STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065188	A. Building B. Wing	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews and record review, the facility failed to ensure one (#9) out of 37 sample residents were kept free from neglect. The facility failed to ensure Resident #9 was not neglected by staff by providing the care and services the resident required to maintain the highest practicable well-being. This is evidenced by the following statements. Specifically, the facility failed to ensure Resident #9 received the care and services required to prevent avoidable pressure injuries from developing and worsening. Resident #9, whose age, clinical condition and assistance needs put her at risk for pressure injuries, was identified with moisture associated skin damage (MASD) on her coccyx on 7/8/21. Record review, observations and interviews with administrative and direct care staff revealed the facility failed to take measures to prevent and heal the resident's pressure injury to her coccyx and to prevent the development of the additional pressure injury to the left heel. The facility failed to comprehensively assess the resident's risk of pressure injuries upon admission and failed to develop a care plan with interventions to minimize these risks. Further, the facility failed to properly assess, document, monitor the coccyx pressure injury, ensure the proper notifications, and implement an appropriate treatment order. Cross reference F686 (pressure injuries) Additionally, the facility failed to consistently monitor weights, identify significant weight loss and timely address Resident #9's nutritional needs. Resident #9 experienced a significant, unplanned weight loss of 9. 3% in two months. Record review and interviews revealed the facility failed to monitor Resident #9's weight in accordance with physician orders and put nutritional interventions into place to support wound healing and weight loss prevention. Interviews confirmed the facility lacked a system to ensure resident weights were being obtained, which contributed to Resident #9's significant weight loss. Cross reference F692 (nutrition). (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Lastly, the facility failed to ensure Resident #9 received bathing services in accordance with her plan of care. Record review revealed Resident #9 did not receive any bathing services for July 2021, which was when the resident's pressure injuries developed. Cross reference F676 (activities of daily living) Findings include: I. Facility policy and procedure The Abuse Prohibition policy and procedure, revised April 2021, was provided by the nursing home administrator (NHA) on 8/25/21 at 3:51 p.m. It revealed, in pertinent part, Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property and exploitation for all patients. Neglect is defined as the failure of the Center, its employees, or service providers to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Actions to prevent abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of patient property, will include: -providing patients, families, and staff with information on how and whom they may report concerns, incidents, and grievances without fear of retribution and provide feedback regarding the concerns that have been expressed; -identifying, correcting, and intervening in situations in which abuse, neglect, and/or misappropriation of patient property is more likely to occur; and -establishing a safe environment that supports, to the extent possible, a patient's consensual sexual relationship. II. Resident #9 status Resident #9, age 88, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included type two diabetes and stage three chronic kidney disease. The 7/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility, dressing, toileting and limited assistance of one person with personal hygiene. It documented the resident was at risk for developing pressure injuries. The resident had a pressure reducing device for a chair and the bed. It indicated the resident was not on a turning or repositioning program. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	It indicated the resident did not have any identified pressure injuries. Although it read that the resident did not have any identified pressure injuries, this was incorrect per the 7/15/21 skin check (see below). II. Failure to prevent avoidable pressure injuries from developing and worsening A. Observations During a continuous observation on 8/19/21 beginning at 9:14 a.m. and ended at 1:30 p.m. The following was observed: -At 9:14 a.m. Resident #9 was observed lying on her back in the middle of the bed. The head of the bed was raised to a 45 degree angle with a potus boot to the left foot. -At 10:26 a.m. Resident #9 continued to lay in bed in the same position. Staff have not entered the resident's room to provide repositioning. -At 11:05 a.m. two certified nurse aides (CNA) were observed entering the resident's room and closed the door. The staff left the room at 11:15 a.m. CNA #2 said they provided incontinence care for Resident #9. Resident #9 was observed after the CNAs left the room. She was lying on her back in the middle of the bed. The head of the bed was raised to a 45 degree angle. The resident was not repositioned following incontinence care. -At 12:50 p.m. CNA #1 entered the room with the lunch tray. The meal was set up on the over bed table. CNA #1 left the room. -At 1:30 p.m. Resident #9 was lying in the same position. On 8/24/21 at 8:45 a.m. Resident #9 was observed lying on her back in the middle of the bed. The head of the bed was raised at a 45 degree angle. The resident had a potus boot to the left foot. -At 9:30 a.m., 10:00 a.m. and 10:15 a.m. 10:45 a.m. and 11:00 a.m. the resident was observed lying in the same position, on her back, in the middle of the bed, with the head of the bed raised at a 45 degree angle. During continuous observations on 8/24/21 beginning at 10:45 a.m. and ending at 12:30 p.m. the following was observed: -Resident #9 was lying in the center of the bed with the head of the bed raised to a 45 degree angle. The resident's shoulders were halfway up the top of the mattress with the top of the resident's head lying on the bottom portion of the pillow, putting pressure on the resident's coccyx area. The resident's feet were at the end of the bed, not covered by the blanket. The blanket was covering the resident from the waist to the knees, and strewn half off the bed. A potus boot was covering the resident's left foot. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	No pillows or other devices were observed to assist with positioning of the resident. -At 11:00 a.m. Resident #9's roommate was interviewed. Resident #37 said the facility staff usually only entered their room when Resident #9 required changing. She said Resident #9 laid in bed all day and did not sit in her wheelchair very often. She said Resident #9's current position was the position she was in on a regular basis. She said she had never seen the facility staff enter the room to reposition Resident #9. -At 12:01 p.m. nurse practitioner (NP) #1, at the nursing station, asked registered nurse (RN) #4 for a description of the residents wound to the coccyx. RN #4 responded she had not seen the wound that day. She said Resident #9 was in bed and thought the certified nurse aides (CNA) would be getting her up out of bed soon. NP #1 walked down the hallway and entered Resident #9's room and closed the door. -At 12:04 p.m. NP #1 exited Resident #9's room and asked RN #4 if she could assist in rolling Resident #9 on her side so she could assess the resident's wound. RN #4 said she did not have time and for NP #1 to push the call light so a CNA would come and assist. NP #1 entered the resident's room and pushed the call light. -At 12:07 p.m. Resident #9's roommate (Resident #37) exited the room and walked down the hallway looking for a CNA. A CNA was observed walking down the hallway, pushing a mechanical lift. Resident #9's roommate said she was busy assisting another resident and told her to go to the front of the facility to look for another CNA to assist Resident #9. -At 12:10 p.m. NP #1 walked out of Resident #9's room and asked an agency nurse to assist her with turning Resident #9. The agency nurse said she was providing wound treatments that day and would assist NP #1. Her and another nurse entered Resident #9's room to assist NP #1. -At 12:18 p.m. NP #1 exited the resident's room. NP #1 was interviewed on 8/24/21 at 12:20 p.m. She said Resident #9's wound looked worse. She said the wound to the resident's coccyx was open, the bone was exposed and had a foul odor. She said, due to her recent lab work that was completed, she suspected the resident had an infection and would start the resident on antibiotics that day. She said she does not remember when she was notified of the resident's wound to the coccyx and the unstageable wound to the left heel. She said in the past few months she had a difficult time finding staff to assist her in assessing different residents. She said she felt the facility did not have enough staff. (cross-reference F725) B. Record review (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review did not reveal documentation that the facility had conducted a comprehensive assessment of the resident's pressure injury risk on admission or as of 7/8/21. Further, the review revealed a comprehensive care plan had not been developed with interventions to minimize the resident's risk of skin breakdown due to age, clinical condition, incontinence and immobility. Interview with nurse practitioner (NP) #2 on 8/26/21 at 12:20 p.m., revealed Resident #9 was immobile and was unable to reposition herself without staff assistance. However, review of the June medication administration record (MAR) revealed no order for repositioning the resident and there was no evidence the nursing staff initiated a turning or repositioning schedule for the resident. Although the 7/1/21 skin check documented the resident did not have any skin injuries or wounds identified, the 7/8/21 skin check documented the resident had a skin injury/wound identified as moisture associated skin damage (MASD) to the coccyx and the July 2021 MAR revealed moisture barrier to the coccyx was ordered 7/10/21 two times per day for skin integrity. The 7/15/21 skin check documented the resident had a pressure injury identified to the coccyx. Contrary to facility policy and administration interviews (see above), there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. Further, although staff indicated the treatment continued to the coccyx, no treatment was documented on either the MAR or treatment administration record (TAR). The resident's electronic medical record did not reveal evidence of a comprehensive care plan, identifying the pressure injury on the resident's coccyx or reveal any interventions to assist in the healing of the pressure injury. The 7/22/21 skin check documented the resident had a previously noted skin injury/wound recorded as MASD to the coccyx. It indicated lotion was applied to the coccyx. However, there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. The 7/29/21 skin check revealed the resident had a previously noted skin injury/wound recorded of MASD and a pressure injury to the coccyx. As on 7/15 and 7/22/21, there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. An 8/1/21 change of condition evaluation revealed there was a change in the resident's wound from the previous week. It documented the pressure injury to the coccyx was 1 cm (centimeter) in size, was larger with black eschar, tunneling, a foul smell and a green tint to the wound bed. RN #4 documented she cleansed the pressure injury with wound cleaner, applied a Mediplex dressing and repositioned the resident for comfort. The documentation indicated the NP would see the resident in the morning for a wound evaluation, diet evaluation and a recommendation for treatment orders for the pressure injury to the coccyx. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	However, record review revealed no treatment orders were obtained the next day and review of the NP progress note 8/2/21 documented the resident was seen due the diagnosis of diabetes with peripheral vascular disease (PVD) and a vitamin D deficiency. It read to monitor the resident for open wounds and to provide local wound care if needed but did not document the NP was notified of the pressure injury to the coccyx or that she assessed the pressure injury while at the facility. Further, review of the resident's medical record did not provide documentation that a treatment order had been obtained to treat the pressure injury. The 8/12/21 skin integrity report documented Resident #9 had a stage 4 pressure ulcer to the coccyx with 5% (percent) necrotic tissue and 95% epithelial tissue. The pressure injury was 1 cm (centimeter) x 1 cm x 1 cm with tunneling at 4 and 8 o'clock. The report indicated the wound was cleaned with wound spray, packed with impregnated gauze and covered with a foam dressing. New orders were obtained. The August 2021 MAR and TAR documented the following treatment: Stage 4 pressure ulcer with 2x1x1 tunneling wound to the coccyx. Clean with wound spray, pack the tunneling wound with thin packing, then apply skin prep to the periwound. Apply a foam bandage. Ensure the resident is off the coccyx every two hours - ordered 8/12/21 and discontinued on 8/19/21. Yet, contrary to facility policy and administration interviews, no care plan to address the resident's coccyx injury was initiated with measures to address the resident's stage 4 pressure injury, including the new order to ensure the resident was off her coccyx every two hours. There were no further skin checks or documentation of the resident's pressure injury after 8/12/21 until 8/20/21, contrary to facility policy for daily monitoring of the site, with or without the dressing. On 8/20/21 (during survey), the resident was seen by the wound physician for an initial consultation and evaluation of her pressure injuries. The notes indicated two wounds: -Wound #1 (coccyx) was a stage 4 pressure injury with a status of non-healed. The wound measurements were as follows: 2.6 cm length x 1.5 cm width x 1/6 cm depth, with an area of 3.9 square cm and a volume of 6.24 cubic cm. The muscle was exposed and undermining was noted at the 12:00 and ends at 12:00 with a maximum distance of 1.8 cm. There was a moderate amount of drainage noted and the wound bed had 20% slough and 80% granulation. -Wound #2 (left heel) was documented as a deep tissue pressure injury to the left heel with persistent non-blanchable deep red, maroon or purple discoloration. The measurements included: 2.5 cm length x 3.5 cm width with no measurable depth, with an area of 8.75 sq cm. The wound bed has 100% epithelialization. The wound physician documented the pressure areas should be offloaded throughout the day for continued preventative measures and documented the following treatments were to be completed: -Apply skin prep to both heels two times per day for a deep tissue injury (DTI) to the left heel and prevention to the right heel-ordered 8/20/21; -Wound care: pack wound with silver alginate packing and cover with a foam dressing every other day and as needed for a stage 4 pressure ulcer-ordered 8/21/21, and discontinued on 8/24/21; (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Cleanse sacral wound with wound cleanser. Apply skin prep to the periwound. Pack the wound with Dakins soaked packing strip. Cover with a foam dressing. Change daily and as needed/soiled for a stage 4 sacral wound - ordered 8/25/21. C. Staff interviews Assistant director of nursing (ADON) #1, the facility's wound nurse, was interviewed on 8/19/21 at 12:12 p.m. She said she was not notified of the change of condition evaluation completed on 8/1/21 that described a significant worsening of Resident #9's coccyx wound. She said if she had been notified, she would have immediately assessed the wound, put a treatment in place and then referred the resident to the wound physician. She said she was first notified of the open area on Resident #9's coccyx on 8/12/21 in the morning management meeting. She said she assessed the wound that day and found it was a stage 4 to the coccyx with tunneling, slough and drainage. She said she put a treatment in place and notified the wound NP for the resident to be placed on the weekly rounds. However, she acknowledged the wound NP had not yet evaluated Resident #9's coccyx wound. She confirmed there was no formal assessment of the resident's coccyx pressure injury until 8/1/21 on the change of condition evaluation and then on 8/12/21 when she completed her assessment of the wound. She confirmed Resident #9 did not have a care plan to address her risk for skin breakdown or the actual skin breakdown with the wound to the coccyx. She confirmed Resident #9's medical record did not reveal documentation that showed the physician had been notified of the resident's wound. She said Resident #9's coccyx started out as MASD and worsened to a stage 4 pressure injury because the facility failed to accurately identify the wound, assess the wound timely, put an appropriate treatment in place, and provide preventative measures such as re-positioning the resident frequently. The DON was interviewed on 8/19/21 at 1:30 p.m. She said she was aware the facility had severe wounds and did not feel the system in place was functional because Resident #9's wound went so long without a proper assessment and treatment. The registered dietitian (RD) was interviewed on 8/25/21 at 11:46 a.m. She confirmed Resident #9 had a 9. 3% weight loss in two months. She said she felt Resident #9's wounds were avoidable and the resident had not been provided frequent repositioning and wound management in accordance with accepted standards of practice. NP #2 was interviewed on 8/26/21 at 12:20 p.m. She said she was not notified of Resident #9's pressure injury on 8/2/21 and was not notified until the pressure injury had worsened to a stage 4. She said if she had known about the resident's wounds, she would never have waited that long to address the wound and it would not have worsened. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	She said she thought it would be beneficial for Resident #9 to be in the dining area and receive cueing and physical assistance with eating. She said it could increase her meal intake and assist with wound healing. She said Resident #9 was immobile and was unable to reposition herself without staff assistance. She said the resident should be repositioned every two hours for wound healing and preventive measures. She said wounds were only unavoidable if all interventions and preventive measures had been exhausted. She said she did not think all preventive measures had been completed and felt the resident's wound was avoidable. The RRNM was interviewed on 8/26/21 at 1:01 p.m. She said there was a complete breakdown in the system of wound care for Resident #9. She said neither ADON #1 and the DON nor the physician were notified of Resident #9's pressure injury. She said there was a breakdown in the identification of Resident #9's wound, based on the documentation indicated on the skin checks. She said the change of condition evaluation should have been caught on the electronic medical record dashboard. She said there was a breakdown in that system because the nurse who completed the change of condition evaluation did not complete a risk management form. She said the risk management form would have alerted the nurse management team. She said the nurses never followed up after the wound was identified to ensure an appropriate treatment was in place to heal the wound. She said barrier cream was not considered an effective wound treatment. She said the facility failed Resident #9 and the stage 4 wound to the coccyx and DTI to the left heel were avoidable and inhouse acquired. III. Failure to consistently monitor weight, timely identify significant weight loss and address Resident #9's nutritional needs A. Record review The resident's electronic medical record was reviewed on 8/19/21 at 10:51 a.m. It did not reveal documentation that a comprehensive care plan had been developed to address the resident's nutritional risk for potential nutritional deficiency and weight loss. The 6/16/21 admission nutritional assessment documented Resident #9's usual body weight was 130 lbs (pounds). The resident was placed on a CCHO (consistent carbohydrate) diet with fair intakes, able to eat independently and voice her needs and preferences. The registered dietician (RD) documented that the resident had not been weighed yet since being admitted to the facility and had requested nursing to obtain the resident's weight. It indicated the RD would follow up as needed once the resident's weight was obtained and add liquid protein one time per day to support healing. