days to offer podiatry services. The SWC was interviewed a second time on 3/28/21 at 3:15 p.m. She said she had followed-up with nursing regarding podiatry services, and the last the provider was in the facility was 8/5/2020. She said she was unsure when the provider would be back in the facility. The director of nursing (DON) was interviewed on 3/29/21 at 6:08 p.m. She said the podiatrist had not come into the facility in December 2020 due to the facility's COVID-19 outbreak, but she was unsure why they had not been in this year. The DON said if the podiatrist was unable to enter the facility, the facility needed to be setting up outside appointments for the residents.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations, record review and interviews, the facility failed to ensure two (#13 and #39) of three residents with limited range of motion received appropriate treatment and services out of 29 sample residents reviewed. Specifically, the facility failed to establish a restorative program within the facility to ensure Resident #13 and #39 did not have a decline in activities of daily living (ADL). I. Facility policy and procedure The Restorative Nursing Management System policy and procedure, dated April 2018, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and documented the following: A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy. Based on identified needs, services are: -Individualized, -Care planned with measurable goals and interventions, -Implemented to assist the resident to attain and/or maintain their physical, mental, and psychosocial well-being to the extent possible, in accordance with the resident's own needs and preferences, and: -Documented in the resident's health record. II. Resident #13 A. Resident status Resident #13, age less than 55, was admitted [DATE]. According to the March 2021 computerized physicians orders (CPO), diagnosis included cerebral palsy. The 1/12/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident required extensive assistance of one person for bed mobility and locomotion on the unit and the extensive assistance of two people for transfers, dressing, toilet use and personal hygiene. The resident received physical and occupational therapy six days during the assessment period. The resident did not receive a restorative nursing program. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review According to an 8/20/2020 in-house communication from the physical therapist, the resident's mode of locomotion changed. It indicated the resident was cleared for modified independent transfers from/to bed and wheelchair and to provide assistance only as needed. The 8/20/2020 transition to restorative therapy form revealed the resident was to receive upper body range of motion (ROM) to decrease the risk of loss of ROM to the left upper extremity. It indicated the resident was to receive passive range of motion (PROM), active assistive range of motion (AAROM) and active range of motion (AROM) to left upper extremity joints, all planes. The activity was to be completed six days per week for 12 weeks. -Review of the record on 3/26/21 revealed no documentation of a restorative program occurring. The care plan, last revised 12/15/2020, revealed the resident had an ADL self-care performance deficit. It also indicated the resident was a high risk for falls. Interventions included: -Observe/document/report and signs and symptoms of immobility: contractures forming or worsening, skin breakdown or fall related injury; -Requires extensive assistance of one to two staff for transfers, last revised 12/15/2020; -Full body lift for all transfers, initiated 1/15/2020 -Resident is able to squat pivot transfer with two staff, last revised 3/11/2020. The resident did not have a care plan for a restorative nursing program. A 2/4/21 in-house communication form from the rehab program manager (RPM) revealed the resident may use the sit to stand lift to assist with toileting tasks. A 3/25/21 nursing progress note revealed the resident requested to go back to doing restorative. C. Interviews The RPM was interviewed on 3/24/21 at 6:12 p.m. She said Resident #13 would definitely benefit from a restorative program but would need to be reassessed to see what type of program would be best for him. She said he should have been put on a program when he was discharged from therapy services. 39261 III. Resident #39 A. Resident #39 status Resident #39, age of 74, was admitted on [DATE]. According to the Mach 2021 computerized physician orders (CPO), diagnoses included nondisplaced fracture of the medial malleolus right tibia, reduced mobility, other abnormalities of gait and mobility, and muscle weakness. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/12/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief mental status (BIMS) score of 15 out of 15. She was independent in all ADLs except for dressing and personal hygiene in which she required one person physical assistance. She did not have any behaviors or rejections of care. The MDS documented the resident did not receive services from the therapy (physical, occupational, or speech) program or from the restorative nursing program. B. Resident interview Resident #39 was interviewed on 3/23/21 at 3:32 p.m. She said she had been in the facility for a few years, and had participated in therapies on and off with most recently having therapy at the end of 2020. The resident said when she came off of therapy she was told she would be placed on a restorative program. The resident said she had never participated in any type of restorative program, and she was worried she might lose the strength she had built up while in therapy. C. Record review The 8/20/2020 Transition to Restorative Therapy form documented the following: Functional areas included in this restorative plan: walking and range of motion. Range of motion: upper and lower body range of motion, to maintain current level of ambulation. Range of motion upper body: Encourage pt (patient) to ambulate with fww (front wheeled walker) outside of (the) room at least once daily. Encourage pt (patient) to ambulate to (the) gym and back. Problems: decreased ROM (range of motion) to rt (righ) ankle. Pt (patient) is safe to ambulate on (her) own with fww (front wheeled walker) around (the) facility as pt (patient) tolerates. Pt (patient) may require encouragement on most days in getting out of her room to improve quality of life. How often is activity to be completed: five days per week for 12 weeks. Range of motion lower body: Goal: To maintain current level of strength and functional endurance on BLE (bilateral extremities). Plan- Activities to be completed: standing LE (lower extremity) with up to three pound ankle weights: march, knee flexion, hip abduction, heel raises time two sets of 10 each. How often: five times a week for 12 weeks. On 3/24/21 at 1:23 p.m. a review of the resident's medical record revealed there was no restorative care plan, or restorative progress notes for the resident. Cross reference: F657 for resident care plans, the facility failed to create and update restorative care plans for the residents. D. Staff interviews (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The rehabilitation program manager (RPM) was interviewed on 3/24/21 at 4:00 p.m. She said Resident #39 had been on the therapy caseload last year, and when she was discharged from therapy she had an order for restorative therapy. The RPM said the resident had an order on 8/6/2020 for restorative therapy. The RPM said it had been identified by the facility about a year ago that the restorative therapy program was not working the way the facility would prefer and was basically nonexistent. The RPM said a certified nurse aide (CNA) had been assigned to completed the restorative programs for the residents was frequently pulled to the floor to work as a CNA due to staffing concerns, the RMP said the staffing concerns were happening prior to COVID-19, and that COVID-19 had only made nursing staffing more difficult. Cross reference: F725 sufficient nursing staff, the facility failed to provide sufficient nursing staff to meet the needs of the residents. The RPM said the facility had been working on a PIP (performance improvement plan) for the restorative program in the facility. The RMP said yesterday and today (during the time of the survey) she had trained two CNAs who would be completing the restorative nursing program for all of the residents. The RPM reviewed Resident #39 medical records and stated she could not find any documentation in her chart regarding any type of restorative nursing program participation, including a care plan. The director of nursing (DON) was interviewed on 3/25/21 at 2:46 p.m. She said the facility was in the process of fixing and implementing a new restorative nursing program in the facility. The DON said the process would include screening all of the residents to identify who would benefit from a restorative program. The DON said when those residents had been identified, the therapy department would create individualized programs, which would be care planned and participation would be documented in the resident's medical records.

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F 0689 Level of Harm - 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** 39261 Based on interviews and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible, and failed to provide supervision and assistance to prevent falls with injuries. The facility failed to ensure one (#13) of two residents reviewed for smoking safety was safe while in the facility smoking area. The facility further failed to failed to prevent falls for three of five residents (#15, #16, and #19) reviewed for falls out of 29 sample residents. Record review and interviews revealed the facility failed to ensure Resident #13 had adequate access back into the facility after smoking outside in sub-zero temperatures. The resident suffered frostbite to his fingers while outside, and when he attempted to gain entry back into the facility he became stuck between the door and the wall, and waited for approximately 20 minutes before staff found him and assisted him back into the facility. Resident #16 sustained six falls over a period of two months. Two of the falls resulted in major injuries. One fall caused re-opening of the surgical wound on his amputated leg, and another fall resulted in a head injury with subdural hematoma. The facility failed to provide adequate and timely supervision and assistance to prevent multiple falls, resulting in two major injuries for Resident #16. Resident #15 had four consecutive falls in less than one month. The facility failed to put in place interventions to prevent the falls after the third fall. The fourth fall resulted in a fracture of the resident's left arm. Resident #15 was not assessed by an RN for any injuries after the fall. The next morning the resident developed arm discoloration and swelling. She called 911 herself and was transferred to the emergency room for evaluation. The facility failures contributed to the resident's fall with fracture. For Resident #19, the facility failed to properly assess, develop and implement interventions to prevent recurring falls. Fall risk assessments were not consistently documented accurately or timely, neurological checks were not consistently performed, and the resident was not consistently assessed by registered nurses after falls. Findings include: I. Facility policies and procedures The Safe Smoking/Tobacco Use policy and procedure was provided by the director of nursing (DON) on 3/24/21 at 11:00 a.m. and read in pertinent part: The interdisciplinary team (IDT) members determine if a resident may safely use tobacco products or e-cigarettes before the resident is permitted the privilege to do so. -A resident who smokes, uses smokeless tobacco or uses an e-cigarette is evaluated to determine whether the resident is safe or unsafe to use tobacco products or e-cigarettes using the following forms: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	-Upon admission or readmission: If the Nursing Admission Data Collection (UDS) identifies that the resident uses tobacco or an e-cigarette, then the Safe Smoking/Tobacco Use Evaluation (UDA) is completed. -Quarterly, annually, with significant change of condition, and/or