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The weights and vitals record documented the resident's first weight was obtained on 6/17/21 (seven days following her admission to the facility), which indicated the resident weighed 129 lbs. The June 2021 meal intake records documented that the resident consumed the following: -100% of meals on seven occasions; -75% of meals on 11 occasions; -50% of meals on 33 occasions; -25% on four occasions; and - no documentation on five opportunities. The June 2021 medication administration record (MAR) documented the following physician orders: -Liquid protein: 30 cc of protein liquid one time per day for three months - ordered 6/17/21; -Weigh the resident every Thursday for two weeks - ordered 6/17/21. Record review showed the facility failed to adequately monitor the resident's weight according to physician orders and within accepted standards of practice. The only weight documented in the resident's electronic medical record was 129 lbs on 6/17/21 until 8/10/21. The July 2021 meal intake records documented that the resident consumed the following: -100% of meals on 11 occasions; -75% of meals on nine occasions; -50% of meals on 26 occasions; -25% of meals on three occasions; -0% of meals on one occasion; and -no documentation on 43 opportunities. The July MAR documented the following physician orders: -Weight weekly every Thursday and notify the physician of a weight gain of greater than five lbs in one week for edema - ordered on 7/8/21 and discontinued on 8/3/21. Record review showed the nursing staff signed off the MAR to indicate the weekly weight had been obtained per physician's order, however the resident's medical record did not document any such weights had been obtained. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The August 2021 meal intake records documented that the resident consumed the following: -100% of meals on three occasions; -75% of meals on 13 occasions; -50% of meals on two occasions; -25% of meals on 17 occasions; -0 % of meals on zero occasions; and -no documentation on 37 opportunities. Record review showed the facility failed to consistently monitor the resident's meal intake percentage to determine if the resident's meal intakes had a negative effect on her nutritional status. The weight and vitals record documented the resident's weight was obtained on 8/10/21 of 125.2 lbs,, a weight loss of 3.8 lbs./2.9%. The 8/11/21 nutrition progress note documented Resident #9 had a pressure ulcer to the coccyx and had a small amount of weight loss in the past two months, since her admission to the facility. The resident was under the desirable body mass index (BMI) range for older adults. Her current BMI was 21.4 and should be over 22. It indicated the resident was tolerating a CCHO (consistent carbohydrate) diet for diabetes mellitus with intakes that were generally poor with an average of 54% in the past week. The resident was able to feed herself independently. The resident benefited from setup assistance. It documented that the resident was falling short of increased energy needs. The RD checked in on the resident during several meals and determined Resident #9 was a slow eater, and did not eat a lot. The resident's responsible party indicated the resident was not a big eater and provided some food preferences for the resident. The resident's recent labs were reviewed which indicated a low albumin level, which the RD documented was from the resident's nutritional status. The interventions included adding a multivitamin, house supplement twice per day and trial some of the resident's favorite foods. The 8/13/21 nutritional progress note documented the RD stopped into the resident's room to see if she would accept dark chocolate. The resident declined and the RD left the candy at the bedside in case she changed her mind. The 8/17/21 at 5:30 p.m. nutritional progress note documented the RD brought a cheese sandwich to the resident's room. Resident #9 was sleeping when she arrived and the lunch tray was still sitting at the bedside, untouched. The RD asked the certified nurse aide (CNA) to ensure the resident was up for dinner. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	B. Staff interviews CNA #2 was interviewed on 8/19/21 at 11:15 a.m. and again on 8/24/21 at 2:24 p.m. She said she had been the primary day shift CNA for Resident #9 for a few months. She said she would deliver the room trays to Resident #9 in her room. She said she would provide setup assistance to the resident and leave the room. She said Resident #9 was not able to make her needs known or use the call light. She said Resident #9 was often forgotten because she could not make her needs known. She said Resident #9 would benefit from cueing during meals. She said, when she had time, she would attempt to go into the resident's room and encourage her to take a bite of food. She said Resident #9 usually responded well to encouragement. She said the resident should be sitting up in her wheelchair for all meals. She said she thought the resident would benefit from sitting in the dining area with staff providing cueing and physical assistance with eating. She said she thought the resident's poor intake was related to her not receiving enough assistance during meals. She said the RD had asked her to check on the resident that day, 8/24/21, and encourage the resident to eat. She said she did not have time that day to provide encouragement to the resident. C. Follow-up The 8/18/21 nutritional progress note documented that the RD dropped off the resident's lunch tray. Resident #9 was sleeping and the breakfast tray was sitting in front of the resident, untouched. The RD woke up Resident #9, raised the head of the bed and left the room. When the RD returned, the resident had eaten 50% of a peanut butter and jelly sandwich and drank 75% of a glass of whole milk. The 8/19/21 nutritional assessment, during the survey process, documented that the RD met with the resident to discuss wound healing and a nutrition plan. It indicated the resident had a worsened stage 4 pressure injury to the coccyx. The RD documented that the resident remained on a consistent carbohydrate diet (CCHO) with generally poor intakes. The RD indicated she checked in with the resident during meal times to ensure she was awake and eating. The interventions included liquid protein one time per day, house supplement twice per day, which was generally accepted 50-100% of the time. The RD added Cheerios with peaches on top for breakfast and to liberalize the resident's diet from CCHO to regular to allow for more menu options. The RD documented that the resident's weight loss was related to poor appetite and cognitive decline. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The nutritional assessment did not address the lack of consistent documentation of the resident's meal intakes or the failure to obtain weekly weights as was ordered by the physician. Record review revealed the facility failed to evaluate the resident's functional limitations to determine if the resident required encouragement or physical assistance with meals following the RD's observations on two different occasions of the resident with an untouched meal in front of her, hours after it had been served. The weights and vitals documentation indicated Resident #9's weight was obtained on 8/23/21 of 117 lbs. The resident had a significant weight loss of 12 lbs/9.3% in two months. The 8/24/21 nutrition progress note documented that the RD set up the resident's lunch that day. The RD raised the head of the bed and made sure the resident was awake with the tray in front of her. The RD checked in several times after setting up the resident, had to wake her and remind the resident to eat. The RD asked the resident to take a bite and the resident did. The RD asked the CNA to continue to check in on the resident and encourage her to eat. Cross reference F692 (nutrition). IV. Failure to ensure Resident #9 received bathing services in accordance with her plan of care A. Observations Resident #9 was observed on 8/19/21 at 9:14 a.m. lying on her back in the middle of the bed. The head of the bed was raised to a 45 degree angle. The resident's hair was pushed up and in disarray in the back with debris by the hairline on the top of the head. The resident had a musky odor. Resident #9 was observed on 8/24/21 at 10:45 a.m. Resident #9 was lying in the center of the bed with the head of the bed raised to a 45 degree angle. The resident's shoulders were halfway up the top of the mattress with the top of the resident's head lying on the bottom portion of the pillow. The resident had Cheerio's on her shirt and debris on the chin and left corner of her mouth. The resident's hair was in disarray and had a musky odor. B. Record review The ADL care plan, initiated and revised on 7/1/21, revealed the resident was at risk for a decreased ability to perform bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion and toileting. The interventions included: monitor for decline in ADL function, refer to therapy if the decline in ADLs is noted and physical/occupational therapy as ordered by the physician. It did not include any person-centered approaches to maintaining the resident's level of care. The July 2021 CNA bathing documentation revealed the resident did not receive a shower, bath or bed bath in the month of July. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The August 2021 CNA bathing documentation revealed the resident received a shower on 8/2/21, 8/18/21 and 8/23/21, which was three times out of 11 opportunities. C. Staff interviews CNA #2 was interviewed on 8/24/21 at 2:24 p.m. She said showers were supposed to be given according to the bathing schedule at the nursing station. She said it was hard to give residents showers or baths because of how busy the CNAs were throughout the day. She said showers and baths were not being provided as they should. She said she was the primary CNA for Resident #9. She said she was aware the resident had not received showers according to her plan of care. Assistant director of nursing (ADON) #1 was interviewed on 8/19/21 at 12:12 p.m. She said showers were not being given throughout

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews, the facility failed to ensure eight (#9, #19, #1, #20, #21, #22, #3 and #4) of eight residents reviewed out of 37 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure Residents #9, #19, #1, #20, #21, #22, #3 and #4 received regular bathing in accordance with their plan of care. Findings include: I. Facility policy and procedure The Activities of Daily Living, policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 8/26/21 at 10:36 a.m. It revealed, in pertinent part, Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) activities are maintained or improved and do not diminish unless circumstances of the individual's clinical condition demonstrate that a change was unavoidable. ADLs include: hygiene - bathing, dressing, grooming and oral care. ADL care is documented every shift by the nursing assistant. II. Resident #9 A. Resident status Resident #9, age 88, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included type two diabetes and stage three chronic kidney disease. The 7/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility, dressing, toileting and limited assistance of one person with personal hygiene. It documented the resident was at risk for developing pressure injuries. The resident had a pressure reducing device for a chair and the bed. It indicated the resident was not on a turning or repositioning program. It indicated the resident did not have any identified pressure injuries. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations Resident #9 was observed on 8/19/21 at 9:14 a.m. lying on her back in the middle of the bed. The head of the bed was raised to a 45 degree angle. The resident's hair was pushed up and in disarray in the back with debris by the hairline on the top of the head. The resident had a musky odor. Resident #9 was observed on 8/24/21 at 10:45 a.m. Resident #9 was lying in the center of the bed with the head of the bed raised to a 45 degree angle. The resident's shoulders were halfway up the top of the mattress with the top of the resident's head lying on the bottom portion of the pillow. The resident's had cheerio's on her shirt and debris on the chin and left corner of her mouth. The resident's hair was in disarray and had a musky odor. C. Record review The ADL care plan, initiated and revised on 7/1/21, revealed the resident was at risk for a decreased ability to perform bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion and toileting. The interventions included: monitor for decline in ADL function, refer to therapy if the decline in ADLs is noted and physical/occupational therapy as ordered by the physician. It did not include any person-centered approaches to maintaining the resident's level of care. The July 2021 CNA bathing documentation revealed the resident did not receive a shower, bath or bed bath in the month of July. The August 2021 CNA bathing documentation revealed the resident received a shower on 8/2/21, 8/18/21 and 8/23/21, which was three times out of 11 opportunities. D. Staff interviews CNA #2 was interviewed on 8/24/21 at 2:24 p.m. She said showers were supposed to be given according to the bathing schedule at the nursing station. She said it was hard to give residents showers or baths because of how busy the CNAs were throughout the day. She said showers and baths were not being provided as they should. She said showers and baths were documented in the point of care (POC) electronic record for each resident. She said she was the primary CNA for Resident #9. She said she was aware the resident had not received showers according to her plan of care. She said she felt there was not enough staff to be able to care for the residents and provide the showers. Registered nurse (RN) #1 was interviewed on 8/24/21 at 10:15 a.m. She said she was responsible for auditing the shower documentation. She said the facility used POC documentation and shower sheets to document when a resident received bathing. She said she was unable to find documentation Resident #9 had received any bathing in July 2021 and not according to her plan of care in August 2021. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse practitioner (NP) #2 was interviewed on 8/26/21 at 12:20 p.m. She said she was not aware Resident #9 had not received bathing for the entire month of July 2021. She said July 2021 was when the resident developed a wound to the coccyx and left heel. She said bathing was crucial in the healing of pressure injuries. Cross reference F686 (pressure injuries). RRNM was interviewed on 8/26/21 at 1:01 p.m. She said bathing was documented in POC and on shower sheets. She said each shower sheet should be signed off by the nurse. She said bathing should be completed in accordance with each resident's plan of care. She confirmed the facility was unable to locate documentation to indicate Resident #9 had received bathing in July 2021 and in accordance with her plan of care in August 2021. III. Resident #19 A. Resident status Resident #19, age 92, was admitted to the facility on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included hypertension, diabetes, chronic kidney disease and depression. The minimum data set (MDS) assessment, dated 7/26/21, revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required extensive assistance of two people with bed mobility, transfers, toileting and personal hygiene. He required extensive assistance with one person to dress. It was very important to him to choose between a shower, tub or sponge bath. There was no rejection of care. B. Observations Resident #19 was observed on 8/23/21 at 1:45 p.m. in his bed. He was naked except for an adult brief on his bottom private area and no sheet or blanket covered him. He was unshaven and his hair was uncombed. His skin was dry including his lips and mouth. He picked at the bandage on his right hand with his nails that were long and unkept. Resident #19 was observed on 8/25/21 at 11:30 a.m. in his bed. He sat on the side of his bed, feet on the floor mat next to him. He was naked with a brief on and socks. His sheets had blood on them from his wound on his left elbow area. He had his hands on his head. He was unshaven and hair was uncombed. C. Record review The preference care plan dated 7/30/21 for Resident #19 revealed it was important that he had the opportunity to engage in daily routines that are meaningful in relation to his preferences. Resident #19 will have opportunities to make decisions and choices related to self-directed involvement. It was important for me to choose between a tub, shower, bed bath or sponge bath. Record review revealed no activities of daily living (ADL) care plan was in the resident's chart. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The July 2021 bathing report for Resident #19 was provided by the regional resource nurse (RRN) on 8/25/21 at 2:00 p.m. it read in part: The report documented 17 times to indicate the bathing activity did not occur in July. There was no documentation to indicate if he refused a shower or bath or if a shower or bath was offered. There was no August bathing report provided and no record found of any refusals of showers or baths. -Resident #9 was not being provided bathing according to his plan of care. (see record review and resident interview above) D. Interviews Certified nurse aide (CNA) #2 was interviewed on 8/26/21 at 2:30 p.m., she said Resident #19 was agitated and two people had to help him with positioning and bathing. CNA #2 said she had not assisted him in the shower, bath or bedbath since she cared for him. She said when a resident refused she documented it on the computer and the nurse was told. She said she did not know when he had a shower bath or bed bath last. Licensed practical nurse (LPN) #3 was interviewed on 8/24/21 at 11:20 a.m. she said Resident #19 refused a lot of personal care and was agitated often. She said he was a hoyer lift for transfers so he received a bed bath instead of a shower. She was not sure when he had one last. She said when there was not enough staff it was difficult to complete the bathing. IV. Resident #1 A. Resident status Resident #1, age 90, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, chronic pain, and history of falling. The 7/22/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of 11 out of 15. She required extensive assistance of one person with bed mobility, dressing, toilet use, and personal hygiene. She required set-up assistance with all other ADLS (activities of daily living). The MDS indicated the resident needed physical help in part of bathing activity. The resident did not have any rejections of care. B. Resident interview Resident #1 was interviewed on 8/19/21 at 1:15 p.m. She said she used to be on hospice, and got a shower at least twice a week from her hospice aide. She said she had graduated from hospice a few months ago, so her showers were now being provided by the facility. She said she was only offered a shower one time a week, and frequently the shower did not occur so she would clean herself up in the sink. She said she would frequently have to remind staff to provide her a shower, and even at that it was hit or miss if she received her shower. Cross-reference F725 sufficient nursing staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The activities of daily living (ADL) care plan, initiated on 12/9/14, documented the resident required ADL assistance of one staff member for bathing. The goal was for the resident's care needs to be anticipated or met in order to maintain the highest practicable level of functioning. The interventions included the resident's preference of three showers per week, on Monday, Thursday and Saturday evening shift. The handwritten certified nurse aide shower sheets for Resident #1 documented the following: July 2021 showers: 7/30/21-shower given No other handwritten shower sheets were provided for July. August 2021 showers 8/13/21-shower refused 8/20/21-no documentation on shower sheeting indicating if shower was given or refused. No other handwritten shower sheets were provided for August. The certified nurse aide (CNA) POC (point of care) electronic documentation revealed the following: July 2021- the resident received a shower on 7/30/21. August 2021- the resident had not been provided a shower. The MAR (medication administration record) documentation revealed the following: July 2021-the resident received a shower every Friday August 2021- the resident received a shower every Friday The MAR and CNA shower sheets did not match. The MAR was signed off by nursing staff as the resident received her showers, however the shower sheets and resident interview indicate she was not receiving showers according to her ADL care plan. V. Resident #20 A. Resident status Resident #20, age 85, was admitted on [DATE]. According to the August 2021 CPO, the diagnoses included unspecified dementia with behavioral disturbance, muscle weakness, difficulty walking, and history of falling. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/5/21 MDS assessment revealed the BIMS had not been completed with the resident. The resident's short term and long term memory were ok, and she was able to recall the location of her room. She had modified independence in cognitive skills for daily decision making. She required extensive assistance of one person with dressing, and personal hygiene. She required set-up assistance with all other ADLS (activities of daily living). The MDS indicated the resident needed physical help in part of bathing activity. The resident rejected care one to three times weekly. B. Record review The activities of daily living (ADL) care plan, initiated on 3/11/21, documented the resident was at risk for decreased ability to perform ADLs related to dementia. The goal was for the resident to maintain the highest capable level of ALD ability through the next review. The interventions included providing the resident with set-up for all ADLs. The handwritten certified nurse aide shower sheets for Resident #1 documented the following: July 2021 showers: 7/1/21, 7/6/21. 7/17/21, 7/22/21, 7/27/21, 7/29/21 and 7/31/21-shower given 7/8/21-no hot water, shower not given 7/10/21 and 7/13/21- resident refused No other handwritten shower sheets were provided for July. August 2021 showers: 8/10/21 and 8/12/21-shower given No other handwritten shower sheets were provided for August. The certified nurse aide (CNA) POC (point of care) electronic documentation revealed the following: July 2021: 7/6/21, 7/22/21, 7/27/21, 7/29/21, and 7/31/21-shower given August 2021: 8/3/21, 8/10/21, 8/12/21, 8/17/21, and 8/19/21-shower given The MAR (medication administration record) documentation revealed the following: July 2021: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/1/21, 7/3/21, 7/6/21, 7/10/21, 7/13/21, 7/17/21, 7/22/21, 7/24/21, 7/27/21, and 7/29/21 shower given 7/8/21, 7/15/21, 7/20/21, and 7/31/21 shower not given August 2021: 8/3/21, 8/5/21, 8/10/21, 8/12/21, 8/17/21, 8/19/21, and 8/24/21-shower given 8/7/21, and 8/14/21-shower not given The nursing progress notes documented the following: 7/8/21-(name of medication) not given d/t (due to) no shower given, no hot water available. 7/20/21-(name of medication) not given, no shower d/t (due to) no hot water. 8/7/21-(name of medication) not given, shower not given, not enough staff. 8/14/21-(name of medication) not given. Shower not given d/t (due to) lack of staffing. VI. Resident #21 A. Resident status Resident #21, age 89, was admitted on [DATE]. According to the August 2021 CPO, the diagnoses included unspecified dementia without behavioral disturbance, and major depressive disorder. The 6/15/21 MDS assessment revealed the BIMS had not been completed with the resident. The resident's short term and long term memory were ok, and she was unable to recall the current season, the location of her room, staff names and faces, or that she was in a nursing home. She had modified independence in cognitive skills for daily decision making. She required extensive assistance of one person for all ADLS (activities of daily living) except for dressing which she requires extensive assistance of two people. The MDS indicated the resident needed physical help in part of bathing activity. The resident rejected care one to three times weekly. B. Record review The activities of daily living (ADL) care plan, initiated on 8/29/19, documented the resident was at risk for decreased ability to perform ADLs related to dementia. The goal was for the resident to maintain the highest capable level of ALD ability through the next review. The interventions included providing the resident with assistance for bathing and offering a bath or shower on Tuesday or Friday. The handwritten certified nurse aide shower sheets for Resident #1 documented the following: (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	July 2021 showers: 7/5/21, 7/27/21 and 7/30/21-shower given No other handwritten shower sheets were provided for July. August 2021 showers: 8/6/21, and 8/9/21-shower given No other handwritten shower sheets were provided for August. The certified nurse aide (CNA) POC (point of care) electronic documentation revealed the following: July 2021, no showers were documented as given. August 2021, no showers were documented as given. The MAR (medication administration record) documentation revealed the following: July 2021: 7/2/21, 7/4/21, 7/11/21, 7/23/21. 7/26/21, 7/30/21-shower given 7/1/21, 7/9/21, 7/16/21 and 7/19/21- shower not given August 2021: 8/2/21, 8/6/21, 8/9/21, 8/13/21, 8/23/21- shower given 8/16/21- shower not given The nursing progress notes documented the following: 7/9/21-Shower not give (sic), d/t (due to) hot water available. 7/19/21-No shower d/t (due to) no hot water this shift. 8/16/21-No shower d/t (due to) no CNA (certified nurse aide). VII. Resident #22 Resident #22, age 89, was admitted on [DATE]. According to the August 2021 CPO, the diagnoses included Alzheimer's disease, vascular dementia with behavioral disturbance, and nervousness. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 8/4/21 MDS assessment revealed the BIMS had not been completed with the resident. The resident's short term and long term memory were ok, and she was able to recall the location of her room. She had modified independence in cognitive skills for daily decision making. She required extensive assistance of one person with all ADLS (activities of daily living). The MDS indicated the bathing activity did not occur. The resident rejected care one to three times weekly. B. Record review The activities of daily living (ADL) care plan, initiated on 8/29/18, documented the resident was at risk for decreased ability to perform ADLs related to dementia. The goal was for the resident to maintain the highest capable level of ADL ability through the next review. The interventions included providing the resident with assistance for bathing and offering a bath or shower. The handwritten certified nurse aide shower sheets for Resident #1 documented the following: July 2021 showers: 7/2/21, 7/28/21, and 7/30/21-shower given 7/7/21- shower refused No other handwritten shower sheets were provided for July. August 2021 showers: 8/6/21- shower given 8/4/21, 8/9/21-shower refused No other handwritten shower sheets were provided for August. The certified nurse aide (CNA) POC (point of care) electronic documentation revealed the following: July 2021, no showers were documented as given. August 2021, no showers were documented as given. The MAR (medication administration record) documentation revealed the following: July 2021: 7/12/21, 7/21/21, 7/23/21, 7/26/21, 7/28/21, and 7/30/21- shower given 7/2/21, 7/5/21-shower refused 7/7/21, 7/9/21, 7/12/21, 7/16/21, 7/19/21,-shower not given (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Morrison	150 Spring St Morrison, CO 80465

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	August 2021: 8/2/21, 8/4/21, 8/6/21, 8/9/21, 8/11/21, 8/13/21- shower given 8/16/21- shower not given 8/18/21, and 8/23/21 shower refused The nursing progress notes documented the following: 7/9/21-Shower not given, d/t (due to) hot water available. 7/19/21-No shower d/t (due to) no hot water. 8/16/21-No shower d/t (due to) no CNA (certified nurse aide). C. Staff interviews Licensed practical nurses (LPN) #6 was interviewed on 8/18/21 at 10:25 a.m. She said she was the day shift nurse on the secure unit (Solona). She said Residents #20, #21, and #22 were residents of the secure unit. She said when the facility was short CNA (certified nurse aide) staff would be the only staff member on the secure unit. She said when that occurred, she was only able to provide the residents with basic care needs, and showers were not provided. She said the shower for the secure unit was located off of the unit, so even if a resident really needed a shower, she would not have been able to safely provide one, while leaving all of the other residents without a staff member on the secure unit. She said the documentation for showers was all over the place, and the only documentation she believed to be accurate was her own in the MAR (medication administration record). Cross-reference F725 sufficient nursing staff. VIII. Resident #3 A. Resident status Resident #3, under the age of 70, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included bipolar disorder, Wernicke's encephalopathy (acute neurologic condition), alcohol abuse, and unspecified disorder of the brain. The 7/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance with one person physical assistance for bed mobility, transfers and dressing. She required supervision and one person physical assistance for toileting and personal hygiene. The MDS did not identify the resident's level of assistance needed for bathing because the activity did not occur during the assessment period. B. Resident interview (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 was interviewed on 8/23/21 at 3:26 p.m. The resident had greasy hair that appeared unwashed. Resident #3 said she was not getting showers regularly. She said she used to take showers every day before she came to the facility and wished she could take one daily, but they put her on a shower schedule. She said the facility is understaffed and the staff who do work are overworked and do not have time to provide showers daily and often do not provide showers according to the shower schedule. -On 8/24/21 Resident #3 was observed wearing the same clothing she was wearing on 8/23/21 and her hair was still greasy. C. Record review Review of the Resident Preference Questionnaire, completed on 4/29/21, revealed Resident #3 showered almost daily prior to admission and that the resident was satisfied with that routine. Resident #3's shower records were provided by the regional resource nurse (RRN) on 8/24/21 at 2:40 p.m. The shower records included documentation of showers on the medication administration record (MAR), the certified nurses aide (CNA) task sheets, and the CNA shower sheets. Review of these shower records revealed the following information: -Per the July and August 2021 MAR, Resident #3 was scheduled to receive a shower during the evening shift every Wednesday, Friday, and Saturday. -However, per the CNA task sheets for July and August 2021, the resident was scheduled to receive a shower during the evening shift every Tuesday, Thursday and Saturday. -The July 2021 CNA task sheet revealed 12 of 14 shower opportunities were marked as not applicable. Two of the shower opportunities were left blank. According to the CNA task sheet, Resident #3 did not receive any showers in July 2021. -However, the July 2021 MAR revealed the resident received 14 out of 14 showers, which contradicts the information on the CNA task sheets. -Only two CNA shower sheets were provided for the month of July, which showed the resident received a shower on 7/8/21 and 7/20/21. -The August 2021 CNA task sheet revealed five out of nine shower opportunities were marked as not applicable. Four of the shower opportunities were left blank. According to the CNA task sheet, Resident #3 did not receive any showers in August 2021. -However, the August 2021 MAR revealed the resident received a shower on seven out of nine shower opportunities. Two showers were marked as not received. -One CNA shower sheet was provided for the month of August 2021, which showed the resident received a shower on 8/20/21. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-As mentioned above, the CNA task sheets and MAR reports showed different shower schedules for the resident. Due to the inconsistencies in shower documentation and shower schedules, the resident did not receive showers according to her plan of care. IX. Resident #4 A. Resident status Resident #4, under the age of 70, was originally admitted on [DATE] with a readmitted [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paranoid schizophrenia, hemiplegia (paralysis) following cerebral infarction (stroke) affecting the left side, seizures, and intellectual disabilities. The 7/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required extensive assistance with two-person physical assistance for bed mobility, transfers, and toileting. He required extensive assistance and one person physical assistance with locomotion on/off the unit, dressing, and personal hygiene. The MDS revealed the resident was totally dependent and required two-person physical assistance for bathing. B. Record review Review of the Resident Preference Questionnaire, completed on 5/10/21, revealed Resident #4 preferred to shower two to three times per week in the morning. -However, per the resident's comprehensive care plan, the resident liked to bathe once a week (initiated 5/10/21). The care plan and preferences did not match. It was unclear in the facility documentation what the resident's preference was for showers or baths and the frequency. Resident #4's shower records were provided by the regional resource nurse (RRN) on 8/24/21 at 2:40 p.m. The shower records included documentation of showers on the medication administration record (MAR), the certified nurses aide (CNA) task sheets, and the CNA shower sheets. Review of the shower records revealed the following information: -Per the July and August 2021 MAR and the CNA task sheets, Resident #3 was scheduled to receive a shower during the day shift every Tuesday, Thursday and Saturday. -The July 2021 CNA task sheet revealed four of 14 shower opportunities were marked as not applicable. Six of the shower opportunities were not marked. According to the CNA task sheet, Resident #4 received two showers in July (7/6/21 and 7/31/21) and two baths (7/15/21 and 7/22/21) in July 2021. -However, the July 2021 MAR revealed the resident received 12 out of 14 showers (two opportunities were left blank) which contradicts the information on the CNA task sheets. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Five CNA shower sheets were provided for the month of July. Per the CNA shower sheets, the resident received a bed bath on 7/2/21, 7/13/21 and 7/22/21. The resident received a shower on 7/6/21. The shower sheet from 7/29/21 did not indicate if the resident received a shower or a bed bath. -The August 2021 CNA task sheet revealed six out of nine shower opportunities were marked as not applicable. Three of the shower opportunities were left blank. According to the CNA task sheet, Resident #3 did not receive any showers in August 2021. -However, the August 2021 MAR revealed the resident received a shower on eight out of nine shower opportunities. One showers was marked as not received. -One CNA shower sheet was provided for the month of August 2021, which showed the resident received a bed bath on 8/3/21. -Due to the inconsistencies in shower documentation, the resident did not receive showers according to his plan of care. X. Additional staff interviews Certified nurse aide (CNA) #4 was interviewed on 8/18/21 at 10:45 a.m. She said the building was typically short CNAs, and that made getting just the basics done very difficult. She said showers took at least 20 minutes to complete correctly, and there was just not enough time in her shift to complete all of the required showers. Certified nurse aide (CNA) #1 was interviewed on 8/18/21 at 11:00 a.m. She said she frequently worked short on every unit she worked on. She said the facility had a shower aide and that helped the CNAs get everything done during their shift, but about two weeks ago the shower aide was moved to the staff scheduler role.The CNA said when they were working short, showers were one of the things that did not get done. The CNA said they were to complete the handwritten shower sheet on a resident's shower day. They were supposed to document if the shower had been given or refused. She said they were also supposed to document in the POC if the shower had been given or refused. Assistant director of nursing (ADON) #1 was interviewed on 8/19/21 at 12:12 p.m. She said showers were not being given throughout the facility. She said the facility struggled with sufficient staffing to ensure showers were given according to each resident's shower schedule and plan of care. She said the CNAs were responsible for providing showers to residents. She said the CNAs documented the showers in POC. The ADON #1 was interviewed again on 8/23/21 at 11:30 a.m. She said documentation for showers was a mess with multiple staff documenting in multiple locations. She said she had been attempting to audit the shower documents, but she simply did not have the time. She said there were simply not enough nursing staff members in the facility to provide basic care, and showers were one of the first things CNAs were not getting done when they were short staffed. Cross-reference F725 sufficient nursing staff. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff scheduler (SS) was interviewed on 8/23/21 at 11:50 a.m. He said prior to being the scheduler he was the shower aide for the facility. He said he had been the shower aide in June and July 2021 and worked five days a week, Monday through Friday only providing showers to residents. He said he was completing 15-20 showers a week. The SS said starting in late July and August, he was being pulled from being the shower aide, and was working the floor as a certified nurse aide. He said he was in the process of trying to find another shower aide for the facility to help complete the showers. 41968 39261 43909