an infraction of facility smoking policy: The Safe Smoking/Tobacco Use Evaluation (UDA) is completed for residents who continue to use tobacco or e-cigarettes. -The degree of supervision is determined based on the Safe Smoking/Tobacco Use Evaluation (UDA), the physical attributes of the smoking area, and other relevant factors. The Incident/Accident Reporting for Residents policy and procedure was provided by the clinical coordinator (CC) on 3/29/21 at 3:46 p.m. and read in pertinent part: All indecent, accidents, and unusual occurrences involving a resident are investigated, documented and reported in accordance with Federal and State law. -Relevant facts regarding the Incident are recorded in the Progress Notes (Electronic Health Record). Relevant facts may include, but are not limited to: the location the resident was found, assessments conducted, care provided, follow-up care provided etc. The Fall Management policy, revised in July 2017, was provided on 3/29/2021 by the nursing home administrator (NHA). The policy read in pertinent part: The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and /or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident's fall risk. A care plan is developed and implemented, based on this evaluation, with ongoing review. II. Failure to ensure Resident #13's safety by providing access into the facility from the smoking patio A. Resident #13 status Resident #13, age under 60, was initially admitted on [DATE] and most recently readmitted on [DATE]. According to the March 2021 computerized physician orders (CPOs), diagnoses included cerebral palsy, chronic pain, insomnia and bipolar disorder. According to the 1/12/21 minimum data set (MDS) assessment, the resident was cognitively intact with the brief interview for mental status (BIMS) score of 15 out of 15. He had behavioral symptoms not directed towards others one to three days during the review period. The resident rejected care for four to six days. He required set-up assistance with eating; one person assistance with locomotion on and off the unit and bed mobility; and two person extensive assistance with transfers, dressing, toilet use and personal hygiene. B. Resident interview (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The resident was interviewed on 3/24/21 at 10:45 a.m. He said he had been outside smoking on 2/13/21 in late morning or early afternoon, he could not recall, and suffered frostbite to the tips of his fingers on his right hand. The resident said he had gone outside to smoke and it was about zero (0) degrees outside. The resident said he was an independent smoker, and his smoking materials were kept in a locker outside per facility policy. He said when he touched the lock his fingers froze to the lock and he had to pull them off, which caused blisters on his thumb and fingers. He said when he was finished smoking he propelled his wheelchair to the handicap accessible door. He said he used the blue handicap button to open the door, and he made it halfway through the door before it closed with him in between the door jam. He said he was basically stuck inside and outside and it took about 20 minutes before staff found him and assisted him into the facility. The resident said he did not notify staff about his fingers until the following day when the raised blisters formed. He said when staff became aware of the blisters they educated him on the importance of telling staff members when he was going to go outside to smoke. He said they also provided him with two additional pairs of gloves, and made sure he had a winter coat to wear when he was outside. The resident said staff continued to state the frostbite occurred when he touched his wheelchair wheels, but he insisted it happened when he touched the lock on his smoking locker. He said staff replaced the lock on his locker and also placed material on his wheelchair so he was not touching metal when he propelled himself. The resident said he always brought his cellular phone outside when he went to smoke, but he had forgotten it that day. He said he always makes sure he has his phone now, and will go back to his room if he forgets to bring it. C. Record review A 2/14/21 nursing note documented the following: Note Text: Pt (patient) has multiple blisters from his fingers sticking to wheelchair outside in the freezing cold weather. Pt (patient) got stuck outside in the snow and his fingers froze to the wheelchair because it was 0 degrees outside. Educated resident on letting staff know when he goes out to smoke so that staff could set a timer for 15 minutes so that staff can check to see if he is ok. Educated resident to possibly not go out to smoke as often when the temperature drops outside. (name of physician) and wife made aware of the blisters right hand. A 2/14/21 SBAR (situation background assessment recommendation) Communication Form and Progress Note documented the following: This started on 2/13/21, Pt (patient) got stuck outside in the snow and his fingers froze to the wheelchair because it was 0 degrees outside. A 2/14/21 Smoking Injury Investigation documented the following: Nursing description: Pt (patient) had multiple blisters from his fingers sticking to the wheelchair outside in the freezing cold weather. Pt (patient) got stuck outside in the snow and his fingers froze to the wheelchair because it was 0 degrees outside. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Resident description: I got stuck at the door try(ing) to get in, I yelled for help and no one came. Immediate action taken: Educated resident on letting staff know when he goes out to smoke so that staff could set a timer for 15 minutes so that staff can check to see if he is ok. Educated resident to possibly not go out to smoke as often when the temperature drops outside. Resident was not taken to the hospital. A 2/15/21 Resident/Family Education Record documented the following: Resident educated on safe smoking in subzero temperatures. Resident is to tell staff when he goes out to smoke so that he will be able to have some help when needed. The skin care plan, last revised on 3/23/21 (during the survey) identified the resident as having frostbite to his right hand from smoking in below zero temperatures. The goal was for the resident's wounds to show signs of healing by the next review. The pertinent interventions included: - Resident agreeing to not go out to smoke if maintenance has not cleared the snow from the ground in the smoking area. - Gloves provided to the resident to wear outside while smoking in below zero temperatures. - Maintenance to move rubber grips to the right wheelchair to ensure the resident does not have to touch cold metal in below zero temperatures. The smoking care plan, last revised 2/15/21, identified the resident as being a smoker. The goal was for the resident not to suffer an injury from unsafe smoking practices. Pertinent interventions included: - Resident agreeing to not go outside if the snow had not been cleared in the smoking area. - Education provided to the resident on risk of smoking outside in below zero temperatures. - Gloves provided to the resident while he is outside smoking in below zero temperatures. - Maintenance to move rubber grips to the right wheel of the residents wheelchair to ensure the resident does not have to touch cold metal in below zero temperatures. D. Staff interviews The staff development coordinator (SDC) was interviewed on 3/24/21 at 1:28 p.m. She said she was the staff member who completed the education to the resident on 2/15/21 regarding safer smoking practices. The SDC said she was part of the investigation and making sure all of the residents who smoke continued to be safe. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	According to the SBAR on 1/17/21, the resident had a witnessed fall in his room. He was assisted by a certified nurse aide (CNA) in the bathroom, lost his balance and was lowered to the floor. At that time the incision broke open. Area was cleansed and pressure dressing applied. -The physician was not notified until the next day, 1/18/21 at 8:00 a.m. -The resident per MDS assessment (see above) needed extensive two-person assistance for transfers and toilet use, however it was documented that one CNA performed the transfer. The resident's vital signs were documented by an LPN. There was no evidence that the resident was assessed by an RN. There were no further notes regarding the resident's wounds that opened up. The fall assessment was completed on 1/17/21, and documented a score of 10 (high risk). The care plan was updated with an intervention: Be sure resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. The IDT review was initiated on 1/18/21 and completed (locked) on 1/26/21. Interventions included to provide two person assistance to the resident. Fall #3 - 1/30/21 According to the SBAR completed on 1/31/21 (one day after the fall), the resident had an unwitnessed fall in his room on 1/30/21. During the fall he bumped his leg that resulted in the dehiscence of the wound. The resident was sent to the emergency room to stop the bleeding. The residents' vital signs and SBAR form were completed by an LPN. There was no evidence that the resident was assessed by an RN. There were no further notes regarding the resident's wound that opened up. The IDT review was initiated on 1/31/21 and completed (locked) on 2/1/21. The note read: resident states, he was sitting in recliner trying to pull the pillow out from under him. Resident states that in the process he somehow 'slid' out of the recliner and bumped his stump as he went to the floor. Interventions included moving the resident closer to the nurses station and conducting frequent checks. The fall assessment was completed on 1/30/21, and documented a score of 12 (high risk). The care plan was updated with an intervention to initiate frequent checks as needed for frequent falls. The emergency room (ER) admission note, dated 1/30/21, revealed that the resident arrived at the ER with a leg injury. Assessment revealed some wound dehiscence, sutures in place, no active bleeding. Wound was redressed and the resident was sent back to the facility. Fall #4 - 2/10/21 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	According to the SBAR on 2/10/21, the resident had an unwitnessed fall in his room. It was documented that the resident had an unattended fall with no apparent injury. No additional information was documented on the SBAR about where the resident was found, what he was wearing and the status of the call light. The resident's vital signs were documented by an LPN. There was no evidence that the resident was assessed by an RN. The fall assessment was completed on 2/10/21, and documented a score of 10 (high risk). The care plan was updated with an intervention: Bedside commode for shorter distance transfers, resident refuses to use commode. The IDT review was initiated on 2/10/21 and completed (locked) on 2/16/21. The note indicated the resident was found by a CNA during rounds. There were no notes regarding the exact location of the fall, the status of the call light or the resident's footwear. The facility initiated the following intervention: offer bedside commode, resident refuses use of commode. No further clarification was added on why the commode was provided to the resident, the reason for resident refusal of the commode, or any additional interventions. According to the physician note dated 2/24/21, the resident had a dehiscence of amputation stump after the fall on 1/30/21 with re-opening of the surgical incision to the stump. The ortho surgeon started a wound vac on 2/17/21 to promote improved healing. The wound vac was in place, and the resident was followed by a wound care team after 2/17/21 and during the survey. Fall #5 - 2/28/21 According to the SBAR on 2/28/21, the resident had an unwitnessed fall in his room. It was documented, resident found on the floor, stated he fell head first on the floor while trying to transfer. Resident has a knot on the side of the forehead. The physician was notified and the resident was sent to the ER for evaluation. There were no fall risk assessment after the fall on 2/28/21 and there were no IDT notes. The care plan was not updated with any new interventions. The ER admission record dated 2/28/21 documented the resident was admitted with a headache and left stump pain after sustaining a fall at the nursing facility. In the ER he was diagnosed with a subdural hematoma and was admitted to the hospital overnight for observations. Fall #6 - 3/7/21 According to the SBAR on 3/7/21, the resident had an unwitnessed fall in his room. A note documented, Resident attempted to self transfer from wheelchair to recliner, wound vac got caught on wheelchair and resident fell to his knees. The resident's vital signs were documented by an LPN. There was no evidence that the resident was assessed by an RN. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	The fall assessment was completed on 2/10/21, with a documented score of 10 (high risk). The care plan was updated with an intervention: resident at times refuses to use call light for assist with transfers. Staff to continue to encourage call light use. Staff to offer frequent help with ADL's (activities of daily living). The IDT review was initiated on 3/7/21 and completed (locked) on 3/23/21. The note documented the resident at most times refuses to use call light for assist with transfers. Staff to continue to encourage call light use. Staff to offer frequent help with ADL's. The facility failed to provide supervision and assistance to prevent repeated falls with injuries for Resident #16. 4. Staff interviews CNA #3 was interviewed on 3/29/21 around noon. She said the Resident #16 needed one-person assist with transfers and mobility, and was mostly independent with other tasks. She said the resident was at risk for falls and they were frequently checking on him, making sure his call light was answered promptly. She said the resident did not have behaviors and did not refuse care. LPN #3 was interviewed on 3/29/21 around noon. She said Resident #16 was alert and oriented, and required one person assistance with most tasks. She said the resident was at risk for falls, but had no falls recently. She said the resident used his call light frequently and had no memory problems and no behaviors. She said he did not refuse care. The rehab program manager (RPM) was interviewed on 3/29/21 around 4:00 p.m. She said Resident #16 was currently working with physical therapy (PT) and occupational therapy (OT). He required one person assistance with ambulation and transfers. She said the resident had multiple falls and at times was impulsive. She said he made several attempts to self transfer and sometimes did not use his call light. The MDS coordinator was interviewed on 3/29/21 around 5:00 p.m. She said she was an RN and MDS coordinator. She said she participated in IDT meetings and was responsible for the update of the care plans. Regarding Resident #16, she said she recalled discussing the falls in IDT meetings. She said the resident refused to use his call light and was not cooperative with care. She said Resident #16 was continuously educated to use the call light and the facility came up with many interventions to prevent his falls. She said the resident refused most of the interventions including a bedside commode. She said she did not talk to the resident in person and did not ask him why he was refusing the bedside commode. She said she did not provide direct care to the resident, but heard it from a third party that the resident was refusing care. The director of nursing (DON) was interviewed on 3/29/21 around 5:00 p.m. in the presence of the corporate consultant (CC). She said Resident #16 had several falls and they reviewed all falls in IDT meetings. She said she did not talk to the resident about refusals to use the call light, and she did not know why he would refuse it. She said they continued to educate him and remind him to call for assistance. B. Resident #15 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	1. Resident status Resident #15, age 81, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included cerebral infarction, encephalopathy, kidney failure, heart failure, hypertension, abnormal weight and mobility. The 1/5/21 MDS assessment revealed the resident was cognitively intact with a BIMS score 13 out of 15. The resident required limited assistance of one person and physical assistance for bed mobility, transfers, dressing, toileting and personal hygiene. She was occasionally incontinent of bowel and bladder. The fall section revealed the resident had at least one fall in the last six months prior to the admission, that resulted in minor injuries. The behavior section indicated the resident did not resist care, and had no hallucinations, delusions or other types of behaviors. 2. Resident interview The resident was interviewed on 3/23/21 around 3:00 p.m. She said she did not recall having any falls and was doing well. She said she was working with physical therapy and was looking forward to going home. No slings were observed on the resident's arms (see 1/14/21 hospital documentation from record review below). She was able to move her arms and propel herself in a wheelchair. 3. Record review The care plan for falls was initiated on 1/4/21 revealed that the resident was at risk for falls. Interventions included to assist with transfers, make sure call light was within reach and encourage the resident to use it for assistance as needed, and to provide prompt response to all requests for assistance. Fall #1 - 1/5/21 According to the SBAR on 1/15/21, the resident had an unwitnessed fall in her room. She was assessed by an LPN. The note read fall without injury. The SBAR note did not mention where the resident was found, what she said, what footwear she was wearing and if her call light was on or off. No progress notes were located to demonstrate that an RN was contacted to complete the assessment. The care plan was updated with an intervention to place a smaller recliner in her room as the one she had was too big. Fall #2 - 1/7/21 According to the SBAR on 1/7/21, the resident had an unwitnessed fall in her room. Resident found sitting on the floor in her room with a recliner at her backside. Res states, 'I slid out of the chair.' She has some pain in her lower back where the footstool of the recliner would have hit her while sliding out. Presents with no bruising or redness anywhere. No abrasions. Assisted to bathroom and back to the recliner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for 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** 37661 Based on observations, record review and interviews, the facility failed to ensure the nutritional and hydration needs were consistently met for one (#142) resident out of three reviewed out of 29 sample residents. Specifically, the facility failed to ensure Resident #142, who was on thickened liquids, consistently received a sufficient amount of fluids throughout the day. Findings include: I. Facility policy and procedure The Hydration Management policy and procedure, last revised July 2017, provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m., revealed in pertinent part, Residents are provided with sufficient fluid intake to maintain proper hydration and nutritional status. Residents' hydration status will be monitored on a regular basis. Sufficient fluid means the amount of fluid needed to prevent dehydration and maintain health. The amount needed is specific for each resident, and fluctuates as the resident's condition fluctuates. II. Resident #142 A. Resident status Resident #142, age 74, was admitted [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included diabetes, gastro-esophageal reflux disease (GERD) and cognitive communication deficit. The 12/30/2020 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 of one to two staff members for his activities of daily living (ADLs) except he was independent with set up assistance only for eating. The resident did not have any signs or symptoms of a possible swallowing disorder however he was on a mechanically altered diet. B. Resident observations and interview On 3/23/21 at 4:27 p.m. the resident was lying in bed. He had an empty water pitcher and an empty Coke can, within reach, on the table in front of him. He said he was thirsty. His lips were dry. On 3/24/21 at 5:22 p.m. the resident was lying in bed. He did not have a water pitcher in his room. He had an empty Coke can sitting on the table in front of him. He said he was thirsty. His lips were dry. On 3/25/21 at 10:01 a.m. the resident was lying in bed with his head under the covers. He did not have a water pitcher in his room. He had an empty Coke can sitting on the table in front of him. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continuous observations were made on 3/26/21 from 10:42 a.m. until 1:35 p.m. The resident was lying in bed with the head of the bed up 30 degrees. He did not have a water pitcher in his room. He was provided with 240 ml of a thickened red fluid with his lunch meal. He was not offered any fluids before or after his meal and no fluids were placed within his reach while he was in bed. C. Record review The March 2021 CPO revealed the following orders: -Dysphagia diet-pureed texture, nectar consistency liquids; -May have non-thickened Coke two times a week for pleasure; and -House supplement 4 ounces (oz) three times a day. According to the 6/26/2020 nutrition registered dietitian (RD) assessment the resident estimated fluid needs were 1,725-2,070 milliliters (ml) a day. This was based on the ideal body weight (IBW) of 69 kilograms (kg) or 25-30 ml/kg. It indicated the resident had swallowing difficulty related to speech therapy findings and had a need for pureed textures and nectar thickened liquids. The January 2021 documentation survey report for the amount of fluids consumed revealed the resident's average fluid intake during meals was 498 ml/day. His average meal intake was 0-50%. The February 2021 documentation survey report for the amount of fluids consumed revealed the resident's average fluid intake during meals was 569 ml/day. His average meal intake was 0-50%. The March 2021 documentation survey report for the amount of fluids consumed revealed the resident's average fluid intake during meals was 694 ml/day. His average meal intake was 0-50%. III. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/26/21 at 1:22 p.m. She said [NAME] should be passed to each resident at least once a shift but they did not always have time to get it done (cross-reference F725 sufficient staff). She said Resident #142 got his fluids during meals since he was on thickened liquids. She said he did have thickened liquids in the refrigerator in his room that could be given to him when he requested. She said it should also be offered frequently but when she got busy she would frequently forget. She said she had not had time to give him any fluid that day but was going to get him a cup with thickened fluids at that time. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The registered dietitian (RD) was interviewed on 3/29/21 at 11:00 a.m. He said he had just started with the company at the beginning of March 2021 and had not had the opportunity to do an in-facility visit yet. He said he was reviewing the resident's records remotely. He said a resident's fluid needs should be based on the resident's body weight with a calculation of 30 ml/kg. He said when he was trying to determine a resident's intakes, he would have to see how much fluid was in the meal being provided and monitor their meal intakes. He said a resident's hydration status should be reviewed quarterly. He said to ensure a resident is getting the amount of fluids needed, the staff should offer increased fluids at meals if their intakes were good and the staff should also be offering fluids in between meals. He agreed documentation showed Resident #142 was not meeting his fluid intake needs. CNA #2 was interviewed on 3/29/21 at 12:09 p.m. She said [NAME] should be passed to all resident's one to two times a shift and as needed. She said that included resident's on thickened liquids. She said Resident #142 got most of his fluids at meal times but had Cokes in his fridge if he wanted one. The director of nursing (DON) was interviewed on 3/29/21 at 6:24 p.m. She said fresh water should be passed every shift and as needed. She said this included residents on thickened liquids. She said staff should be offering the residents a drink whenever they pass the fresh water and anytime they go into the resident's room.