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review, and interviews, the facility failed to take measures to prevent and heal pressure injuries and to prevent the development of additional pressure injuries, affecting four (#9, #7, #19 and #6) of six residents reviewed out of 37 sample residents. Specifically: IMMEDIATE JEOPARDY IN PRESSURE INJURY MANAGEMENT Resident #9, whose age, clinical condition and assistance needs put her at risk for pressure injuries, was identified with moisture associated skin damage (MASD) on her coccyx on 7/8/21. An order was obtained 7/10/21 for barrier cream. However, a skin check revealed the skin damage progressed to a pressure injury (not further described by staff) on 7/15/21, and then, per a change of condition evaluation, to a pressure injury with black eschar, tunneling, and foul smell on 8/1/21. On 8/12/21, a skin integrity report documented the pressure injury as a stage 4 pressure injury. The initial wound physician evaluation of the injury on 8/20/21 (during survey) confirmed a stage 4 wound with exposed muscle and undermining. There was an additional deep tissue pressure injury to the resident's left heel. Record review and interviews with administrative and direct care staff revealed the facility failed to take measures to prevent and heal the resident's pressure injury to her coccyx and to prevent the development of the additional pressure injury to her left heel. The facility failed to comprehensively assess the resident's risk of pressure injuries on admission and failed to develop a care plan with interventions to minimize these risks. Further, the facility failed to properly assess, document and monitor the coccyx pressure injury from 7/15/21 until 8/1/21, and, although the assessment 8/1/21 indicated the pressure injury was worsening, this failed to trigger notification to the resident's physician, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON)/facility wound nurse and placement of the resident on the wound round list to be seen by the wound physician. This, in turn, failed to trigger evaluation of interventions and revision of treatment orders. The treatment order for barrier cream to buttocks remained in place until 8/12/21 and as of 8/19/21, the resident lacked a care plan with measures to promote healing of the coccyx injury and to prevent the development of additional pressure injuries. In addition, although treatment orders 8/12/21 included to ensure the resident is off the coccyx every two hours, and the wound physician documented on 8/20/21 that the pressure areas should be offloaded throughout the day, observations 8/19/21 for four hours and 8/24/21 for approximately two hours, revealed this order was not being implemented. The resident remained on her back with pressure on her coccyx. Finally, observations of wound care on 8/25/21 revealed care inconsistent with infection control measures to promote healing and prevent infection. The findings above represented systemic failures in the facility's management of Resident #9's pressure injuries. Resident #9's coccyx pressure injury was inadequately assessed, documented and monitored, care planned and treated to promote healing and prevent infection. The facility's management of the resident's coccyx pressure injury contributed to actual harm for Resident #9, and the potential for further, serious harm if not immediately corrected. ADDITIONAL FAILURES IN PRESSURE INJURY MANAGEMENT (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Residents #7, #6, and #19 also developed pressure injuries that were not accurately assessed, documented, monitored and treated to promote healing and prevent infection. Cross reference F692 (nutrition), F600 (neglect), F835 (administration), and F867 (QAPI). Findings include: I. Immediate jeopardy A. Situation of immediate jeopardy Resident #9, whose age, clinical condition and assistance needs put her at risk for pressure injuries, was identified with moisture associated skin damage (MASD) on her coccyx on 7/8/21. An order was obtained 7/10/21 for barrier cream. However, a skin check revealed the skin damage progressed to a pressure injury (not further described by staff) on 7/15/21, and then, per a change of condition evaluation, to a pressure injury with black eschar, tunneling, and foul smell on 8/1/21. On 8/12/21, a skin integrity report documented the pressure injury as a stage 4 pressure injury. The initial wound physician evaluation of the injury on 8/20/21 (during survey) confirmed a stage 4 wound with exposed muscle and undermining. There was an additional deep tissue pressure injury to her left heel. Record review and interviews with administrative and direct care staff revealed the facility failed to take measures to prevent and heal the resident's pressure injury to her coccyx and to prevent the development of the additional pressure injury to her left heel. The facility failed to comprehensively assess the resident's risk of pressure injuries on admission and failed to develop a care plan with interventions to minimize these risks. Further, the facility failed to properly assess, document and monitor the coccyx pressure injury from 7/15/21 until 8/1/21, and, although the assessment 8/1/21 indicated the pressure injury was worsening, this failed to trigger notification to the resident's physician, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON)/facility wound nurse and placement of the resident on the wound round list to be seen by the wound physician. This, in turn, failed to trigger evaluation of interventions and revision of treatment orders. The treatment order for barrier cream to buttocks remained in place until 8/12/21 and as of 8/19/21, the resident lacked a care plan with measures to promote healing of the coccyx injury and to prevent additional pressure injuries. In addition, although treatment orders 8/12/21 included to ensure the resident is off the coccyx every two hours, and the wound physician documented on 8/20/21 that the pressure areas should be offloaded throughout the day, observations 8/19/21 for four hours and 8/24/21 for about two hours, revealed this order was not being implemented. The resident was positioned on her back, placing pressure on her coccyx. Finally, observations of wound care on 8/23 and 8/25/21 revealed care inconsistent with infection control measures to promote healing and prevent infection. The findings represented systemic failures in the facility's management of Resident #9's pressure injuries. Resident #9's coccyx pressure injury was inadequately assessed, documented and monitored, care planned and treated to promote healing and prevent infection. The facility's management of the resident's coccyx pressure injury contributed to actual harm for residents #9, and the potential for further, serious harm if not immediately corrected. B. Imposition of immediate jeopardy (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 8/19/21 at 2:50 p.m. the nursing home administrator (NHA), director of nursing (DON) and regional resource nurse manager (RRNM) were notified of the immediate jeopardy situation created by the facility's failure to prevent and heal pressure injuries and to prevent the development of additional pressure injuries. C. Facility plan to remove immediate jeopardy On 8/23/21 at 3:10 p.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: 1. Corrective action -The skin integrity coordinator/assistant director of nursing, the resident's primary certified registered nurse practitioner, and therapy completed an assessment on Resident #9 on August 19, 2021. Development of the care plan has been initiated. Assessment and treatment documentation will be developed after the certified registered nurse practitioner (NP) completes an assessment by 8/20/21. The wound NP or medical doctor to do an assessment of the resident by August 20, 2021. 2. Identification of others -The center nurse executive and/or designee will complete a 100% skin sweep and implement the skin management policy and procedure for any identified skin impairments by August 21, 2021. The center's wound NP will conduct an assessment of all skin concerns identified during the skin sweep to determine the appropriate treatment and develop the plan of care. The wound NP will assess any resident that is identified by the skin sweep by August 23, 2021. -The wound NP will conduct a skin sweep of all residents on or before August 25, 2021. 3. Systemic changes -On August 19, 2021, the center nurse executive, unit managers, and/or designee initiated education with staff on skin management/prevention of avoidable pressure injuries. Education includes: skin assessment, documentation, treatment, notification and monitoring of skin impairments. Skin assessment education includes: assessing on admission, weekly and as needed (PRN). Documentation education includes: documentation of findings from skin assessment on skin check assessment, change in condition assessment, risk management system and weekly wound documentation. Furthermore, education for documentation also includes: development of comprehensive care plan addressing resident's risk in development of pressure injuries and resident centered interventions to prevent the development of avoidable pressure injuries and/or healing of pressure injuries. Treatment education includes: obtaining appropriate and timely treatment orders, entering orders timely into PCC and implementing orders per physician orders. Notification education includes notifying the following individuals upon new skin impairment and/or decline in skin impairment, center nurse executive, and/or designee, resident, residents ' responsible party and residents ' provider. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitoring skin impairment education includes the following: nurse educated to check skin with cares, weekly and during skin treatments and/or PRN, wound nurse and/or wound nurse designee to complete weekly measurements, staging and status of the wound (improvement, decline or healed). All nursing staff will be re-educated by August 25, 2021. Employees with scheduled time off, on leave of absence, vacation or PRN staff will be re-educated prior to returning to duty. -If non-compliance is identified during reviews the center executive director, center nurse executive, and/or wound nurse will be notified and on the spot education will be provided on adherence to skin management practices. 4. Monitoring -On August 23, 2021, center executive director and center nurse executive will conduct a root cause analysis on skin management program and submit findings to the quality assurance performance improvement committee. The quality assurance performance improvement committee will review findings and make recommendations to promote changes and compliance of skin management practices. The quality assurance performance improvement committee will review and analyze findings from audits and observations monthly and develop additional measures on an ongoing basis to sustain compliance on August 26, 2021. D. Removal of the immediate jeopardy The above plan was accepted on 8/23/21 at 3:45 p.m. and the immediate jeopardy was removed. However, record review, observations and interviews revealed deficient practice remained at a G level, actual harm that is isolated. II. Facility policy and procedures A. Document review The Skin Integrity Management policy and procedure, revised June 2021, was provided by the NHA on 8/25/21 at 3:51 p.m. It read, in pertinent part: The implementation of an individual patient's skin integrity management occurs within the care and delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. Purpose: to provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds. Identify patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Include all patients who have newly identified skin impairments on the 24 hour summary report. Perform skin inspection on admission, readmission and weekly. Perform wound observations and measurements and complete the skin integrity report upon initial identification of altered skin integrity, weekly, and with anticipated decline of wound. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Perform daily monitoring of wounds or dressings for presence of complications or declines and document. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Implement pressure ulcer prevention for identified risk factors. Document daily monitoring of the ulcer site, with or without the dressing. B. Administration interviews 1. The assistant director of nursing (ADON) #1 was interviewed on 8/19/21 at 12:12 p.m. She said she was the assigned wound nurse for the facility. She said upon the development of a new skin concern or pressure injury, the nursing staff should notify her and the director of nursing (DON) immediately to ensure the wound was properly assessed and an appropriate treatment in place. She said each resident's skin should be assessed weekly and documented in the weekly skin check. She said each nurse should put eyes on the resident before completing the skin check. She said the skin check was not accurate unless the nurse physically evaluated the resident. 2. The director of nursing (DON) was interviewed on 8/19/21 at 1:30 p.m. She said a skin assessment should be completed, at a minimum, weekly for each resident. She said ideally, it should be completed with every care being provided and shower/bath given. She said if the nurse or CNA identified a new skin concern, an assessment should be completed along with the physician, DON and ADON #1 being notified immediately. 3. The regional resource nurse manager (RRNM) was interviewed on 8/19/21 at 1:37 p.m. and again on 8/26/21 at 1:01 p.m. She said each resident's skin should be assessed on their bathing day. She said the nurse should physically assess each resident's skin and complete a skin check. She stated when a nurse received a report about a resident's skin, they should immediately view, assess, measure and describe the area in a note. She stated the nurse should complete a risk management, a change in condition and a skin assessment and notification made to the physician, DON and ADON #1 immediately. She said once notified, ADON #1 should put the resident on the wound round list to be seen by the wound physician. She said the wound physician rounded weekly on those residents with identified skin concerns. She stated once orders from the physician were obtained, the treatment should be completed according to the physician's orders. She stated the care plan should be updated with the new or identified skin conditions and any treatments and new interventions placed. III. Failure in pressure injury management - Resident #9 A. Resident status (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #9, age 88, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included type 2 diabetes and stage 3 chronic kidney disease. Review of the admission nursing assessment revealed the resident did not have any pressure injuries on admission. The 7/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility, dressing, toileting and limited assistance of one person with personal hygiene. The resident was incontinent of bowel and bladder. The MDS further documented the resident was at risk for developing pressure injuries and had a pressure reducing device for a chair and the bed. Although it read the resident did not have any identified pressure injuries, this was incorrect per the 7/15/21 skin check (see below). B. Record review and interview revealed the facility failed to take measures to prevent and heal the resident's pressure injury to her coccyx and to prevent the development of the additional pressure injury to her left heel. The resident's electronic medical record was reviewed on 8/19/21 at 10:51 a.m. 1. Record review 6/10/21 to 7/8/21 - Facility failure to comprehensively assess the resident's risk of pressure injuries on admission and failure to develop a care plan with interventions to minimize these risks. Record review did not reveal documentation the facility had conducted a comprehensive assessment of the resident's pressure injury risk on admission or as of 7/8/21. Further, the review revealed a comprehensive care plan had not been developed with interventions to minimize the resident's risk of skin breakdown due to age, clinical condition, incontinence and immobility. Interview with nurse practitioner (NP) #2 on 8/26/21 at 12:20 p.m., revealed Resident #9 was immobile and was unable to reposition herself without staff assistance. However, review of the June medication administration record (MAR) revealed no order for repositioning the resident and there was no evidence the nursing staff initiated a turning and repositioning schedule for the resident. 2. 7/8/21-7/29/21 - Development of a pressure injury and facility failure to properly assess, document and monitor the coccyx pressure injury. -Although the 7/1/21 skin check documented the resident did not have any skin injuries or wounds identified, the 7/8/21 skin check documented the resident had a skin injury/wound identified as moisture associated skin damage (MASD) to the coccyx and the July MAR revealed moisture barrier to the coccyx was ordered 7/10/21 two times per day for skin integrity. -The 7/15/21 skin check documented the resident had a pressure injury identified to the coccyx. Contrary to facility policy and administration interviews (see above), there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further, although staff indicated the treatment continued to the coccyx, no treatment was documented on either the MAR or treatment administration record (TAR). And, contrary to facility policy and administration interviews, the resident's electronic medical record did not reveal evidence of a comprehensive care plan, identifying the pressure injury on the resident's coccyx or reveal any interventions to assist in the healing of the pressure injury. -The 7/22/21 skin check documented the resident had a previously noted skin injury/wound recorded as MASD to the coccyx. It indicated lotion was applied to the coccyx. However, there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. -The 7/29/21 skin check revealed the resident had a previously noted skin injury/wound recorded of MASD and a pressure injury to the coccyx. As on 7/15 and 7/22/21, there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 or that the resident was put on the wound round list to be seen by the wound physician. Although the RRNM said each resident's skin should be assessed on their bathing day, a review of the certified nurse aide (CNA) task point of care (POC) documentation for July 2021 revealed the resident did not receive bathing services for the entire month of July. (Cross-reference F676)] 3. 8/1/21 to 8/20/21 - Worsening pressure injury - failure to conduct an assessment, timely communicate changes to the pressure injury and failure to implement a treatment to prevent the worsening of the pressure injury to a stage 4. Wound physician consult and discovery of two pressure injuries. 8/1/21 to 8/12/21: -A 8/1/21 change of condition evaluation revealed there was a change in the resident's wound from the previous week. It documented the pressure injury to the coccyx was 1 cm (centimeter) in size, was larger with black eschar, tunneling, a foul smell and a green tint to the wound bed. RN #4 documented she cleansed the pressure injury with wound cleaner, applied a Mediplex dressing and repositioned the resident for comfort. The documentation indicated the NP would see the resident in the morning for a wound evaluation, diet evaluation and a recommendation for treatment orders for the pressure injury to the coccyx. However, record review revealed no treatment orders were obtained the next day and review of the NP progress note 8/2/21 documented the resident was seen due the diagnosis of diabetes with peripheral vascular disease (PVD) and a vitamin D deficiency. It read to monitor the resident for open wounds and to provide local wound care if needed but did not document the NP was notified of the pressure injury to the coccyx or that she assessed the pressure injury while at the facility. Further, review of the resident's medical record did not provide documentation that a treatment order had been obtained to treat the pressure injury. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the wound NP on 8/26/21 at 12:20 p.m. confirmed the NP did not assess the resident's pressure injury or order treatment for it. Rather, the interview revealed the NP did not recall ever being told on 8/2/21 about the resident's worsening pressure injury. She said if she had been notified, she would have assessed the wound that day and put a treatment order in place. She also confirmed she had not heard about the resident's pressure injury on her coccyx until it had already worsened to a stage 4 (8/12/21), stating if she had known about the resident's wound, she would never have waited that long to address it and it would not have worsened. -The 8/5/21 skin check documented the resident had a previously noted pressure injury to the coccyx. It indicated a treatment continued to the coccyx area. However, despite the documentation of the pressure injury worsening, there was no evidence staff assessed, measured and described the area in a note, completed a risk management, a change in condition and a skin assessment and notified the physician, DON and ADON #1 of the wound or that the resident was put on the wound round list to be seen by the wound physician. There was no description of the treatment that was continued. -The 8/12/21 skin integrity report documented Resident #9 had a stage 4 pressure ulcer to the coccyx with 5% (percent) necrotic tissue and 95% epithelial tissue. The pressure injury was 1 cm (centimeter) x 1 cm x 1 cm with tunneling at 4 and 8 o ' clock. The report indicated the wound was cleaned with wound spray, packed with impregnated gauze and covered with a foam dressing. New orders were obtained. The August 2021 MAR and TAR documented the following treatment: Stage 4 pressure ulcer with 2x1x1 tunneling wound to coccyx. Clean with wound spray, pack tunneling wound with thin packing, then apply skin prep to periwound. Apply a foam bandage. Ensure the resident is off the coccyx every two hours - ordered 8/12/21 discontinued on 8/19/21. Yet, contrary to facility policy and administration interviews, no care plan to address the resident's coccyx injury was initiated with measures to address the resident's stage 4 pressure injury, including the new order to ensure the resident was off her coccyx every two hours. 8/12/21 to 8/20/21 There were no further skin checks or documentation of the resident's pressure injury after 8/12/21 until 8/20/21, contrary to facility policy for daily monitoring of the site, with or without the dressing. On 8/20/21 (during survey), the resident was seen by the wound physician for an initial consultation and evaluation of her pressure injuries. The notes indicated two wounds: -Wound #1 (coccyx) was a stage 4 pressure injury with a status of non-healed. The wound measurements were as follows: 2.6 cm length x 1.5 cm width x 1/6 cm depth, with an area of 3.9 square cm and a volume of 6.24 cubic cm. The muscle was exposed and undermining was noted at the 12:00 and ends at 12:00 with a maximum distance of 1.8 cm. There was a moderate amount of drainage noted and the wound bed had 20% slough and 80% granulation. -Wound #2 (left heel) was documented as a deep tissue pressure injury to the left heel with persistent non-blanchable deep red, maroon or purple discoloration. The measurements included: 2.5 cm length x 3.5 cm width with no measurable depth, with an area of 8.75 sq cm. The wound bed has 100% epithelialization. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The wound physician documented the pressure areas should be offloaded throughout the day for continued preventative measures and documented the following treatments were to be completed: -Apply skin prep to both heels two times per day for a deep tissue injury (DTI) to the left heel and prevention to the right heel - ordered 8/20/21; -Wound care: pack wound with silver alginate packing and cover with a foam dressing every other day and as needed for a stage 4 pressure ulcer - ordered 8/21/21, and discontinued on 8/24/21; -Cleanse sacral wound with wound cleanser. Apply skin prep to the periwound. Pack the wound with Dakins soaked packing strip. Cover with a foam dressing. Change daily and as needed/soiled for a stage 4 sacral wound - ordered 8/25/21. C. Observations and interviews revealed continued failure of the facility to take measures to heal the resident's pressure injury to her coccyx and to prevent infection. 1. 8/19/21 - Failure to position resident off her coccyx for approximately four hours, contrary to orders 8/12/21. A continuous observation was conducted on 8/19/21 beginning at 9:14 a.m. and ending at 1:30 p.m. The following was observed: -At 9:14 a.m. Resident #9 was observed lying on her back in the middle of the bed. The head of the bed was raised to a 45-degree angle with a Potus boot to the left foot. -At 10:26 a.m. Resident #9 continued to lay in bed in the same position. Staff have not entered the resident's room to provide repositioning. -At 11:05 a.m. two certified nurse aides (CNAs) entered the resident's room and closed the door. The staff left the room at 11:15 a.m. CNA #2 said they provided incontinence care for Resident #9. -At 11:15 a.m., after the CNAs left the resident's room, Resident #9 was lying on her back in the middle of the bed. The head of the bed was raised to a 45-degree angle. The resident was not repositioned following incontinence care. -At 12:50 p.m. CNA #1 entered the room with the lunch tray. The meal was set up on the over bed table. CNA #1 left the room. -At 1:30 p.m. Resident #9 was lying in the same position, on her back in the middle of the bed. CNA #2 was interviewed on 8/19/21 at 11:15 a.m. She said she had been the primary day shift CNA for Resident #9 for the past few months. She said she would provide incontinence care and showers for the resident. She did not indicate she had been instructed to reposition the resident and review of the CNA POC did not reveal it was documented there to turn and reposition the resident. She said Resident #9 had a wound to the buttocks for a while, and when she would provide care to Resident #9, sometimes the wound would be covered with a treatment and sometimes it would not be covered. 2. 8/23/21 - Failure to reposition the resident and dress her pressure injury, as ordered. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The regional resource nurse manager (RRNM) was observed on 8/23/21 at 3:30 p.m. to complete a skin assessment of Resident #9. The resident was positioned on her back. Her left foot had a small raised dry area and her left heel was blackened and measured 4 x 2.5 cm. The right heel was boggy and red. Her coccyx had a very large wound, red and open to air underneath the briefs she had on. The RRNM said the resident had a shower today and the nurse had not redressed the wounds yet. The wound measured 4 x 2 cm and 3/4 cm deep. The red area around the wound was large and measured 13 by 10 cm with three smaller open wound areas around that. Posterior to the large wound was an open area that measured 1 x 1 cm. The open area next to that was 1 x 2 cm and another open area that measured 3 x 1.5 cm. RRNM put a clean brief on the resident but did not redress the wounds to the coccyx. She said the nurse would do that. She said the wound doctor was there on Friday (8/20/21) and wrote new orders but she did not have time yet to put those orders into the system for the nurses to follow. The resident's spine was red (blanchable) and measured 10.5 x 5.5. She had a small red area to the right of the spine that looked like a red line. Although a reddened area on the resident's spine was found during the assessment, an area not identified 8/20/21 by the wound physician (see above), after the skin assessment, the resident was positioned on her back. 3. 8/24/21 - Failure to reposition the resident off her coccyx for approximately two hours and reports of the resident consistently not repositioned and a report that pressure injury was worsening. -At 8:45 a.m., Resident #9 was observed lying on her back in the middle of the bed. The head of the bed was slightly raised at a 45-degree angle. The resident had a Potus boot to the left foot. A continuous observation began at 10:45 a.m. and ended at 12:30 p.m. -At 10:45 a.m., Resident #9 was lying in the center of the bed with the head of the bed raised to a 45-degree angle. The resident's shoulders were halfway up the top of the mattress with the top of the resident's head lying on the bottom portion of the pillow, putting pressure on the resident's coccyx area. The resident's feet were uncovered by the blanket. A Potus boot covered the resident's left foot. No pressure relief measures were in place for the resident's right heel which was observed to be boggy and red the day before. Further, no pillows or other devices were observed to assist with positioning of the resident off her back. -At 11:00 a.m. Resident #9's roommate was interviewed. She said the facility staff usually only entered their room when Resident #9 required changing. She said Resident #9 laid in bed all day and did not sit in her wheelchair very often. She said the resident's current position was the position she was in on a regular basis. She said she had never seen the facility staff enter the room to reposition Resident #9. -At 12:01 p.m. nurse practitioner (NP) #1, at the nursing station, asked registered nurse (RN) #4 for a description of the resident's wound to the coccyx. RN #4 responded she had not seen the wound that day. She said Resident #9 was in bed and thought the CNAs would be getting her out of bed soon. NP #1 walked down the hallway and entered Resident #9's room and closed the door. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-At 12:04 p.m. NP #1 exited Resident #9's room and asked RN #4 if she could assist in rolling Resident #9 on her side so she could assess the resident's wound. RN #4 said she did not have time and for NP #1 to push the call light so a CNA would come and assist. NP #1 re-entered the resident's room and pushed the call light. -At 12:07 p.m. Resident #9's roommate exited the room and walked down the hallway, looking for a CNA. A CNA was observed walking down the hallway, pushing a mechanical lift. Resident #9's roommate said the CNA said she was busy assisting another resident and told her to go to the front of the facility to look for another CNA to assist Resident #9. -At 12:10 p.m. NP #1 walked out of Resident #9's room and asked an agency nurse to assist her with turning Resident #9. The agency nurse and another nurse entered Resident #9's room to assist NP #1. NP #1 exited the resident's room at 12:18 p.m. NP #1 was interviewed on[TRUNCATED]

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41968 Based on record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for two (#19, and #4) residents out of three of 37 sample residents. Specifically, the facility failed to: -Ensure Resident #19 had a neurological assessment completed after any unwitnessed falls, and -Ensure Resident #4's fall mat was in place while the resident was in bed according to fall interventions. I. Facility policy The Fall Management policy, revised on 6/1/21, was provided by the regional resource nurse (RRN) on 8/25/21 at 3:50 p.m., it read in pertinent part: Residents will be assessed for fall risks as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. Residents experiencing a fall will receive appropriate care and investigation of the cause. The purpose was to reduce risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall. Practice standards when a resident fell was to utilize the fall response protocol for both witnessed and unwitnessed falls. Perform neurological evaluation flow sheet for all unwitnessed falls and witnessed falls with injury to the head or face. Document the incident or accident and update the care plan. The neurological evaluation flow sheet provided by the regional resource nurse (RRN) on 8/25/21 at 3:50 p.m., read in pertinent part: Neurological assessment to be completed every 15 minutes for the first two hours after a fall. Every 30 minutes for two hour, every hour for four hours and every eight hours for 64 hours. II. Resident #19 A. Resident status Resident #19, age 92, was admitted to the facility on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included hypertension, diabetes, chronic kidney disease and depression. The minimum data set (MDS) assessment, dated 7/26/21, revealed the resident had mild cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He required extensive assistance of two people with bed mobility, transfers, toileting and personal hygiene. He required extensive assistance with one person to dress. He had a risk of falls. B. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The fall care plan revised on 8/9/21 for Resident #19 revealed Resident #19 was at risk for falls. The goal said the resident will have no falls with injury. The interventions were to assess for changes in medical status, pain status, mental status and report to the physician any indicated. Medication evaluation as needed. Provide verbal cues for safety and sequencing when needed. Provide verbal cues for proper pacing and energy conservation techniques, call light within reach while in bed or close proximity to the bed. Remind the resident to use call light when attempting to ambulate or transfer, have a clutter-free environment in the resident's room and consistent furniture arrangement. When the resident is in bed, place all necessary personal items within reach and monitor for and assist with toileting needs. 1. Fall #1 The risk management system (RMS) event summary report dated 8/19/21 for Resident #19 was provided by the RRN on 8/25/21 at 9:00 a.m. it read in pertinent part: The circumstances reported by LPN #7 on 8/19/21 at 5:22 a.m. said Resident #19 got himself to a seated position on the side of the bed. The bed was in the lowest position at the time. He needed assistance to get back to the proper position on the bed. LPN left the room to get assistance and upon returning to the room the resident was on the floor. The situation background assessment recommendations (SBAR) dated 8/19/21 at 6:10 a.m. for Resident #19 was provided by the RRN on 8/25/21 at 9:00 a.m. and completed by LPN #7. The nursing documentation for status post fall for Resident #19 was completed by LPN #5 dated 8/19/21 at 1:22 p.m., it read in the neurological section the resident was alert, no change in his mental status and oriented to person and place. The nurse progress note dated as a late entry on 8/20/21 at 4:41 a.m. for the 8/19/21 fall was completed by registered nurse (RN) #1. It read in pertinent part; RN #1 responded to Resident #19 room at 1:00 a.m after staff reported to her that the resident was found on the floor. She said neurological assessments were started and change from residents baseline was noted Record review showed no record of the neurological evaluation flow sheet for Resident #19s unwitnessed fall on 8/19/21 or what the change from the residents baseline was. 2. Fall #2 The SBAR note dated 8/20/21 at 1:05 a.m. for Resident #19 was completed by LPN #8 and read there was a change of condition due to a fall. The nurse progress note dated 8/20/21 at 4:52 a.m. was completed by RN #1. It read in pertinent part: RN responded to Resident #19 room at 1:10 a.m. after staff reported to her the resident was found on the floor with a large hematoma noted to his left upper forehead. Neurological check showed the resident was at his baseline. The resident was sent to the emergency room . Resident #19 returned from the emergency room at 7:30 a.m. on 8/20/21. Facility failed to ensure the neurological assessments after an unwitnessed fall with head injury was completed after the resident returned from the emergency room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Interviews LPN #2 was interviewed on 8/25/21 at 10:10 a.m. She said when a resident fell an RN assessment was completed, first aid given if needed and a neurological assessment. She said neurological assessments were done especially when the fall was unwitnessed and a head injury had occurred. RN #3 was interviewed on 8/25/21 at 10:20 a.m. She said when a resident fell and the fall was unwitnessed a neurological assessment was completed, the physician was notified and a change of condition filled out. RN #4 was interviewed on 8/24/21 at 11:10 a.m. She said a neurological assessment flow was completed for any unwitnessed falls and when anyone hit their head. She said the neurological assessment was every 15 minutes for two hours, every 30 minutes for four hours and then every eight hours for 64 hours. She said the care plan was updated after each fall. The regional resource nurse (RRN) was interviewed on 8/26/21 at 1:00 p.m. She said when a resident fell an RN assessment was completed right away before the resident was moved. She said a change of condition was documented and an SBAR was filled out. Neurological assessments were completed for unwitnessed falls. She said she could not locate any neurological assessments for Resident #19 falls. -No further documentation was provided after the survey. 43909 III. Resident #4 A. Resident status Resident #4, under the age of 70, was originally admitted on [DATE] with a readmitted [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paranoid schizophrenia, hemiplegia (paralysis) following cerebral infarction (stroke) affecting the left side, seizures, and intellectual disabilities. The 7/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required extensive assistance with two-person physical assistance for bed mobility, transfers, and toileting. He required extensive assistance and one person physical assistance with locomotion on/off the unit, dressing, and personal hygiene. Per the MDS, the resident sustained two or more falls without injury since the previous assessment period. B. Resident observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/23/21 at 9:40 a.m. Resident #4 was in bed eating breakfast. There was no fall mat next to the bed. -At 2:45 p.m. Resident #4 was in bed for a skin assessment. After the skin assessment, the resident remained in bed with his bedside table next to him and the bed in a raised position. The fall mat was not next to the bed. -At 3:22 p.m. Resident #4 was in bed watching TV. There was no fall mat next to the bed. On 8/24/21 at 9:04 a.m. Resident #4 was asleep in bed with his breakfast tray in front of him. There was no fall mat next to the bed. -At 9:58 a.m. Resident #4 was still asleep in his bed leaning toward the wall on his right side. Certified nurses aide (CNA) #2 entered the room and found the fall mat folded up behind the fan in Resident #4's room. She then placed the fall mat next to the resident's bed. -At 10:27 a.m. Resident #4 was still in bed but the fall mat had been moved away from the bed and was on the floor toward the middle of the room with part of the mat leaned up against the bedside table. -At 11:12 a.m. Resident #4 was still in bed and the fall mat was observed pushed aside leaning up against the wall. C. Record review No fall risk assessment was found in the resident's electronic medical record. The resident's comprehensive care plan, last reviewed 8/11/21, revealed the resident was at risk for falls related to his stroke. Pertinent interventions included: -Add fall mat next to bed (initiated 5/12/21); -Apply bolster to side of bed (initiated 5/24/21); -Keep bedside table from his reach. He will pull it toward him and it will fall on him (initiated 5/14/21); -Make sure to offer food and coffee every couple of hours when the resident is awake (initiated 5/12/21); and, -When the resident is in bed, place all necessary personal items within reach (initiated 7/17/2020). D. Staff interviews CNA #3 was interviewed on 8/25/21 at 4:03 p.m. CNA #3 said that Resident #4 had not fallen in several months so she was not sure what his fall interventions were. CNA #3 said Resident #4 fell when he was in bed because he tried to get out of bed on his own. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physical therapist (PT) was interviewed on 8/26/21 at 11:52 a.m. The PT said Resident #4 had been seen by physical therapy and occupational therapy several times because of his tendency to lean toward his right side. The PT said they moved his bed against the wall because the resident would lean to his right and fall out of bed when his bed was in a different position. The PT said before they moved the resident's bed she had seen him close to falling out of bed many times and had gone into the room to reposition him to prevent him from falling. The regional resource nurse (RRN) was interviewed on 8/26/21 at 2:34 p.m. The RRN said Resident #4 had a sign in his room to keep his bedside table near him and that he had a fall mat. The RRN said the fall mat should have been in place anytime the resident was in bed.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews the facility failed to ensure for two (#9 and #5) of three residents reviewed received the care and services necessary to meet their nutrition needs and to maintain their highest level of physical well-being, out of 37 sample residents. Specifically, the facility failed to consistently monitor weights, identify significant weight loss and timely address Resident #9's nutritional needs. Resident #9 experienced a significant, unplanned weight loss of 9. 3% in two months. In addition, Resident #9 developed a pressure injury which worsened to a stage 4. The facility failed to identify the resident was a nutritional risk and develop a comprehensive care plan. Record review and interviews revealed the facility failed to monitor Resident #9's weight in accordance with physician orders and put nutritional interventions into place to support wound healing and weight loss prevention. Interviews confirmed the facility lacked a system to ensure resident weights were being obtained to accurately monitor any significant weight loss or weight gain. The facility's failure to have a system that ensured timely weights were obtained and nutritional interventions in place contributed to Resident #9's significant weight loss. Cross-reference: F686 (pressure injuries), F600 (neglect), F725 (staffing), F835 (administration) and F867 (QAPI). Additonally, the facility failed to ensure Resident #5 was weighted according to RD recomendations. Findings include: I. Facility policy and procedure The Nutrition/Hydration policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 8/25/21 at 3:51 p.m. It revealed, in pertinent part, The implementation of an individual patient's nutrition/hydration management occurs within the care delivery process. Staff will consistently observe and monitor patients for changes and implement revisions to the plan of care as needed. Practice standards: -Review appropriate assessment information; -Address any changes in condition that affect or potentially affect the patient's nutritional status with the dietician and physician; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Use the diet order and communication form to initiate a consult with the dietician when indicated; -Review dietician recommendations on the nutritional care recommendations form; -Develop an interdisciplinary plan of care for enhancing oral intake and promoting adequate nutritional and hydration. Include interventions for patients who have functional difficulties which may affect ability to eat or drink independently; -Observe oral intake of meals, supplements and snacks and complete the meal monitor data collection sheet when ordered or indicated; -Monitor the patient's weight as ordered; -Review the dietician's progress notes to identify ongoing progress and recommendations; -Revise patient's care plan as needed. II. Resident #9 A. Resident status Resident #9, age 88, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included type two diabetes and stage three chronic kidney disease. The 7/20/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility, dressing, toileting and limited assistance of one person with personal hygiene. -It documented that the resident was independent with eating. Based on record review and staff interviews this would be inaccurate. Resident #9 was not coded for weight loss and was not on a physician prescribed weight loss regimen. B. Record review Resident #9's record revealed she experienced a significant, unplanned weight loss of 12 lbs (pounds) and 9. 3% from 6/17/21 to 8/23/21. 1. Resident #9's nutritional status upon admission to the facility in June 2021 The resident's electronic medical record was reviewed on 8/19/21 at 10:51 a.m. It did not reveal documentation that a comprehensive care plan had been developed to address the resident's nutritional risk for potential nutritional deficiency and weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 6/16/21 admission nutritional assessment documented Resident #9's usual body weight was 130 lbs (pounds). The resident was placed on a CCHO (consistent carbohydrate) diet with fair intakes, able to eat independently and voice her needs and preferences. The registered dietititian (RD) documented the resident had not been weighed yet since being admitted to the facility and had requested nursing obtain the resident's weight. It indicated the RD would follow up as needed once the resident's weight was obtained and add liquid protein one time per day to support healing. (cross-reference F686 failed to prevent the development of pressure ulcers) The weights and vitals record documented the resident's first weight was obtained on 6/17/21 (seven days following her admission to the facility), which indicated the resident weighed 129 lbs. 2. Resident #9's significant weight loss and the facility failure to reassess the resident's functional status for eating, effectively monitor the resident's weight and significant skin deterioration The June 2021 meal intake records documented that the resident consumed the following: -100% of meals on seven occasions; -75% of meals on 11 occasions; -50% of meals on 33 occasions; -25% on four occasions; and - no documentation on five opportunities. The June 2021 medication administration record (MAR) documented the following physician orders: -Liquid protein: 30 cc of protein liquid one time per day for three months - ordered 6/17/21; -Weigh the resident every Thursday for two weeks - ordered 6/17/21. Record review showed the facility failed to adequately monitor the resident's weight according to physician orders and within accepted standards of practice. The only weight documented in the resident's electronic medical record was 129 lbs on 6/17/21 and not again until 8/10/21. (Cross reference F835: failure to ensure sufficient administrative oversight and F867: failure to identify areas of concern to prevent substandard care). The July 2021 meal intake records documented that the resident consumed the following: -100% of meals on 11 occasions; -75% of meals on nine occasions; -50% of meals on 26 occasions; -25% of meals on three occasions; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-0% of meals on one occasion; and -no documentation on 43 opportunities. The July MAR documented the following physician orders: -Weight weekly every Thursday and notify the physician of a weight gain of greater than five lbs in one week for edema - ordered on 7/8/21 and discontinued on 8/3/21. Record review showed the nursing staff signed off the MAR to indicate the weekly weight had been obtained per physician's order, however the resident's medical record did not document any such weights had been obtained. The August 2021 meal intake records documented that the resident consumed the following: -100% of meals on three occasions; -75% of meals on 13 occasions; -50% of meals on two occasions; -25% of meals on 17 occasions; -0 % of meals on zero occasions; and -no documentation on 37 opportunities. Record review showed the facility failed to consistently monitor the resident's meal intake percentage to determine if the resident's meal intakes had a negative effect on her nutritional status. The weight and vitals record documented the resident's weight was obtained on 8/10/21 of 125.2 lbs, a weight loss of 3.8 lbs./2.9%. 3. Nutritional assessments and documentation following the resident's initial weight loss The 8/11/21 nutrition progress note documented Resident #9 had a pressure ulcer to the coccyx and had a small amount of weight loss in the past two months, since her admission to the facility. The resident was under the desirable body mass index (BMI) range for older adults. Her current BMI was 21.4 and should be over 22. It indicated the resident was tolerating a CCHO (consistent carbohydrate) diet for diabetes mellitus with intakes that were generally poor with an average of 54% in the past week. The resident was able to feed herself independently. The resident benefited from setup assistance. It documented that the resident was falling short of increased energy needs. The RD checked in on the resident during several meals and determined Resident #9 was a slow eater, and did not eat a lot. The resident's responsible party indicated the resident was not a big eater and provided some food preferences for the resident. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The resident's recent labs were reviewed which indicated a low albumin level, which the RD documented was from the resident's nutritional status. The interventions included adding a multivitamin, house supplement twice per day and trialing some of the resident's favorite foods. The August 2021 MAR documented: -House supplement: 4 ounces of house supplement twice per day. Document the percentage on the MAR - ordered 8/10/21. It documented the following house supplement intakes from 8/10/21 to 8/25/21: -100% on 12 occasions; -75% on two occasions; -50% on six occasions; -20-25% on three occasions; and -zero percent on five occasions. The 8/13/21 nutritional progress note documented the RD stopped into the resident's room to see if she would accept dark chocolate. The resident declined and the RD left the candy at the bedside in case she changed her mind. The 8/17/21 at 5:30 p.m. nutritional progress note documented the RD brought a cheese sandwich to the resident's room. Resident #9 was sleeping when she arrived and the lunch tray was still sitting at the bedside, untouched. The RD asked the certified nurse aide (CNA) to ensure the resident was up for dinner. C. Staff interviews CNA #2 was interviewed on 8/19/21 at 11:15 a.m. and again on 8/24/21 at 2:24 p.m. She said she had been the primary day shift CNA for Resident #9 for a few months. She said she would deliver the room trays to Resident #9 in her room. She said she would provide setup assistance to the resident and leave the room. She said Resident #9 was not able to make her needs known or use the call light. She said Resident #9 was often forgotten because she could not make her needs known. She said when the resident first was admitted to the facility, she was able to feed herself independently. She said over the past month, Resident #9's physical abilities had declined. She said Resident #9 would benefit from cueing during meals. She said, when she had time, she would attempt to go into the resident's room and encourage her to take a bite of food. She said Resident #9 usually responded well to encouragement. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	She said the resident should be sitting up in her wheelchair for all meals. She said she thought the resident would benefit from sitting in the dining area with staff providing cueing and physical assistance with eating. She said she thought the resident's poor intake was related to her not receiving enough assistance during meals. She said the RD had asked her to check on the resident that day, 8/24/21, and encourage the resident to eat. She said she did not have time that day to provide encouragement to the resident. She said the dining area by the nursing station had a staff member present at all times. She said the resident would benefit from sitting in the dining area. She said staff would be able to provide encouragement and physical assistance. Nurse practitioner (NP) #2 was interviewed on 8/26/21 at 12:20 p.m. She said Resident #9 was immobile and was unable to reposition herself without staff assistance. She said she was aware the resident had decreased meal intakes. She said she had not been notified the resident had sustained a significant weight loss of 9.3% in two months. She said it would be beneficial if a staff member would sit with the resident, encourage her to eat and even provide physical assistance. She said Resident #9 was a very slow eater and thought it would help if staff sat and engaged the resident during the meal. She said the facility staff had not approached her regarding the resident's functional level. She said Resident #9 was immobile, which made it hard for her to understand how the resident was independent with eating. She said the resident did not make her needs known and would only answer yes and no questions. She said she felt Resident #9 would benefit from being in a restorative program for eating assistance. She said she felt if the resident had staff assistance with cueing and physical assistance, her meal intake would significantly improve. She said the resident's meal intake and gaining of weight was crucial in the healing of the stage 4 wound to the resident's coccyx and DTI (deep tissue injury) to the left heel. She said wounds were only unavoidable if all interventions and preventative measures had been exhausted. She said she did not think all preventative measures had been completed, including meal assistance and a re-evaluation of the resident's functional needs and felt the wounds were avoidable. The RD was interviewed on 8/25/21 at 11:46 a.m. She said obtaining weights had been a concern for a few months at the facility. She said she had brought up the concern in the morning management meetings, but the weights were still not being obtained. She said it had gotten to the point where it was just her problem and the facility management did not step in to assist. She said the social services director (SSD), who was also a CNA, and the occupational therapist assisted her in obtaining the weights on 8/23/21. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	She confirmed she was unable to properly monitor resident weights throughout the facility and potential significant weight loss. She said Resident #9 was admitted on [DATE] and she completed her nutritional assessment on 6/16/21. She said the facility staff had not obtained the resident's weight prior to her completing her assessment. She said the resident had a history of being on nutritional supplements and skin breakdown, however Resident #9's skin was intact upon admission. She confirmed she had not developed a nutritional comprehensive care plan upon the resident's admission to the facility. She said she had developed a nutrition care plan for Resident #9 during the survey process. She said she forgot to develop a nutrition care plan for Resident #9. She said Resident #9 did not have dementia, however would not answer appropriately when asked a question. She said the resident usually just stared at her and would not answer the question. She confirmed the physician had ordered for the resident to be weighed weekly. She said the facility staff had not followed physician orders to weigh the resident weekly. She said she assessed the resident on 8/10/21 and added a house supplement twice per day and on 8/19/21 added peaches on the top of her cereal to her breakfast preferences. She confirmed Resident #9 had a 9.3% weight loss in two months, which was considered significant. She said she encouraged the resident to eat on 8/24/21. She said Resident #9 was responsive to encouragement. She said she would take a bite of food only when prompted. She said she asked the CNA to continue throughout the meal to encourage the resident. She said she did not know if the CNA assisted the resident. She said the CNAs often did not listen to her when she asked them to do something. She said she felt the facility did not have enough staff and that affected residents like Resident #9 who would benefit from cueing and physical assistance. (cross-reference F725, failed to provide sufficient staffing to ensure residents needs were met) She said Resident #9's assessments indicated she only required set up assistance with eating. She said she had seen the resident on 8/24/21 for lunch. She said she prompted the resident and she would eat. She said she felt Resident #9 would benefit from being cued and even provided hands-on assistance with eating. She said Resident #9's functional status had not been re-evaluated for increased level of assistance. She said she had not discussed with Resident #9's family, coming into the facility during meals to see if that would increase the resident's meal intake. She said she had not put anything in place, other than the house supplement and adding to the resident's preferences on the meal ticket. The regional resource nurse manager (RRNM) was interviewed on 8/26/21 at 1:01 p.m. She said each resident should have their weight obtained upon admission, a nutrition assessment and a nutrition care plan in place. She said the dietician was responsible for the nutritional assessments for all residents and the development of each resident's nutritional care plan. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	She said each resident with identified weight loss should have interventions implemented in a timely manner, as well as consult the resident and responsible party for additional interventions. She said a root cause analysis should be conducted to determine the cause and beginning of the weight loss. She said the facility had a consistent problem with obtaining resident weights. She said the dietician wanted the weights to be completed on the same day and that was not possible. She said the RD had brought up the concern of weights not being obtained in the management meeting on many occasions. She said they had the lab tech, unit managers and therapy assisting, however the weights were still not being obtained. She said the facility was unable to monitor weight loss and implement interventions timely without resident's weights being obtained. She confirmed Resident #9 had a significant weight loss. She confirmed a nutritional care plan was not developed until the survey process. She said she was unable to determine what interventions had been put into place, other than a house supplement twice per day and peaches to cheerios, when the resident's weight loss had been discovered. She confirmed that facility staff did not weigh the resident weekly according to the physician's order. D. Follow-up The 8/18/21 nutritional progress note documented that the RD dropped off the resident's lunch tray. Resident #9 was sleeping and the breakfast tray was sitting in front of the resident, untouched. The RD woke up Resident #9, raised the head of the bed and left the room. When the RD returned, the resident had eaten 50% of a peanut butter and jelly sandwich and drank 75% of a glass of whole milk. The 8/19/21 nutritional assessment, during the survey process, documented that the RD met with the resident to discuss wound healing and a nutrition plan. It indicated the resident had a worsened stage 4 pressure injury to the coccyx. Cross reference F686 (pressure injuries). The RD documented that the resident remained on a consistent carbohydrate diet (CCHO) with generally poor intakes. The RD indicated she checked in with the resident during meal times to ensure she was awake and eating. The interventions included liquid protein one time per day, house supplement twice per day, which was generally accepted 50-100% of the time. The RD added Cheerios with peaches on top for breakfast and to liberalize the resident's diet from CCHO to regular to allow for more menu options. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD documented that the resident's weight loss was related to poor appetite and cognitive decline. The nutritional assessment did not address the lack of consistent documentation of the resident's meal intakes or the failure to obtain weekly weights as was ordered by the physician. Record review revealed the facility failed to evaluate the resident's functional limitations to determine if the resident required encouragement or physical assistance with meals following the RD's observations on two different occasions of the resident with an untouched meal in front of her, hours after it had been served. The weights and vitals documentation indicated Resident #9's weight was obtained on 8/23/21 of 117 lbs. The resident had a significant weight loss of 12 lbs/9.3% in two months. The 8/24/21 nutrition progress note documented that the RD set up the resident's lunch that day. The RD raised the head of the bed and made sure the resident was awake with the tray in front of her. The RD checked in several times after setting up the resident, had to wake her and remind the resident to eat. The RD asked the resident to take a bite and the resident did. The RD asked the CNA to continue to check in on the resident and encourage her to eat. 39261 III.Resident #5 A. Resident #5 status Resident #5, age 76, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included pressure ulcer of the sacral (bottom of the spine) region, schizophrenia, obesity, and insomnia. The 8/2/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance of two people with bed mobility, transfers, and toileting. He required extensive assistance of one person with dressing, and personal hygiene. The resident did not reject care. B. Record review A review of the resident's electronic medical record from the time of admission (7/26/21) until the time of discharge (8/15/21) revealed no weights had been taken for the resident. The 8/3/21 Nutritional Assessment, completed by the registered dietitian (RD) revealed the following: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident has not been weighed since admission. He reports a UBW (usual body weight) around 240 pounds and hospital weight was 252. He denies any recent chnages (sic) in weight. RD has requested weight from (the) nursing staff. C. Staff interview The registered dietitian (RD) was interviewed on 8/19/21 at 3:37 p.m. She said when a resident is first admitted to the facility she wants a weight as close to the date of admission as possible, and then weekly for the first month to establish a baseline weight. She said if the weights for the resident were stable, she would then want monthly weights after that. She said the certified nurse aides (CNAs) were responsible for resident weights, and just getting monthly weights had been a struggle. She attributed the lack of weights to their not having enough CNAs in the building, and those who were working simply having too much to do on a daily basis. She said Resident #5 should have been weighed on admission, and then weekly weights should have been completed for the first month. She said not having weights made it difficult for her to accurately monitor potential weight loss in the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43909 Based on observations, record review, and interviews, the facility failed to provide necessary respiratory care and services consistent with professional standards of practice for one (#4) of three residents reviewed for respiratory care out of 37 total sample residents. Specifically, the facility failed to: -Ensure oxygen was provided to Resident #4 as ordered by the physician; -Clarify oxygen orders when needed; and, -Ensure staff were aware of the correct liter flow that was ordered. Findings include: I. Resident #4 A. Resident status Resident #4, under the age of 70, was originally admitted on [DATE] with a readmitted [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paranoid schizophrenia, hemiplegia (paralysis) following cerebral infarction (stroke) affecting the left side, seizures, chronic obstructive pulmonary disease, and intellectual disabilities. The 7/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required extensive assistance with two-person physical assistance for bed mobility, and transfers. He required extensive assistance and one person physical assistance with locomotion on/off the unit, dressing, and personal hygiene. The resident received oxygen therapy. B. Observations of Resident #4 receiving