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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** 37661 Based on interviews and record review, the facility failed to manage the pain of one (#18) of three residents reviewed out of 29 sample residents in a manner consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences. The facility failed to identify when Resident #18 was having increased complaints of pain and failed to perform a current comprehensive pain evaluation to determine the root cause of the resident's increasing complaint of pain and adjust the resident's plan of care to provide optimal pain management. Resident #18 had frequent complaints of moderate sacral pain during her dialysis sessions that were communicated to the facility but were not addressed or treated by the facility. These failures led to the resident ending her dialysis sessions early frequently due to her unresolved pain. Findings include: I. Facility policy and procedure The Pain Management policy and procedure, last revised July 2017, provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m., revealed in pertinent part, The facility will evaluate and identify residents experiencing pain; evaluate the existing pain and cause (s); determine the type and severity of the pain; and develop a care plan for pain management consistent with the comprehensive care plan and the resident's goals and preferences. An evaluation of pain should be completed when the resident has a new complaint of pain or when pain is suspected to be present. Consult with the resident or resident's representative when developing an individualized care plan related to the signs and symptoms of their pain. Interventions should be focused on approaches that help to control the resident's level of pain, whether it is by managing pain by the use of pain medication or other non-pharmacological approaches. Staff should be proactive to address the resident's pain to aid in achieving relief. Evaluation of pain, implementation of interventions, monitoring the resident response to those interventions, and communicating with the care team regarding pain management strategies are important components of a successful pain management system. II. Resident #18 A. Resident status Resident #18, age 56, was admitted [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included end stage renal disease with dependence on dialysis. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The 1/28/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent or required the extensive assistance of two people for her activities of daily living (ADLs). The resident did not have any complaints of pain during the assessment period. She had one stage 2 pressure ulcer at the time of the assessment and was receiving pressure ulcer care. She had a pressure reducing device for her chair and bed. B. Resident interview and observation Resident #18 was interviewed on 3/24/21 at 4:00 p.m. She said she left dialysis early that day because her bottom hurt. She said it was hurting, even after lying in bed for a while. She said she was not offered any pain medications when she returned from dialysis. She said she rated her pain 3 out of 10 (on a scale of 0 - no pain to 10 - severe pain) at that time because she could lay down, but it was a 6 out of 10 when she was sitting up in the chair at dialysis. She said she could tolerate a pain level of 3 out of 10 but not much more. She said she did not know if she had orders for any pain medications other than Tylenol and it did not work for the pain to her bottom. Observations revealed an approximate two centimeter (cm) diameter, nonblanchable, dark pink, stage 1 pressure area to the resident's coccyx surrounded by approximately 4 cm diameter lighter pink skin that was blanchable. No open areas were seen. The resident was lying on an air mattress and had a pressure relieving cushion in her wheelchair. C. Record review Coccyx and sacral to describe the location of the resident's pain will be used interchangeably throughout the citation. According to the March 2021 CPO, the resident had the following orders for pain management: -Tylenol Extra Strength 500 milligrams (mg) give one tablet by mouth every eight hours as needed for pain, ordered 10/21/2020; and -Observe pain every shift. If pain present, complete pain flow sheet and treat trying non-pharmacological interventions prior to medication if appropriate and document in the progress notes, ordered 10/22/2020. The 10/28/2020 pain evaluation revealed the resident complained of generalized pain, treated with non-medication interventions. It indicated the resident had no complaints of pain during the assessment period and no further evaluation was needed. -Review of the record on 3/25/21 revealed the resident did not have another pain evaluation completed, even after the resident started having new complaints of pain (see below). Review of the Dialysis Communication Records from 2/1/21 until 3/25/21 revealed the resident's dialysis session (dialysis sessions are usually four to six hours long) was terminated (termed) early due to the resident complaining of pain on the following days: 2/6/21 - termed one hour and 40 minutes early due to pain; (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	2/9/21 - termed treatment early due to pain; 2/11/21 - Tylenol given at dialysis; 2/16/21 - resident signed out against medical advice (AMA); 2/18/21- termed early per her request; 2/20/21 - termed treatment two and a half hours early due to pain; 2/25/21 - termed early due to pain; 2/27/21 - resident chose to end treatment 100 minutes early; 3/2/21 - resident only had 50 minutes of treatment done; 3/4/21 - resident termed early for discomfort and signed AMA; 3/9/21 - termed 100 minutes early due to pain; 3/13/21 - resident complained of pain in her coccyx immediately going into the dialysis chair. She was repositioned with no relief and refused Tylenol. She stated she was in too much pain to treat. 3/16/21- termed three hours early per resident request due to her bottom hurting despite repositioning. AMA signed; 3/18/21 - termed early due to pain; 3/20/21 - termed early due to pain; and 3/25/21 - termed early due to pain. A 2/5/21 physician progress note revealed the dialysis staff was getting on the resident about early termination due to complaints of pain to the dialysis staff, however the resident stated to the facility she was incontinent during the dialysis session due to diarrhea and had to be changed. It indicated the resident started routine Imodium on dialysis days in January (2021) with improvement in compliance. -No new orders were implemented regarding the resident's complaint of pain during dialysis. Review of the progress notes on 3/26/21 revealed the facility frequently documented the resident returned from dialysis early due to pain but did not document any interventions to address the resident's pain. A 2/20/21 nursing progress note revealed the resident terminated dialysis treatment two and a half hours early related to pain and the physician was notified. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A 2/27/21 nursing progress note revealed the resident returned from dialysis after she chose to end treatment 100 minutes early and the physician was notified. A 3/4/21 nursing progress note revealed the resident returned from dialysis after requesting to stop treatment early due to being uncomfortable and she signed AMA. It indicated the resident denied any pain or discomfort when she returned to the facility. A 3/13/21 nursing progress note revealed the resident returned from dialysis early after dialysis reported the resident had a complaint of pain in the coccyx area immediately after going into the dialysis chair. It indicated the resident had no complaints of pain after returning to the facility and being put back into bed. A 3/20/21 nursing progress note revealed the resident returned from dialysis early with a complaint of pain. Another 3/20/21 nursing progress note revealed the resident's primary physician made rounds via telehealth and all concerns were addressed. (See physician progress note below). A 3/20/21 physician progress note revealed the resident was having sacral pain during dialysis treatment despite changes to position and cushioning. It indicated the resident would be evaluated for optimal pain relief. The plan was to use Lidocaine in the wound bed. -Review of the record revealed this did not occur. A 3/23/21 nursing progress note revealed the resident complained of having more pain that day after returning from dialysis. An order was written by the physician on 3/24/21 at 4:15 p.m. that revealed on dialysis days, at least one hour prior to dialysis, Lidocaine 5% cream was to be applied to the sacral area and covered with a bordered foam dressing to cushion. The dressing was to be removed after the dialysis session on Tuesday, Thursday and Saturday due to sacral pain. -This order was not entered into the electronic medical record (EMR) until the following day, 3/25/21 at 4:41 p.m. so the resident did not get it done prior to going to dialysis on the morning of 3/25/21. A 3/25/21 nursing progress note revealed the resident got off dialysis early due to pain. The February 2021 MAR revealed the resident received Tylenol one time during the month, on 2/27/21 at 5:22 a.m., for neck pain rated 4 out of 10 and the effectiveness was documented as being unknown due to the resident being at dialysis. The February 2021 MAR also revealed the observation of pain was being done twice a day at 6:00 a.m. and 6:00 p.m. The resident's pain was documented 0 out of 10 (no pain) for the entire month except on 2/19/21, when the resident had a pain rating of 2 out of 10. The March 2021 MAR revealed the observation of pain, done twice a day from 3/1 until 3/24/21, documented the resident rated her pain 2-4 out of 10, 21 times, showing an increase in the resident's complaint of pain. The MAR revealed the resident did not receive any Tylenol. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the record revealed the resident was not offered any non-pharmacological pain interventions. The resident did not have a care plan to address her complaints of pain. III. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 3/24/21 at 4:25 p.m. She said the resident usually spent most of her time in bed when she was not at dialysis. She said she would get up in her wheelchair for short periods of time and usually did not complain of any pain. The registered nurse (RN) at the dialysis center was interviewed on 3/26/21 at 11:45 a.m. She said the resident received dialysis three times a week for four to six hours at a time. She said when the resident arrived she was transferred into the dialysis chair with the use of a full weight bearing lift. She said the resident had frequently requested to stop her dialysis session early due to complaints of pain to her coccyx. She said she thought it was possible the resident had a pressure ulcer on her coccyx but she was unsure. She said they frequently repositioned the resident but it usually did not help. She said the resident was offered Tylenol but did not want to take it because she had a hard time swallowing pills and the resident said it did not work anyway. She said the dialysis center communicated this information with the facility in hopes that maybe they would be able to pre-medicate her before dialysis, or provide some other type of intervention to assist with the resident's pain control. Licensed practical nurse (LPN) #1 was interviewed on 3/26/21 at 10:31 a.m. She said Resident #18 stayed in bed most of the time when she was not at dialysis. She said she would sit up in her wheelchair for short periods of time and did not complain of pain when she was up. She said the resident was frequently sent back from dialysis early due to complaints of pain, but once she got here she never complained of pain so she did not give her anything. She said the physician had seen her last weekend after her dialysis appointment and did not write any orders but the physician was contacted again two days ago (during the survey) and new orders were obtained for lidocaine to be applied before the resident went to dialysis. Certified medication aide (CMA) #1 was interviewed on 3/29/21 at 12:15 p.m. She said she always asked the residents if they were in any pain whenever she had any contact with them. She said if the resident was non-verbal, she tried to use the PAINAD (Pain Assessment in Advanced Dementia) scale to determine if they were having any pain. She said she would offer a non-pharmacological intervention first and if it was not effective, then she would give the resident pain medication. She said if the pain medication was ineffective, she would notify the nurse so a request could be made from the physician for something stronger or a different alternative. She said Resident #18 usually did not complain of pain when she was lying in bed. She said it seemed like the resident only had complaints of pain when she was at dialysis. She said she did not give the resident any pain medication because she did not request it. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 3/29/21 at 6:24 p.m. She said pain evaluations were done upon admission, quarterly and with any change in the residents' complaints of pain. She said a resident's acceptable level of pain should be part of that evaluation. She said the nurse should offer non-pharmacological interventions first then pain medication. If the interventions and medication were ineffective, the physician should be notified. She said the physician was addressing the resident's complaint of pain during dialysis. She said she was not aware the resident was not completing her dialysis sessions due to pain until this past week (during survey).

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and staff interviews, the facility failed to ensure one (#16) out of two residents reviewed for dialysis care, out of 29 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to: -Check fistula (a connection that's made between an artery and vein for dialysis access) on the left arm for bruit and thrill (an audible vascular sound associated with turbulent blood flow and occasionally palpated) every shift since Resident #16 was admitted on [DATE]; -Have an order not to take blood pressure on the left arm with dialysis fistula/shunt; -Monitor peritoneal dialysis (PD) port from admission 1/13/21 until 2/5/21; and, -Update the dialysis care plan with PD port care. Findings include: 1. Facility policy and procedure The Hemodialysis, Care of Residents policy and procedure, last revised August 2017, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: Review and ensure orders upon admission are received for follow-up dialysis center appointments, shunt care, diet and fluid restrictions. -Do not take blood pressure on the arm with dialysis shunt. -Provide routine arteriovenous access (AV) shunt or hemodialysis catheter care and monitor in accordance with physician's orders and facility policies and procedures. -Check vital signs every shift for the 24 hours post-dialysis or in accordance with physician's orders. -Upon return from dialysis, the nurse will check for thrill and bruit of the AV shunt twice during the first eight hours after the resident's return. -The nurse will assess the condition of the access site for bleeding, redness, tenderness or swelling. If any of these conditions are noted, contact physician and document findings. 2. Resident #16 a. Resident's status (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16, age under 60, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included acquired absence of left leg, diabetes type two, end stage renal disease, and dependence on dialysis. The 1/18/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score 15 out of 15. The resident required extensive two person physical assistance for bed mobility, transfers, dressing, toileting and personal hygiene. He was occasionally incontinent of the bowel and bladder. Resident was receiving dialysis services three times a week. b. Resident interview Resident #16 was interviewed on 3/23/21. He said he was receiving dialysis services outside the facility three times a week. He said he had two ports, an abdominal port that was not used, and fistula on his left arm that was used for dialysis every other day. He said both ports were monitored by dialysis staff every time he visited the dialysis center. He said nurses at the facility did not look at the fistula or other port. c. Record review The dialysis care plan initiated on 1/18/21 read resident was receiving dialysis services. Interventions included checking for thrill and bruit twice per shift every day, maintain communication with the dialysis center, to monitor vital signs every shift for 24 hours post-dialysis, and to notify the physician about significant changes. The care plan did not mention that the resident had a second port on his abdomen. Review of the March 2021 CPO revealed there were no orders to monitor Resident #16's fistula on the left arm, additionally there was no order to not take the blood pressure in the residents left arm. According to the medical administration record (MAR) for March 2021, resident had following order: -Visually ensure every shift that white cap is on the resident's PD port. If it is not, replace it with white cap immediately and notify the nurse at the dialysis center. The order was initiated on 2/5/2021, a month after the resident was admitted . There was no order on the MAR to monitor the fistula on the left arm for bruit and thrill and no order not to take blood pressure in the resident's left arm. Progress notes reviewed from admission to survey (3/23/21 to 3/29/21) revealed only two notes by nursing staff, one on the day of the admission 1/13/21 and a second on 3/25/21 during survey to monitor dialysis fistula on the left arm. d. Staff interviews (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #4 was interviewed on 3/29/21 at 12:30 p.m. She said she was a primary nurse for Resident #16. She said she was a traveling nurse but was familiar with the resident and had worked with him for the last several weeks. She said the resident was receiving dialysis three times a week and she was monitoring his fistula side every time he returned from the clinic. She did not document that anywhere but was monitoring it daily. Registered nurse (RN) #2 was interviewed 3/29/21 around 12:40 p.m. He said he was a charge nurse for the day shift. He said the resident had two ports for dialysis. The abdominal port was not used and only the left forearm port was used. He said nurses monitored both ports every shift. He said the order to monitor the ports should be on the MAR and on the care plan. He said he was not aware the fistula monitoring was not on the MAR. The director of nursing (DON) was interviewed on 3/29/21 around 2:30 p.m. She said she did not know why the order to monitor both ports was not initiated on admission. She said both dialysis ports must be monitored every shift to ensure proper functioning of the fistula, and to assess for signs and symptoms of infection. In addition, all dialysis care for boths ports should be documented on the care plan. She said she will review current orders and the care plan and correct it immediately.

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Sterling Health and Rehabilitation Center	1420 S 3rd Ave Sterling, CO 80751

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on record review and interviews, the facility failed to ensure two (#142 and #14) of five residents reviewed for physician visits out of 29 sample residents, were seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Specifically, the facility failed to ensure: -Resident #142 was seen by the physician every 60 days; and, -Resident #14 was seen by the physician every 30 days for the first 90 days after admission. Findings include: I. Resident #142 A. Resident status Resident #142, age 74, was admitted [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), cerebrovascular disease and convulsions. The 12/30/2020 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 of one to two staff members for his activities of daily living (ADLs) except he was independent with set up assistance only for eating. B. Record review Review of the resident's record on 3/28/21 revealed the resident had not had a visit done by any provider, physician, physician assistant or nurse practitioner since 12/1/2020. II. Resident #14 A. Resident status Resident #14, over the age of 80, was admitted [DATE]. According to the March 2021 CPO, diagnoses included osteoporosis, hypertension and hypothyroidism. The 1/18/21 MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 13 out of 15.The resident required limited to extensive assistance of one staff member for her ADLs. B. Record review Review of the resident's record on 3/28/21 revealed the resident had not had a visit done by any provider, physician, physician assistant or nurse practitioner since 1/27/21. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Staff interviews The health information coordinator (HIC) was interviewed on 3/28/21 at 3:43 p.m. He said he was responsible for keeping track of the physician visits and ensuring they were done timely. He said it had been more difficult because of the COVID-19 restrictions and the start of telehealth. The corporate consultant (CC) and the director of nursing (DON) were interviewed on 3/29/21 at 6:24 p.m. They said it was medical records responsibility to track physician visits to ensure they were being done according to regulation. They said it had been an ongoing battle with the physicians to get them to do their visits. They said the medical director was aware and had spoken with the other physicians and it had been brought up to the quality assurance performance improvement (QAPI) committee.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on interviews, record review and observations, the facility failed to provide sufficient nursing staff to ensure the resident's received the care and services they required in maintaining their comprehensive plans of care, to achieve and maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to consistently provide adequate nurse staff, which considered the acuity and diagnoses of the facility's resident population, resident census and daily care. As a result of inadequate staffing, the facility failed to provide assistance with activities of daily living (ADLs), ensure residents were provided meals in a timely manner, ensure fall interventions were in place to prevent resident injury and provide an effective restorative nursing program. Cross-reference F677: the facility failed to provide assistance with activities of daily living (ADL) for dependent residents. Cross-reference F688: the facility failed to have an effective restorative nursing program. Cross-reference F689: the facility failed to ensure resident safety while smoking, failed to implement interventions to prevent falls with injuries and failed to have an assessment completed by a registered nurse (RN) after residents fell . Cross-reference F692: the facility failed to ensure residents were provided sufficient fluids to maintain hydration status. Cross- reference F804: the facility failed to provide palatable food. I. Resident census and condition The Census and Conditions of Residents form, provided by the facility and dated [DATE], revealed 42 residents resided at the facility. Care needs of the residents were documented as follows: -15 residents were dependent on staff for bathing and 22 residents needed the assistance of one or two staff to bathe; -37 residents needed the assistance of one or two staff to dress; -One resident was dependent on transferring and 31 residents needed the assistance of one or two staff to transfer; -One resident was dependent on toilet use and 35 residents needed the assistance of one or two staff for toilet use; -18 residents needed the assistance of one or two staff to eat; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-29 residents were occasionally or frequently incontinent of bladder; -22 residents were occasionally or frequently incontinent of bowel; -One resident had an intellectual and/or developmental disability; -12 residents had a diagnosis of dementia; -14 residents had behavioral healthcare needs; -10 residents had psychiatric diagnosis; -27 residents were in their wheelchair all or most of the time; -42 residents received preventative skin care; -Six residents were receiving respiratory treatment; -One resident received ostomy care; -Six residents had contractures; and, -22 residents were on a pain management program. II. Resident interviews Residents, who per facility and assessment were interviewable, made the following statements when asked if the facility provided sufficient nursing staffing. Resident #30 was interviewed on [DATE] at 11:55 a.m. He said the staffing in the building had been bad for as long as he could remember. He said it took staff at least 20 minutes to answer his call light. He said he had gotten used to waiting for staff, and tried to put his light on before he really needed anything. Resident #10 was interviewed on [DATE] at 12:05 p.m. She said she was a two person transfer, meaning it required two staff members to assist her with ADLs (activities of daily living). The resident said the least amount of time she waited for staff on a daily basis was 20 minutes. The resident said she did not like it, but she had adjusted to it. The resident said she had not told management about her concerns, because they already knew that staffing was a problem in the building. Resident #10 was interviewed on [DATE] at 3:45 p.m. She stated she had to wait a long time for her call light to be answered at times. Resident #37 was interviewed on [DATE] at 2:02 p.m. She said when she would ask for help it would take so long for them to come into the room. Resident #12 was interviewed on [DATE] 3:20 p.m. She said she often has to wait 10 minutes but usually around 30 minutes for her call light to be answered. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #34 was interviewed on [DATE] at 2:40 p.m. She said she would like to have her shower at least twice a week and have the hair shaved off her chin at least every other day but she did not think the staff had enough time or help for her to be able to get it done that often. Resident #35 was interviewed on [DATE] at 2:40 p.m. She said she needed assistance form the staff with bathing and with removing her facial hair but she often did not get it because they were short handed and did not have the time. III. Staff interviews Certified nurse aide (CNA) #4 was interviewed on [DATE] at 11:50 a.m. She said the staffing in the building had been really hit or miss. She said today ([DATE]) she was not scheduled to work, but accidentally showed up for work. She said she was the only person working on her hall, which had 11 residents. She said the building was frequently short staffed, especially CNAs. She said it was difficult to get everything done during her shift, and often she would have to delay showers for residents and try to do them the following day. The CNA said when she had to assist a resident that was a two person transfer, meaning two staff members were needed, she would have to find a nurse or another CNA to assist her, but that would often take at least 10 minutes to locate assistance and get back to the resident. Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 10:38 a.m. She said she was the only nurse for the back hallway which had 32 residents. She said it was hard to get all of her daily nursing tasks, done plus assist the CNAs as needed. She said there had been an increase in falls in the facility, mostly on the evening and night shift. The LPN said the residents had been isolated in their room due to a recent COVID-19 outbreak, and there were not enough nursing staff members available to make sure all of the residents were safe. The nursing home administrator (NHA), the director of nursing (DON) and the corporate consultant (CC) were interviewed on [DATE] at 3:44 p.m. They said they had been working on their staffing problems since 2019, trying to hire more staff by offering incentives and bonuses. They said 30% of the certified nurse aides (CNAs) working were agency staff. They said they had two full time staff interested in being restorative aides and would be providing restorative services only and would not be pulled to the floor to work as CNAs. CNA #1 was interviewed on [DATE] at 1:22 p.m. She said staffing in the facility was really bad and the management was talking about decreasing it even more. She said she had a hard time getting all her tasks done already and it would only get worse if they decreased the staffing even more. She said tasks such as showers, passing water, changing bed linens were often not done because they did not have enough time or staff. She said fresh water should be passed to each resident at least once a shift but they did not always have time to get it done. She said the CNAs were responsible for passing meal trays also and sometimes the residents had to wait to get their food if the staff was providing personal care to other residents. She said sometimes it felt like all she could do was try to keep up with answering the call lights. CNA #2 was interviewed on [DATE] at 12:09 p.m. She said the residents were scheduled to receive showers two to three times a week but if they were short handed, they did not always get done. She said fresh water should be passed one to two times a shift and as needed but this also did not always get done if they did not have enough staff. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Certified medication aide (CMA) #1 was interviewed on [DATE] at 12:15 p.m. She said she was responsible for passing all the resident's medications but was often pulled to assist the CNAs with resident's personal care because they did not have enough help. Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:30 p.m. She said it was very difficult to get all tasks done timely if they did not have enough staff on the floor. She said showers were often skipped and other tasks, such as linen changes or passing ice, often did not get done either. She said the CNAs did the best they could with what they had. She said if a resident fell , she would call the director of nursing (DON) and give her the details on the phone and the DON would determine if further assessment was needed. The minimum data set (MDS) coordinator was interviewed on [DATE] at 1:11 p.m. She said several of the managers had multiple responsibilities in the facility. She said, for example, the staff development coordinator (SDC) was also the infection control nurse, a unit manager, the restorative nurse and had also been the RN coverage on nights for the last couple of weeks. She said they had been without a social worker on and off for several months and the nursing department was covering a lot of the social worker duties, such as behavior tracking and monitoring, ensuring consents for restraints and psychoactive medications were obtained, scheduling and following through with ancillary services. She said with the multiple tasks each person was responsible for, some things were falling through the cracks and getting missed. The CC, NHA and DON were interviewed again on [DATE] at 4:06 p.m. They said their RN waiver had expired the previous month so the DON and the SDC, being the only RNs in the building, were covering all the RN shifts during the day and night. They said if there was a fall in the building, they would come in to do the assessment. They said they just recently hired two traveling RNs to cover all the shifts and this would allow the DON and SDC to focus more on their responsibilities.