oxygen during the day On 8/23/21 at 9:40 a.m. Resident #4 was in bed eating his breakfast. He was not wearing oxygen. -At 1:32 p.m. the resident was in his wheelchair in his room. He was wearing his oxygen nasal cannula. -At 1:53 p.m. the resident was in his room in his wheelchair wearing his oxygen. The oxygen concentrator was set at 3 liters per minute (LPM). On 8/24/21 at 9:04 a.m. Resident #4 was asleep in his bed with his breakfast in front of him on his bedside table. He was wearing his oxygen. -At 9:58 a.m. the resident was still asleep in bed wearing his oxygen. His oxygen concentrator was set at 2LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 11:12 a.m. the resident was in bed awake wearing his oxygen. On 8/25/21 at 3:13 p.m. the resident was in his wheelchair in his room watching television. He was wearing his oxygen. -At 4:03 p.m. the resident was in his room in his wheelchair. His oxygen tubing was around his ears but he had pulled it out of his nose. The concentrator was set to 3LPM. -At 4:51 p.m. the resident was still in his room in his wheelchair wearing his oxygen, which was now being worn properly and the nasal cannula was in his nose. On 8/26/21 at 11:52 a.m. the resident was in his wheelchair in his room watching television. He was wearing his oxygen and the concentrator was set to 3LPM. During the above observations, the resident was seen wearing his oxygen tubing and being administered oxygen during the day. The resident only had orders for oxygen to be administered at night. (see CPO below) C. Record review The August 2021 CPO revealed a physician order for oxygen at 3LPM via nasal cannula at night only (started 7/30/21). The order did not specify the underlying diagnosis or a time frame for at night. Review of Resident #4's comprehensive care plan revealed the resident exhibited or was at risk for respiratory complications related to chronic obstructive pulmonary disease (COPD) and that he used oxygen. Pertinent interventions included: -Oxygen as ordered via nasal cannula (initiated 7/17/2020); -Document in nurses notes if the resident removes his oxygen, change oxygen tubing weekly and as needed, and notify the physician with any change in condition (initiated 5/7/21); -Observe for sign/symptoms such as sneezing, watery eyes, or nasal congestion and report to the physician as indicated (initiated 5/7/21); -Observe respiratory status and assess for changes as well as changes in mental status (initiated 5/7/21); and, -Provide respiratory treatment as ordered and monitor for effectiveness (initiated 5/7/21). Review of the resident's electronic medical record revealed his oxygen levels, which were measured both from room air and during the administration of oxygen via a nasal cannula, were above 90% every time it was checked (multiple times per day) for the last three months. The residents record also failed to document or indicate why the oxygen orders were not followed and oxygen was administered to the resident during the day. D. Staff interviews (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurses aide (CNA) #2 was interviewed on 8/24/21 at 9:58 a.m. CNA #2 said she did not know Resident #4 used oxygen and she had not seen him use oxygen. She said she thought the resident's family wanted him to have oxygen, but she did not know what his orders for oxygen were or why he was using it. The assistant director of nursing (ADON) was interviewed on 8/24/21 at 10:27 a.m. The ADON said Resident #4's oxygen order was to have 3LPM via nasal cannula at night. The ADON said she was not sure what at night meant but she thought it meant whenever the resident was in bed sleeping. She said it was not surprising that the resident was still wearing oxygen at 10:30 a.m. because he liked to sleep in. She said the resident had lower oxygen levels when he was in bed due to his positioning so it was acceptable for him to wear his oxygen when in bed. She said that nurses had to administer oxygen and CNAs could not touch the oxygen settings. She said that the resident's oxygen saturation was checked along with his vitals as part of the normal COVID-19 vitals protocol, multiple times per day. She said she did not know if his oxygen should be checked while he was receiving oxygen therapy or if it should be checked when he was just breathing room air. The ADON checked the concentrator in Resident #4's room and verified that the resident's oxygen concentrator was set at 2LPM so she adjusted it to 3LPM to match his current liter flow order. She did not remove the oxygen from the resident. The regional resource nurse (RRN) was interviewed on 8/26/21 at 2:21 p.m. The RRN said any oxygen order should contain the pertinent diagnosis for the oxygen use, the liter flow, the type of delivery and the frequency of use. The RRN said she did not know what Resident #4's order for at night meant but she believed it meant from the time the resident went to sleep to the time the resident woke up. The RRN said the order would need to be clarified with the physician. No further documentation was provided after the survey.

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F 0725 Level of Harm - Actual harm Residents Affected - Few	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** 39261 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide an adequate number of nursing staff to address the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents. As a result of inadequate staffing, the facility failed to: -Provide necessary goods and services to prevent resident neglect (Cross-reference F600G) -Provide necessary care and services to maintain residents' hygiene (Cross-reference F676E) -Provide necessary care and services to prevent and heal residents' pressure injuries (Cross-reference F686J) -Provide necessary care and services to prevent resident significant weight loss (Cross-reference F692G) These failures contributed to Resident #9 experiencing actual harm, as evidenced by declines in the resident's physical well-being, specifically, the development of stage 4 and deep tissue pressure injuries and significant, unplanned weight loss of 9.3% in two months I. Resident census and conditions According to the 8/18/21 Resident Census and Conditions of Residents report, the resident census was 99. The following care needs were as identified: -88 residents needed assistance of one or two staff with bathing and 9 residents were dependent. Two residents were independent. -87 residents needed assistance of one or two staff members for toilet use and 12 residents were independent. -90 residents needed assistance of one or two staff members for dressing and nine residents were independent. -84 residents needed assistance of one or two staff members for transfers and one was dependent. Fourteen residents were independent. -79 residents needed assistance of one or two staff members with eating and 20 residents were independent. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	II. Staffing requirements for each unit The regional financial advisor (RFA) and staff scheduler (SS) were interviewed on 8/24/21 at 3:34 p.m. and provided the staff requirements for each unit in the facility based on the current census and resident needs. For all of the units in the facility, the licensed nurses worked 12 hour shifts from 6:00 a.m. to 6:00 p.m. The next shift worked 6:00 p.m. to 6:00 a.m. The certified nurse aides (CNAs) worked eight hour shifts from 6:00 a.m. to 2:00 p.m. for day shift and 2:00 p. m. to 10:00 p.m. for the evening shift, and 10:00 p.m. to 6:00 a.m. for the night shift. A. Bear Paw - the census at the time of the survey was 28 residents Day shift: Two licensed nurses (12 hours shift) and three CNAs. Evening shift: Two CNAs. Night shift: Two licensed nurses (12 hours shift) and two CNAs. B. Elk Run - the census at the time of the survey was 34 residents Day shift: Four licensed nurses (12 hours shift) and five CNAs Evening shift: Four CNAs. Night shift: Three licensed nurses (12 hours shift) and three CNAs. C. Solana - the census at the time of the survey was 15 residents Day shift: One licensed nurse (12 hours shift) and one CNA. Evening shift: One CNA. Night shift: One licensed nurse (12 hours shift) and one CNA. D. Deer Creek - the census at the time of the survey was 18 residents Day shift: One licensed nurse (12 hours shift) and two CNAs. Evening shift: Two CNAs. Night shift: One licensed nurse (12 hours shift) and one CNA. III. Working schedule (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of the facility working schedule from 8/16/21 to 8/21/21 revealed, at times, the working schedule did not have licensed nurses or CNAs scheduled according to resident needs and current census and as detailed in the staff requirements for each unit (see above). The regional financial advisor (RFA) and staff scheduler (SS) were interviewed on 8/24/21 at 3:34 p.m. The SS said his first day as the scheduler was 8/23/21, and the RFA had come to the facility on [DATE] to train him on how to correctly schedule the facility. The RFA said the first issue they had identified on 8/24/21 (during the survey), was in regard to the accuracy of the working schedule. -The RFA said the previous scheduler had left staff names on the schedule even if they were not scheduled to work. The RFA said when she looked at the schedule, the staffing ratios looked okay, but when she went to confirm if staff were in the facility working, it was identified they were not and all of the units, except Solana, were short-staffed for all shifts. -The RFA said after reviewing the schedules and comparing them to the actual working staff members, all of the units, except Solana, had half the required number of nursing staff scheduled to work. IV. Effect of working schedule - Cross-reference deficiencies F600G, F686J, F676E, and F692G A. F600G, F686J and F692G The facility failed to ensure Resident #9 was provided the goods and services necessary to maintain her physical well-being. Resident #9 sustained actual harm. Pressure injuries: The facility failed to provide care to prevent the development of a stage 4 pressure injury on the resident's coccyx and a deep tissue injury on her heel after admission. Observations revealed the resident was not turned and repositioned by staff. Interviews revealed the resident laid in the same position on her back much of the day, most days. During continuous observations on 8/24/21 beginning at 10:45 a.m. and ending at 12:30 p.m., Resident #9 was lying in the center of the bed with the head of the bed raised to a 45 degree angle. No pillows or other devices were observed to assist with positioning of the resident. Resident #9's roommate said the facility staff usually only entered their room when Resident #9 required changing. She said Resident #9 laid in bed all day and did not sit in her wheelchair very often. She said Resident #9's current position (lying on her back) was the position she was in on a regular basis. She said she had never seen the facility staff enter the room to reposition Resident #9. At 12:04 p.m. nurse practitioner (NP) #1 exited Resident #9's room and asked RN #4 if she could assist in rolling Resident #9 on her side so she could assess the resident's wound. RN #4 said she did not have time and for NP #1 to push the call light so a CNA would come and assist. NP #1 entered the resident's room and pushed the call light. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	At 12:07 p.m. Resident #9's roommate exited the room and walked down the hallway looking for a CNA. A CNA was observed walking down the hallway, pushing a mechanical lift. The CNA told Resident #9's roommate that she was busy assisting another resident and told her to go to the front of the facility to look for another CNA to assist Resident #9. At 12:10 p.m. NP #1 asked for and received assistance from an agency nurse. NP #1 was interviewed on 8/24/21 at 12:20 p.m. She said in the past few months she had a difficult time finding staff to assist her in assessing different residents. She said she felt the facility did not have enough staff. CNA #2 was interviewed on 8/24/21 at 2:24 p.m. She confirmed Resident #9 had been in the same position all day. She said she had not had time that day to reposition the resident. She said Resident #9 was usually in the same position all day, on her back with the head of the bed raised to about 45 degrees. She confirmed the resident's position put pressure on the coccyx. She said Resident #9 was unable to use the call light and never called out for help. She said Resident #9 was often forgotten because she did not make her needs known. She said she was really busy with the other residents on the hallway and would often forget to reposition Resident #9. She said it was not uncommon for Resident #9 to remain in the same position throughout the day. Weight loss: The facility failed to provide Resident #9 the care and services necessary to maintain her nutritional status; Resident #9 experienced a significant, unplanned weight loss of 9.3% in 2 months. Staff interviews revealed Resident #9 would benefit from cueing during meals and having staff provide physical assistance. CNA #2 said the registered dietitian (RD) had asked her to check on the resident today (8/24/21) and encourage the resident to eat. However, she said she did not have time today to provide encouragement to the resident. NP #2, who was aware of the resident ' s weight loss, said it would be beneficial if a staff member would sit the resident, encourage her to eat and even provide physical assistance. The RD said she felt the facility did not have enough staff and that affected Resident #9 who would benefit from cueing and physical assistance. Record review also revealed resident weights were not being taken. The RD said CNAs were responsible for resident weights, and just getting monthly weights had been a struggle. She attributed the lack of weights to their not having enough CNAs in the building, and those who were working simply having too much to do on a daily basis. See F600, F686 and F692 for detailed findings on the facility's failures. B. F676E The facility failed to ensure Residents #9, #19, #1, #20, #21, #22, #3 and #4 received regular bathing in accordance with their plan of care. Record review revealed all eight residents failed to receive baths in July and August as planned. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Licensed practical nurses (LPN) #6 was interviewed on 8/18/21 at 10:25 a.m. She said she was the day shift nurse on the secure unit (Solona). She said she frequently did not have a day shift CNA on the unit, so she was frequently by herself with all 15 residents. She said when that happened, resident showers were not completed, and at best, she was able to complete just the basic resident cares. CNA #1 was interviewed on 8/18/21 at 11:00 a.m. She said she frequently worked short on every unit she worked on. She said the facility had a shower aide and that helped the CNAs get everything done during their shift, but about two weeks ago, the shower aide was moved to the staff scheduler role. The CNA said showers became the responsibility of the CNAs again. The CNA said showers were not consistently happening in the facility because there was not enough staff or time to complete them. The CNA said all of the residents had been eating in their rooms since the beginning of August. The CNA said between passing all the drinks, room trays, and trying to provide meal assistance, the CNAs were lucky to provide basic care to the residents. The assistant director of nursing (ADON) said showers had improved in the building a few months ago when the facility had a shower aide whose sole responsibility was to provide showers. She said about a month ago the staff was very short in the building and the shower aide was pulled to the floor as a CNA, and then was hired as the staff scheduler. She said during that month when shower aide was pulled to the floor, and then ultimately hired as the staff scheduler, showers in the facility were not occurring as they should, and residents were lucky to get one shower a week. Resident #1 was interviewed on 8/19/21 at 1:15 p.m. She said she used to be on hospice, and got a shower at least twice a week from her hospice aide. She said she had graduated from hospice, and was no longer being seen by them, so she was provided a shower one time a week, at best, and usually after she had asked the CNAs several times. IV. Additional resident and staff interviews confirmed the facility failed to have an adequate number of staff to meet the residents' needs. LPN #1 was interviewed on 8/18/21 at 10:40 a.m. She said the building was always short of nursing staff. She said it was difficult to get the basic resident care done when there was typically one CNA for 17 to 20 residents. The LPN said the staff in the facility had reported the staffing concerns to management, but nothing ever changed. Registered nurse (RN) #5 was interviewed on 8/18/21 at 10:47 a.m. She said staffing in the building was consistently short. She said the schedule was very inaccurate, and she never knew who was going to show up to work. She said management had been made aware of the continued staffing concerns, but there was consistent turnover in management so nothing seemed to change. The RN said the CNAs and nurses were doing their best to ensure the residents basic needs were met, but things like showers, consistent meal assistance, and consistent repositioning were difficult when there were one or two staff for 34 residents. (continued on next page)

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F 0725 Level of Harm - Actual harm Residents Affected - Few	ADON #2 was interviewed on 8/19/21 at 9:45 a.m. She said the staffing in the facility had been a consistent problem since she had started in February of 2021. She said she and other nursing managers had repeatedly told the facility corporate consultants of the staffing needs and concerns and nothing had changed. She said the basics were being completed for most residents, but if a resident was dependent and quiet, they would simply fall through the cracks, like what happened with Resident #9. The ADON said Resident #9 did not use her call light or call out for help, so she was often just forgotten in her room. Resident #30 was interviewed on 8/25/21 at 12:50 p.m. She said there was a long wait for staff to provide care, and at times she had to wait up to an hour before staff would come and assist her. She said she felt bad for the CNAs who had 30 residents to care for. Resident #26 was interviewed on 8/25/21 at 12:55 p.m. She said it took staff a long time to answer call lights, so she typically would yell down the hallway for staff assistance. She said her roommate needed more help than she did, and she was unable to call for help. She said it made her feel like no one cared about them. Resident #34 was interviewed on 8/25/21 at 1:07 p.m. She said her care needs were not always met, and it seemed like the staff called off a lot so there were not enough of them in the building for all of the residents. She said she was scared no one would come and care for her when she needed them, and that was a horrible feeling. Resident #32 was interviewed on 8/25/21 at 1:13 p.m. She said the facility needed more help, and it was terrible in the facility. She said she was more independent than other residents so she tried to help the other residents who needed more help as much as possible. Resident #31 was interviewed on 8/25/21 at 1:18 p.m. She said the only time there was enough staff in the facility was when the surveyors were in the building. She said it was bothersome, and she felt like she was just a number. V. Follow-up See above; during the interview with the regional financial advisor (RFA) and staff scheduler (SS) on 8/24/21 at 3:34 p.m., they said they had been comparing employees' timesheets with the current schedules and they were not matching up. -The RFA said when that was identified, she told the facility they needed to stop using the daily schedules since they were inaccurate. The RFA said moving forward, the facility would be utilizing a master pattern schedule which would include every nurse staff member's schedule for the month, and using that pattern, the scheduler would be able to identify when there was an open shift that needed to be filled. -The RFA said the facility had been using agency nursing staff and would continue to do so until their staffing needs had improved. The nursing home administrator (NHA) was interviewed on 8/24/21 at 5:00 p.m. He said the facility had put an admission hold in place since the beginning of August 2021, and would continue the admission hold until staffing had improved in the facility.