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and staff interviews, the facility failed to provide the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being for one (#7) of three residents reviewed for mood and behavior of 29 sampled residents. Specifically, the facility failed to follow-up on a physician order for a mental health screening to determine if Resident #7 would have benefitted from mental health services following an inpatient psychiatric hospitalization . Findings include: I. Facility policy and procedure The Behavioral Management System policy and procedure, last revised March 2018, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: Residents receive behavioral health care and services, including those residents diagnosed with mental disorder or psychosocial adjustment difficulty, to attain or maintain their highest practicable physical, mental, and psychosocial well-being in accordance with the resident's comprehensive assessment and care plan. II. Resident status Resident #7, under the age of 60, was admitted on [DATE]. According to the Mach 2021 computerized physician orders (CPO), diagnoses included fibromyalgia, anxiety disorder, altered mental status, major depressive disorder, obsessive-compulsive disorder and insomnia. The 1/1/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief mental status (BIMS) score of nine out of 15. She did not have any rejections of care or behaviors. The resident wandered one to three days. She required two person assistance with bed mobility, transfering, walking, toilet use, and personal hygiene. She required one person physical assistance with bed mobility, walking in her room and in the corridor, dressing, toilet use and personal hygiene, she was independent with eating. III. Record review A 12/16/2020 physician order documented the following: (Name of behavioral health outside provider) may provide psychological services. Please schedule patient for intake eval/treat(ment) due to recent inpatient psych hospitalization at (name of facility). The 12/28/2020 Initial Social Services Assessment document the following: (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Name of resident's husband) was unable to take care of the physical, mental, and emotional needs of his wife. She requires supervision with almost all ADLs (activities of daily living) as well and for med (medication) management. (Name of resident's husband) reports that he feels the needs of Resident #7 has and the care that she needs for her mental and emotional state are way more that he can handle. He reports that Resident #7 needs LTC (long term care). A 3/29/21 review of the resident's medical revealed no additional documentation regarding behavioral health services being offered to the resident, including the physician ordered behavioral health consultation. VI. Staff interviews The director of nursing (DON) was interviewed on 3/29/21 at 9:20 a.m. She said at the time of the physician order (December 2020), the outside behavioral health facility was not seeing residents due to the pandemic. The DON said starting January 2021 they began seeing residents. The DON said Resident #7 behavioral health consultation was never set-up and she was unsure why. The DON said the resident was currently doing much better and the facility had notified the physician regarding not completing the physician order. The DON said the physician felt the resident was now stable, and would reassess her need for a psychiatric consult. The social work consultant (SWC) was interviewed on 3/29/21 at 4:04 p.m. She she had reviewed the resident's medical record and confirmed the physician order for Resident #7 to have a behavioral health consultation. The SWC said the resident should have been evaluated as soon as possible, even if that initial needed to be completed via telehealth due to the COVID-19 outbreak in the facility at the time of the physician order. The SWC said she had spoken with Resident #7 and she was doing much better than when she was admitted in December of 2020, but that it would still be important to follow-up with the outside behavioral health provider to ensure the resident did not need any additional services.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and interviews, the facility failed to ensure three (#25, #16 and #15) of five residents reviewed out of 29 sample residents were as free from unnecessary medications as possible. Specifically the facility failed to accurately track behaviors, and failed to document interdisciplinary team (IDT) meetings regarding discussions about the continued needed for psychotropic medications for Resident #25, #16, and #15. Findings include: I. Facility policy and procedure The Psychotropic Management System policy and procedure, last revised November 2017, was provided by the corporate consultant CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: The licensed nurse will institute the appropriate behavior monitoring form associated with the medication category via the behavior care record and the side effects record to: -Identify and document objective and quantifiable specific behaviors; -Document the number of episodes of behaviors; -Document the interventions and outcomes; and -Document the presence or absence of side effects and interventions implemented to address the identified side effects. The IDT (interdisciplinary team) will individualize the resident's care plan and address: -The reason for the medication; -Opportunities for non-pharmacological interventions; -The goal for reducing or eliminating the medication, if not contraindicated; -The resident's goals and preferences; and -The expected outcomes. Monitoring and evaluation of the resident for the potential reduction psychotropic medication will be reviewed at the resident's quarterly care plan meeting. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Behavior monitoring A. Resident #25 1. Resident status Resident #25, age of 87, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included bipolar disorder, essential hypertension, need for assistance with personal care, and muscle weakness. The 1/1/21 minimum data set (MDS) assessment revealed the resident was cognitive intact with a brief mental status (BIMS) score of 14 out of 15. She did not have any rejections of care or behaviors. She required one person assistance with bed mobility, transfering, walking, toilet use, and personal hygiene. She required one person physical assistance with bed mobility, locomotion on and of the unit, and personal hygiene. She required set-up assistance with transfers, walking, eating, and toilet use. She was coded as taking antipsychotic and antianxiety medication for six days. 2. Record review The care plan, initiated 1/31/19, revealed the resident used antipsychotic and anti-anxiety medications related to bipolar disorder. Interventions included: -Discussion with physician and family regarding the ongoing need for the use of the medication. -Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. -Observe and record occurrence of targeted behavior symptoms and document per facility protocol. The March 2021 CPO revealed the following orders: Lithium carbonate capsule 150 MG (milligrams) give one capsule by mouth three times a day related to bipolar disorder. Order date 3/2/21 Lorazepam concentrate 2 MG/ML (milligrams per milliliter) give 0.125 ML by mouth two times a day related to bipolar disorder. Order date 3/4/21 Observation: Antipsychotic Medication (Lithium) - Observe for behavior: hallucinations. Document: Y (yes) if resident is free of behaviors. N (no) if the resident is not free of behaviors. If no document behaviors in the progress notes- ordered 3/22/2020 Observation: Anti-Anxiety Medication: Observe behavior: pacing, air hunger. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Document: Y (yes) if resident is free of side effects. N (no) if the resident is not free of side effects. If no document behaviors in the progress notes- ordered (2/9/21) A review of the residents medication administration record (MAR) from January 2021 through March 2021 revealed the facility nursing staff was documenting the resident's behavior with a checkmark. It was unclear if the check mark indicated the resident was experiencing the behavior or was free from the behavior. 3. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/29/21 at 11:15 a.m. She said every resident in the facility had the same behaviors listed on the CNA tracking sheets. She said it made it difficult to know if a resident had specific behaviors CNAs should be monitoring. The CNA said she was providing care for Resident #25 today (3/29/21) and she was unsure of all the behaviors she should be monitoring for the resident. Licensed practical nurse (LPN) #1 was interviewed on 3/29/21 at 11:22 a.m. She said the behavior tracking on the MAR was not very clear as to if a resident was or was not having a specific behavior. The LPN said when she was working she would create her own list of specific behaviors for each resident and would use it to monitor if they were having behaviors. The LPN said she would chart those behaviors in progress notes if they were occurring. The LPN said she was not aware of any behaviors Resident #25 was having. The social work consultant (SWC) was interviewed on 3/29/21 at 4:04 p.m. She said for each antipsychotic medication there should be specific behaviors for the staff should monitor. The SWC reviewed Resident #25 MAR and stated it was unclear if the resident was having any of the behaviors or not. The SWC said during the pandemic many of the providers, including herself, had been working off-site and accessing medical records off-site. She said it made it difficult to review behaviors and the overall well being of the residents when the documentation was not clear. The SWC said behavior tracking should be consistent among all disciplines, and all staff should be aware of resident specific behaviors. B. Resident #16 1. Resident status Resident #16, age under 50, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included acquired absence of left leg, diabetes type two, end stage renal disease, and dependence on dialysis. The 1/18/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score 15 out of 15. The resident required extensive two person physical assistance for bed mobility, transfers, dressing, toileting and personal hygiene. He was coded as taking antidepressant medication. 2. Record review (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan, initiated 1/25/21, revealed the resident used antidepressant medication related to depression. Interventions included: -Administer antidepressant medications as ordered by a physician. -Observe/document side effects and effectiveness every shift. -Observe/document/report adverse reactions to antidepressant therapy. The March 2021 CPO revealed the following orders: Escitalopram Oxalate tablet, give 20 mg by mouth one time a day every Monday, Wednesday, Friday, and Sunday for depression. Order date 2/24/2021 Observation: Antidepressant medication: Escitalopram Observe for behavior: agitation. Document: Y (yes) if resident is free of behaviors. N (no) if the resident is not free of behaviors. If no document behaviors in the progress notes- ordered 2/9/21. A review of the residents medication administration record (MAR) from January 2021 through March 2021 revealed the facility nursing staff was documenting the resident's behavior with a checkmark. It was unclear if the check mark indicated the resident was experiencing the behavior or was free from the behavior. 3. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/29/21 at 12:15 p.m. She said Resident #16 did not have any behaviors. She said he was alert and oriented, able to tell what he needs and she never observed any behaviors. She was not sure what behaviors she was supposed to watch for. Licensed practical nurse (LPN) #5 was interviewed on 3/29/21 at 1:22 p.m. She said Resident #16 did not have any behaviors. She said he was monitored for high risk for fall and use of call light, but not any other behaviors. She said usually everything they needed to monitor the resident for was on the MAR or treatment administration record (TAR) and they were monitoring him for side effects of medications that he was on. C. Resident #15 1. Resident Status Resident #15, age 81, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included cerebral infarction, encephalopathy, kidney failure, heart failure, hypertension, abnormal weight and mobility. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 1/5/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score 13 out of 15. The resident required limited assistance of one person and physical assistance for bed mobility, transfers, dressing, toileting and personal hygiene. The behavior section indicated the resident did not resist care, and had no hallucinations, delusions or other types of behaviors. She was coded as taking antipsychotic medication for seven days. 2. Record review The care plan, initiated 1/4//21, revealed the resident used antipsychotic medication related to anxiety and agitation. Interventions included: -Administer antipsychotic medications as ordered by a physician. -Observe/document side effects and effectiveness every shift. -Observe/record occurrence of for target behavior symptoms (pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. The March 2021 CPO revealed the following orders: Seroquel Tablet 25 mg (Quetiapine Fumarate) give 0.5 tablet by mouth two times a day for anxiety/agitation 12.5mg twice a day -order date 1/18/2021 Observation: Antipsychotic medication: Seroquel Observe for behavior: exit seeking, verbal aggression, delusions. Document: Y (yes) if resident is free of behaviors. N (no) if the resident is not free of behaviors. If no document behaviors in the progress notes- ordered 1/18/21. A review of the residents medication administration record (MAR) from January 2021 through March 2021 revealed the facility nursing staff was documenting the resident's behavior with a checkmark. It was unclear if the check mark indicated the resident was experiencing the behavior or was free from the behavior. 3. Staff interviews CNA #4 was interviewed on 3/29/21 at 2:15 p.m. She said Resident #15 did not have any behaviors. She said when the resident initially came, she was having an exit seeking behaviors, and was talking to the ghosts. Now, she did not have any behaviors, always used her call light and was always asking for anything she needed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #5 was interviewed on 3/29/21 at 1:22 p.m. She said Resident #15 was alert and oriented, she did not wander around and always asked if she could go to the library. She was always cooperative with care, used her call light and did not display any behaviors. She said Resident #15 was not observed for any behaviors, they just made sure they know where she was due to the history of wandering behaviors. III. Failure to have documentation of IDT (interdisciplinary team) reviews for resident on psychotropic medications A. Resident #25 Record review A review of the resident's medical record revealed the resident had been reviewed by the psychotropic IDT on the following dates regarding her use of psychotropic medications (see physician orders above): - 4/23/2020 IDT review of psychotropic medications - 2/13/2020 IDT review of psychotropic medications No additional IDT psychotropic team notes were noted in the residents medical record. B. Resident #16 Record review A review of the resident's medical record revealed no IDT psychotropic team notes. C. Resident #15 Record review A review of the resident's medical record revealed no IDT psychotropic team notes. D. Staff interviews The SWC was interviewed on 3/29/21 at 9:13 a.m. She said she was unsure if the facility had been having monthly psychotropic IDT meetings. She said she was unable to locate documentation regarding the meeting, including which residents had been reviewed, and if there were any recommendations from the meeting. The SWC was interviewed a second time on 3/29/21 at 5:50 p.m. She said she had contacted the pharmacist who participated in the IDT meeting, and she had notes she would provide to the facility. The SWC said that was a good place to start but she would review all of the residents currently taking psychotropic medications and ensure they were reviewed at the next psychotropic IDT meeting. The SWC said moving forward a note would be created in the resident's electronic medical record so all providers had access to that information. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 3/29/21 at 6:08 p.m. She said she participated in the psychotropic IDT meeting, which was held monthly following the facility's QAPI (quality assurance performance improvement) meeting. The DON said she was unsure who in the facility was documenting the meeting, but moving forward the notes of the meeting would be documented in the resident's medical record. 37166

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observations and interviews, the facility failed to ensure the medication error rate was not greater than five percent. Specifically, nursing staff failed to prime the insulin needle prior to administering an insulin injection, resulting in an eight percent medication error rate. Findings include: I. Resident #16 status Resident #16, age under 50, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included acquired absence of left leg, diabetes type two, end stage renal disease, and dependence on dialysis. A. Record review According to the medical administration record (MAR) for March 2021,the resident was scheduled to receive the following medications: -Novolog flex pen solution 100 Units per milliliter (U/ml) per sliding scale. B. Observations On 3/24/21 at 5:10 p.m., licensed practical nurse (LPN) #2 was observed during medication administration. She prepared to administer five units of insulin to the resident. She turned the dial on the flex pen to five units, attached the needle and administered the insulin. The above observations were reported to the director of nursing 3/24/21 around 5:15 p.m. LPN #2 was interviewed 3/24/21 around 5:20 p.m. She said priming the needle meant to check the needle for any defects. She said she did not recall the last time she received education about insulin pens. The director of nursing (DON) was interviewed on 3/24/21 around 5:30 p.m. She said the insulin needle has to be primed prior to an insulin injection to ensure that the resident received the appropriate amount of insulin. She said she would provide immediate education to all nurses on the floor and for the incoming shift as well, and she would contact the resident's physician to report the insulin administration error. II. Resident #5 status Resident #5, age 68, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included major depressive disorder and type two diabetes. (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A. Record review According to the medical administration record (MAR) for March 2021, the resident was scheduled to receive the following medications: -Novolog flex pen solution 100 Units per milliliter (U/ml) per sliding scale. B. Observations On 3/28/21 at 6:20 p.m. licensed practical nurse (LPN) #4 was observed during medication administration. She prepared to administer ten units of insulin to the resident. She turned the dial on the flex pen to two units, squirted insulin into a trash bin, attached the needle to the flex pen, set the dial to ten units, and administered the insulin. (Cross-reference F760, significant medication errors.) C. Staff interviews LPN #4 was interviewed 3/28/21 around 6:30 p.m. She said she was a traveling nurse. She said she received the education on priming insulin pens before her shift. She said what she remembered from the training was that insulin pen needed to be primed and this is what she did when she set the pen to two units and squirted insulin into the trash bin. She did not recall anything about priming the needle. The DON was interviewed on 3/28/21 around 6:40 p.m. She said she provided education to all nursing staff. She demonstrated written material that was presented to nurses on proper insulin pen priming and a list of nurses who completed the education. She said she would contact the resident's physician and report the insulin administration error, and she would re-educate the nurse and implement a return demonstration to make sure staff understood the instructions correctly. III. Facility follow-up On 3/29/21 around 8:30 a.m. the DON provided logs of staff education and written material that was presented to staff. All nurses that were on the schedule received education on proper insulin administration with return demonstrations.

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observations and interviews, the facility failed to keep two (#5 and #16) of four residents on one of two hallways free of any significant medication errors. Specifically, the facility failed to prime the flex pen insulin needles prior to administering insulin injections for Residents #5 and #16. Findings include: I. Facility standards The Medication Administration policy, revised June 2008, was provided by the clinical nurse consultant (CNC) on 1/14/2020 at 10:45 a.m. It read, in pertinent part: Resident medications are administered in an accurate, safe, timely, and sanitary manner. II. Manufacturer ' s recommendations The Novolog flexpen package insert (2020) read in pertinent part: Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: -Turn the dose selector to select 2 units. -Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. - Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. -A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. -If you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen. -A small air bubble may remain at the needle tip, but it will not be injected. -Check and make sure that the dose selector is set at 0. -Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose. III. Resident #16 status (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 - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16, age under 50, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included acquired absence of left leg, diabetes type two, end stage renal disease, and dependence on dialysis. A. Record review According to the medical administration record (MAR) for March 2021, the resident was scheduled to receive the following medications: -Novolog flex pen solution 100 Units per milliliter (U/ml) per sliding scale. B. Observations On 3/24/21 at 5:10 p.m. licensed practical nurse (LPN) #2 was observed during medication administration. She prepared to administer five units of insulin to the resident. She turned the dial on the flex pen to five units, attached the needle and administered the insulin. The above observations were reported to the director of nursing on 3/24/21 around 5:15 p.m. LPN #2 was interviewed 3/24/21 around 5:20 p.m. She said priming the needle meant to check the needle for any defects. She said she did not recall the last time she received education about insulin pens. The director of nursing (DON) was interviewed on 3/24/21 around 5:30 p.m. She said the insulin needle had to be primed prior to insulin injection to ensure that the resident received the appropriate amount of insulin. She said she would provide immediate education to all nurses on the floor and for oncoming shifts as well, and she would contact the resident's physician to report the inaccurate insulin administration. IV. Resident #5 status Resident #5, age 68, was admitted on [DATE]. According to the March 2021 CPO, diagnoses included major depressive disorder and type two diabetes. A. Record review According to the medical administration record (MAR) for March 2021, the resident was scheduled to receive the following medications: -Novolog flex pen solution 100 Units per milliliter (U/ml) per sliding scale. B. Observations On 3/28/21 at 6:20 p.m. licensed practical nurse (LPN) #4 was observed during medication administration. She prepared to administer ten units of insulin to the resident. She turned the dial on the flex pen to two units, squirted insulin into a trash bin, attached the needle to the flex pen, set the dial to ten units, and administered the insulin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interviews LPN #4 was interviewed 3/28/21 around 6:30 p.m. She said she was a traveling nurse. She said she received the education on priming insulin pens before her shift. She said what she remembered from the training was that the insulin pen needs to be primed and this is what she did when she set the pen to two units and squirted insulin into the trash bin. She did not recall anything about priming the needle. The DON was interviewed on 3/28/21 around 6:40 p.m. She said she provided education to all nursing staff. She demonstrated written material that was presented to nurses on proper insulin pen priming and a list of nurses who completed the education. She said she would contact the resident's physician and report the insulin administration, and she would re-educate the nurse and implement a return demonstration to make sure staff understood the instructions correctly. V. Facility follow-up On 3/29/21 around 8:30 a.m. the DON provided logs of staff education and written material that was presented to staff. All nurses that were on the schedule received education on proper insulin administration with return demonstrations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 39261 Based on observations and interviews, the facility failed to provide food that was palatable, attractive, and appetizing for residents on two out two hallways. Specifically, the facility failed to serve food at a palatable temperature. I. Facility policy and procedure The Food and Nutrition Services policy and procedure, last revised February 2017, was provided by the corporate consultant (CC) on 3/29/21 at 3:00 p.m. and read in pertinent part: The facility takes reasonable steps to ensure that: Each resident is served food that is: -Palatable, attractive, and at the proper temperature. II. Observations and staff interviews Lunch meal service observations on 3/23/21 on the middle hallway. The kitchen staff brought the metal holding cart to the unit, and then left the unit, one certified nurse aide (CNA) #4 was observed passing all the meal trays. -At 11:39 a.m. the metal holding cart with resident food trays was brought to the hallway. -At 11:47 a.m. the first lunch tray was pulled from the metal cart and served to a resident. -At 12:15 p.m. the last meal tray was served to a resident on the middle hallway. The total time from when the resident trays arrived on the unit until the last tray was passed was 36 minutes. CNA #4 was interviewed on 3/23/21 at 12:15 p.m. following passing all the resident meals. The CNA said she was the only CNA for the hallway, and she had to get the residents their drinks, and then pass the meal tray which was not a fast process. The CNA said she also set-up the tray for the residents offering them assistance cutting their meal. She said it took her at least 30 minutes to pass all the trays, and that was if she did not have to answer a call light. The CNA said there was not enough nursing staff in the building to help pass the meal trays. Cross-reference F725 for sufficient nurse staffing. Breakfast meal service observations on 3/29/21 on the back hallway, three CNAs were observed passing all the meal trays. -At 7:53 a.m. the metal holding cart with resident food trays was brought to the unit by the kitchen staff. -At 8:10 a.m. the last meal tray was served on the back hallway. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The total time from when the resident meal trays arrived on the unit until the last tray was passed was 17 minutes. CNA #2 was interviewed on 3/29/21 at 8:10 a.m. She said there were typically three CNAs who worked on the back hallway. She said the residents had been eating meals in their rooms for almost a year on and off because of the COVID-19 pandemic. The CNA said although there were three CNAs passing the trays, it still took them about 30 minutes to pass drinks and trays. III. Test tray evaluation A test tray was received on 3/29/21 at 8:11 a.m. It contained the following: -Pancakes and bacon. The temperature of the pancakes were 78 degrees, and the temperature of the bacon was 72 degrees. Both food items were bland and served too cold. IV. Administrative interview The corporate dietary manager (CDM) and dietary manager (DM) were interviewed on 3/29/21 at 11:00 a.m. The DM said it was difficult to ensure food was served quickly when it left the dining room since the nursing staff, specifically the CNAs, were responsible for passing the food trays. The CDM said he was sure the food would not be served at the correct temperature if it was sitting for 30 minutes prior to being served. The CDM said hot food should be served hot and cold food should be served cold. The DM said the temperatures of the test tray items would not have been palatable. The DM said the facility had been doing room trays for all of the residents for the past year due to the COVID-19 pandemic. The DM said the facility had a plan for reopening communal dining, and was in the process of beginning communal dining in the coming weeks. The DM said she would work with the facility managers to develop a plan for facility management to assist with the meal service.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37166 Based on observation, record review, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to provide sufficient leadership to address and/or avoid significant concerns. Findings include: I. Accidents Cross-reference F689 for being free from falls and accidents. The facility failed to create a safe environment for Resident #13, #15 and #16. II. Pain management Cross-reference F697 for pain management. The facility failed to keep Resident #18 free from pain. III. Staffing Cross-reference F725 for sufficient staffing. The facility failed to consistently provide adequate nurse staff, which considered the acuity and diagnoses of the facility's resident population, resident census and daily care. IV. Quality of care Cross-reference F684 for quality of care, F688 for restorative services and F712 for physician visits . The facility failed to complete skin assessments in a timely manner. In addition, the facility failed to provide assistance with activities of daily living (ADL) for dependent residents, to have an effective restorative nursing program, and to provide physician's visits to residents every 30 days for the first 90 days after admission. V. Quality assurance and performance improvement (QAPI) Cross-reference F865 for the quality assurance and performance improvement (QAPI) program and having a good faith attempt. The failicy failed to identify multiple concerns related to behavior tracking/psychotropic medication reviews, skin concerns, accident hazards and homelike and safety environmental concerns. VI. Leadership Interviews (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The nursing home administrator (NHA) and corporate consultant (CC) were interviewed on 3/29/21 at 5:00 p. m. The NHA said the facility was recovering from the recent outbreak of COVID-19. For the last several months, their primary focus was on infection prevention and dedicated less time to other ongoing concerns in order to contain the spread of COVID-19. She said the facility was in the process of getting back to normal since outbreak status was lifted a few days ago. The CRC said they were working with a lot of travelling nurses and agency staff due to inability to hire more local staff. In addition, the facility applied for a waiver for a registered nurse (RN) as it was difficult to find staff due to the location of the facility. The NHA and CRC said they would begin educating all of the staff, including management, to ensure that all of the staff were on the same page. The NHA said that COVID-19 had really caused problems in the facility and that has caused everything else in the building to struggle, but that the areas identified management would be working on.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37661 Based on observations, record review and interviews, the facility failed to ensure accuracy of medical records for one (#13) out of 29 sample residents. Specifically, the facility failed to ensure Resident #13's Medical Orders for Scope of Treatment (MOST) form was complete and signed by the physician. Findings include: I. Resident #13's status Resident #13, age under 65, was admitted on [DATE]. According to the March 2021 computerized physician orders (CPO), diagnoses included cerebral palsy. The 1/12/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required extensive assistance of one person for bed mobility and locomotion on the unit and the extensive assistance of two people for transfers, dressing, toilet use and personal hygiene. II. Record review The Medical Orders for Scope of Treatment (MOST) signed by the resident on 12/11/2020 was incomplete. It did not have a physician signature, physician address or phone number, or a date of signature by the physician. (Cross-reference F578, right to formulate advance directives.) III. Staff interviews The certified medication aide (CMA) was interviewed on 3/29/21 at 12:15 p.m. She said she would look in the electronic health record, to see if a resident was a DNR or not. She was not aware of the MOST form or who was responsible to have it completed. Licensed practical nurse (LPN) #1 was interviewed on 3/29/21 at 12:30 p.m. She said if she needed to know if a resident was a DNR (do not resuscitate) or not, she would go to the hard chart and look at the MOST form. She said it was medical records' responsibility to get the MOST form signed by the physician. The health information coordinator (HIC) was interviewed on 3/29/21 at 3:43 p.m. He said he was responsible for the medical records in the facility. He said he had been in the position since June 2020. He said it was his responsibility to get physician orders signed and ensure MOST orders were signed. He said he was not aware Resident #13 ' s MOST form was incomplete and said he would take it to the physician to get it filled out right away. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065174	A. Building B. Wing	03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sterling Health and Rehabilitation Center	1420 S 3rd Ave Sterling, CO 80751

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The corporate consultant (CC) and the director of nursing (DON) were interviewed on 3/29/21 at 6:24 p.m. They said upon admission, the nurse should go over the MOST form with the resident or resident's representative and determine if the resident is a full code or a DNR, then they should contact the physician and get orders to match. They said it was medical records' responsibility to get the MOST form signed by the physician.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 37166 Based on observations, interviews and record review, the facility failed to develop, implement, monitor and reevaluate its quality assurance performance improvement (QAPI) program to ensure the unique care and services the facility provided were maintained at acceptable levels of performance and continuously improved. Specifically, the facility's QAPI program failed to systematically self-identify, investigate, analyze and correct problems relating to staffing, quality of care and resident safety. This failure contributed to serious adverse outcomes and the likelihood of further serious adverse outcome. Cross-reference F689 for accident hazards, F697 for pain, and F725 for sufficient staffing. Findings include: I. Facility policy and procedure The QAPI Committee policy and procedure were requested from the nursing home administrator (NHA) on 3/29/21 at approximately 9:00 a.m. The facility policies were not located among provided documents. II. The recertification survey (3/23/21- 3/29/21) revealed multiple areas in which the facility failed to deliver care and services to its complex and unique resident population at an acceptable level of performance. According to 4/28/2020 facility assessment, the facility's resident profile included the following diseases/conditions, physical and cognitive disabilities: psychiatric/mood disorders including, psychosis, impaired cognition, anxiety disorder and behaviors that need interventions. The services and care the facility offered based on resident need included hospice, bariatric care, palliative care and respite care. The recertification survey findings revealed deficiencies in the facility's level of performance in keeping residents free from accidents, in ensuring residents ' safety, in delivering quality resident care and in promoting residents ' quality of life that were neither new nor uncommon. However, there was little evidence the findings had triggered a QAPI plan with corrective actions prior to survey. (Cross-reference F835 for administration). Specifically: A. Cross-reference F689 for failure to ensure resident safety from accidents, cited at H level, actual harm with a pattern. Survey findings revealed the facility failed to ensure Resident #13 had adequate access back into the facility after smoking outside in sub-zero temperatures. The resident suffered frostbite to his fingers while outside, and when he attempted to gain entry back into the facility he became stuck between the door and the wall, and waited for approximately 20 minutes before staff found him and assisted him back into the facility. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #16 sustained six falls over a period of two months. Two of the falls resulted in major injuries. One fall caused re-opening of the surgical wound on his amputated leg, and another fall resulted in a head injury with subdural hematoma. The facility failed to provide adequate and timely supervision and assistance to prevent multiple falls, resulting in two major injuries for Resident #16. Resident #15 had four consecutive falls in less than one month. The facility failed to put in place interventions to prevent the falls after the third fall. The fourth fall resulted in a fracture of the resident's left arm. Resident #15 was not assessed by a registered nurse (RN) for any injuries after the fall. The next morning the resident developed arm discoloration and swelling. She called 911 herself and was transferred to the emergency room for evaluation. The facility failures contributed to the resident's fall with fracture. For Resident #19, the facility failed to properly assess, develop and implement interventions to prevent recurring falls. Fall risk assessments were not consistently documented accurately or timely, neurological checks were not consistently performed, and the resident was not consistently assessed by registered nurses after falls. B. Cross-reference F697 for failure to manage resident's pain. Cited at G level, actual harm that is isolated. Survey findings revealed he facility failed to identify when Resident #18 was having increased complaints of pain and failed to perform a current comprehensive pain evaluation to determine the root cause of the resident's increasing complaint of pain and adjust the resident's plan of care to provide optimal pain management. Resident #18 had frequent complaints of moderate sacral pain during her dialysis sessions that were communicated to the facility but were not addressed or treated by the facility. These failures led to the resident ending her dialysis sessions early frequently due to her unresolved pain. C. Cross-reference F725 for failure to provide sufficient nursing stuffing. Cited at F level, no actual harm with potential for more than minimal harm that is widespread. Survey findings revealed the facility failed to consistently provide adequate nurse staff, which considered the acuity and diagnoses of the facility's resident population, resident census and daily care. As a result of inadequate staffing, the facility failed to provide assistance with activities of daily living (ADLs), ensure residents were provided meals in a timely manner, ensure fall interventions were in place to prevent resident injury and provide an effective restorative nursing program. D. Cross-reference F677, F688 and F712 for failure to provide assistance with activities of daily living (ADL) for dependent residents, to have an effective restorative nursing program, and to provide physician's visits to residents every 30 days for the first 90 days after admission. Cited at E level, a pattern with the potential for more than minimal harm. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F. Cross-reference F684 for failure to complete resident care (skin assessments and wound care) in a timely manner. The facility's failure to complete skin assessments timely, cited at a D level, a potential for more than minimal harm that is isolated. These failures contributed to the facility's inability to effectively care plan and promote each resident's highest practicable level of physical, mental and psychosocial well-being. III. Leadership interviews The nursing home administrator (NHA) and corporate consultant (CC) were interviewed on 3/29/21 around 3:00 p.m. The NHA said the facility currently had a QAPI committee which consisted of herself, the medical director, the director of nursing, the infection control nurse, the dietary manager, and the maintenance director. The NHA stated the QAPI committee had identified some concerns. Specifically, number of falls in the facility, assessments after the falls, accurate documentation and effective interventions. They had developed plans and corrective actions for identified problems. In addition, NHA said the current issues the facility had identified were staffing, and infection control. However, the facility failed to identify the lack of restorative programs, social services assessments, availability of electronic medical records, timeliness of the physician visits, and inadequate assistance with ADLs. The CC said she and the other corporate manager provided support to the facility.She said the facility was visited by a corporate manager on at least a monthly basis. She personally visited the facility a few months previously and was working on the falls and accidents concerns. The CRC said QAPI would be one of the systems she and her team would be working on to ensure the facility was able to self-identify system failures, and hopefully implement systems to correct any problems.