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39261 Based on record review and interviews, the facility failed to ensure medically related social services were provided for one (#1) of three out of 37 sample residents. Specifically, the facility failed to address Resident #1 missing hearing aids for over a year. Findings include: I. Facility policy and procedure The ancillary/hearing services policy and procedure was requested on 8/25/21 from the regional resource nurse (RNC), who stated the facility did not have any policy regarding resident hearing aids. II. Resident #1 status Resident #1, age 90, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, chronic pain, and history of falling. The 7/22/21 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of 11 out of 15. She required extensive assistance of one person with bed mobility, dressing, toilet use, and personal hygiene. She required set-up assistance with all other ADLS (activities of daily living). The MDS indicated the resident's ability to hear was highly impaired, and a hearing aid was used. B. Resident interview Resident #1 was interviewed on 8/19/21 at 1:15 p.m. She said had difficulty hearing for a few years, and had purchased hearing aids about a year ago, which had since been lost or misplaced by the facility. She said she had repeatedly told the social worker about her missing hearing aids, but the social worker had yet to work with her in replacing the hearing aids. She said not having her hearing aides had really bothered her, as she struggled to watch television and visit on the phone with her family. C. Record review A medical receipt from 5/3/19 documented the resident had purchased hearing aids for both ears. A 3/5/2020 audiologist patient visit summary documented the following; Resident to be seen for hearing test and consult. No mention of previous hearing aids from 5/3/19. Will place (an) order for new hearing aids for (the) resident. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2021 physician orders documented the following order: -One time a day and every evening shift remove hearing aides (sic) every HS (hour of sleep), and remove battery. Ordered 3/9/2016. The July MAR (medication administration record) revealed the following: Nursing staff documented placing the hearing aids in the resident's ears everyday except the following: 7/2/21, 7/21/21, 7/26/21, and 7/27/21 The August MAR revealed the following: Nursing staff documented placing the hearing aids in the resident's ears everyday except the following: 8/6/21, 8/9/21, 8/10/21, 8/12/21, 8/14/21, 8/16/21, 8/19/21, and 8/23/21. The nursing progress notes documented the following: 6/2/21- Hearing aids are lost 6/3/21- HA (hearing aid missing) 6/7/21 - No hearing aids 6/19/21 - Unable to find hearing aids 7/21/21 - Hearing aids are no longer available 7/26/21 - Hearing aid not available to remove battery 8/6/21 - As per resident hearing aids are lost. 8/11/21 - Hearing aid battery, hearing aids are no longer available to remove battery. 8/14/21 - No hearing aid available to remove 8/19/21 - No HA (hearing aid) available to place in cart, as per resident they are lost. 8/23/21 - Unable to find (hearing aids) at this time notified DON (director of nursing) and manager of unit. The 6/22/21 care planning meeting notes documented the following: -Resident needs appointment for hearing aid. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 8/19/21 at 1:40 p.m. She said she had worked with the resident for the past six months, and had never seen the resident with hearing aids, nor had she ever assisted the resident with her hearing aids. The CNA said the resident was hard of hearing and she would use a whiteboard to write questions for her so she was not screaming at her. Registered nurse (RN) #4 was interviewed on 8/19/21 at 1:50 p.m. She said she had been Resident #1 nurse in the past, and was her nurse for the day shift, 6:00 a.m.until 6:00 p.m. The RN said she had documented that she placed Resident #1 hearing aids in her ears this morning, but she could not recall if she actually had. The RN went to Resident #1 room to verify placing the hearing aids, at which time Resident #1 told RN #4 that her hearing aids had been missing for over a year. The RN told the resident she would report the missing hearing aids to the social worker, to which the resident responded she already knows, and hasn ' t done a thing. The RN stated she should not have documented that she placed the hearing aids in the resident ' s ears. The RN said she would notify management of the missing hearing aids. The social service director (SSD) was interviewed on 8/19/21 at 2:10 p.m. She said Resident #1 had been missing her hearing aids for at least a year, and she had been aware of them missing for the entire time. The SSD said the facility had an audiologist who was scheduled to come into the facility in August 2021, but he was unable to do so due to the facility's COVID-19 outbreak. The SSD said she had done nothing prior to the August 2021 audiologist visit due to COVID-19. The SSD said she would add Resident #1 to the list of residents to be seen by the audiologist, and ensure that she was seen. The director of nursing (DON) was interviewed on 8/19/21 at 4:55 p.m. She said if a resident had misplaced or lost their hearing aids, the facility would need to ensure they were promptly seen by an audiologist. The DON said waiting over a year to have hearing aids replaced was far too long.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43909 Based on record review and interviews, the facility failed to ensure residents were free of unnecessary psychotropic medication for one (#4) of three residents investigated for unnecessary medication usage out of 37 sample residents. Specifically, the facility failed to: -Ensure consents were obtained for the use of psychotropic medications for Resident #4; -Ensure gradual dose reduction (GDR) recommendations were communicated to the physician for Resident #4; and, -Ensure a care plan was implemented for the psychotropic medications. Findings include: I. Resident #4 A. Resident status Resident #4, under the age of 70, was originally admitted on [DATE] with a readmitted [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included paranoid schizophrenia, hemiplegia (paralysis) following cerebral infarction (stroke) affecting the left side, seizures, and intellectual disabilities. The 7/21/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. He required extensive assistance with two-person physical assistance for bed mobility, transfers, and toileting. He required extensive assistance and one person physical assistance with locomotion on/off the unit, dressing, and personal hygiene. Per the MDS, the resident received antipsychotic, antianxiety, antidepressant, and opioid medications daily during the seven day assessment period. B. Record review Review of the CPO revealed the following orders: -Paliperidone Palmitate (antipsychotic) ER (extended release) suspension prefilled syringe 117 miligrams (mg)/0/75 milliliters (ml). Inject one syringe intramuscularly every month on the 24th in the evening for schizophrenia (started 7/24/21, originally started this medication and dosage on 10/6/2020); (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Fluoxetine HCL (hydrochloride) (antidepressant) capsule 40mg. Give one capsule by mouth one time a day for depression (started 6/3/21, originally started this medication and dosage on 7/17/2020); -Olanzapine (antipsychotic) tablet 20mg. Give one tablet by mouth at bedtime for schizophrenia (started 6/2/21, originally started this medication and dosage on 7/17/2020); and, -Lorazepam (sedative) tablet 0.5mg. Give one tablet by mouth three times a day for anxiety (started 6/2/21, originally started this medication and dosage on 7/17/2020). Review of the Psychotherapeutic Medication Administration Disclosure revealed Resident #4 had signed consents for the use of Olanzapine and Lorazepam. Consent was obtained by the resident ' s medical durable power of attorney (MDPOA) and education was given to the MDPOA on 7/27/2020. -However, no education or consents were found in the residents chart to indicate the facility educated or obtained consent for the use of Paliperidone Palmitate or Fluoxetine after the resident was readmitted to the facility. There was no care plan documentation related to the resident ' s use of antipsychotic or antidepressant medications. The 7/16/21 medication management note revealed the recommendation to consider a trial gradual dose reduction (GDR) of Olanzapine in the future. -However, no documentation was found or provided to indicate if this recommendation was communicated to the physician or if a GDR was attempted. The 8/13/21 medication management note again revealed the recommendation to trial a GDR of Olanzapine. -However, no documentation was found or provided to indicate if this recommendation was communicated to the physician or if a GDR was attempted. II. Staff interviews The social services director (SSD) was interviewed on 8/25/21 at 3:37 p.m. The SSD said she was familiar with Resident #4 ' s psychotropic medication use, but that the facility did not adjust psychotropic medications for residents who had a major mental illness (MMI) with a Preadmission Screening and Resident Review (PASRR) level two in place. The SSD was interviewed again on 8/26/21 at 12:53 p.m. The SSD said an outside medication management company reviewed residents on psychotropic medications and made their own recommendations to the facility. The facility was responsible for relaying any recommendations to the physician. The SSD said the staff member in charge of medical records left the facility in July 2021 and the physicians had not been receiving recommendations since then. The SSD said the outside medication management team did notify her when they were reviewing a resident. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD said the facility held a psychopharmacological (psych/pharm) team meeting once a month and would discuss the resident ' s on psychotropic medications quarterly. The SSD said she did not always have time to put her notes from the psych/pharm meetings into the resident medical records. She said nurses were responsible for obtaining medication consent forms. She said she was not aware of any GDRs for any of Resident #4 ' s medications and she did not believe the physicians were made aware of the recommendations to trial a GDR of Resident #4 ' s Olanzapine as seen in the 7/16/21 and 8/13/21 medication management notes. She said she would now ensure the medication management notes were entered into resident medical records and notify the physician of any recommendations. The regional resource nurse (RRN) was interviewed on 8/26/21 at 2:21 p.m. The RRN said the medical director and SSD were responsible for documenting and facilitating psychotropic medication GDRs. The RRN said any resident on a psychotropic medication should be reviewed within the first 30 days of admission and ideally a GDR should be attempted every 90 days. The RRN said the SSD should be documenting psych/pharm meetings in the resident ' s medical records. The RRN said psychotropic medication consents should be obtained by nursing staff immediately upon admission or starting a medication. The RRN said any recommendations made by the outside medication management team should be communicated to the provider as soon as the facility received their notes. -At 3:30 p.m. the corporate consultant verified that she could not find any medication consent forms or education to the MDPOA for the use of Paliperidone Palmitate or Fluoxetine for Resident #4.

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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. 38185 Based on observations, interviews and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically: -Observations, record review and interviews revealed the facility failed to ensure care and services were provided to prevent pressure injuries. The facility failed to develop comprehensive care plans that identified resident risk for skin breakdown, identify resident's with avoidable pressure injuries, conduct thorough assessments, implement treatments timely to prevent the pressure injuries from worsening. These failures contributed to a situation of immediate jeopardy. Cross-reference F686 -Observations, record review and interviews revealed the facility failed to consistently monitor weights, identify significant weight loss and timely address nutritional needs. The facility failed to monitor weights in accordance with physician orders and put nutritional interventions into place to support wound healing and weight loss prevention. Interviews confirmed the facility lacked a system to ensure resident weights were being obtained to accurately monitor any significant weight loss or weight gain. The facility's failure to have a system that ensured timely weights were obtained and nutritional interventions in place contributed to a resident's significant weight loss. Cross-reference F692 -Observations, record review and interviews revealed the facility failed to ensure a resident was not neglected by staff by providing the care and services the resident required to maintain the highest practicable well-being. Cross-reference F600 -Observations, record review and interviews revealed the facility failed to ensure sufficient staffing was in place to ensure residents received the care and services required to maintain their highest practicable well-being. Cross-reference F725 -Observations, record review and interviews revealed the facility failed to ensure residents received bathing in accordance with each resident's plan of care. Cross-reference F676 Findings include: I. Current findings in the area of pressure injuries - failure to timely and adequately address facility acquired pressure injuries to prevent worsening Cross reference F686G. Facility administration failed to have a system/plan to ensure residents received preventative measures and comprehensive care plans to prevent facility acquired pressure injuries. The facility failed to ensure pressure injuries received a thorough assessment and implement treatments timely to prevent pressure injuries from worsening. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	II. Current findings in the area of nutrition - failure to consistently monitor weight to identify significant weight loss and put interventions into place timely. Cross reference F692G. Facility administration failed to have a system in place to obtain resident weights, identify significant weight loss and timely address resident nutritional needs. The facility failed to monitor resident weights in accordance with physician orders and put nutritional interventions into place to support weight loss prevention. III. Current findings in the area of abuse - failure of the facility to prevent neglect. Cross reference F600G. Facility administration failed to ensure a resident was not neglected by staff by providing the care and services the resident required to maintain the highest practicable well-being. The facility failed to prevent the worsening of facility acquired wounds, prevent the resident from significant weight loss and failed to provide bathing services in accordance with the plan of care. IV. Current findings in the area of staffing - failure of the facility to provide sufficient staffing Cross reference F725 G. Facility administration failed to provide sufficient staffing to ensure residents received the care and services required to maintain their highest practicable level of well-being. V. Current findings in the area of activities of daily living - failure of the facility to provide bathing Cross reference F676 E. Facility administration failed to ensure residents received bathing services in accordance with their plan of care. Residents went an entire month without receiving bathing services. VI. Staff interviews The director of nursing (DON) was interviewed on 8/19/21 at 1:30 p.m. She said she had only been the DON at the facility for two weeks. She said she was supposed to be sent to another facility to receive one on one training with another DON, but that had not happened, and she had not been provided training on facility or corporate processes since she was hired. She said she had never worked in a long term care facility. She said the assistant director of nursing (ADON) #1 was barely able to complete her job duties when she arrived at the facility. She said the RRNM had placed ADON #1 in the role of wound nurse when she was aware she had no formal wound training. She said the RRNM had no plan for the ADON #1 to receive wound care training. She said she was aware the facility had severe wounds and did not feel the system in place was functional because wounds went so long without proper assessments and treatments. The regional resource nurse manager (RRNM) was interviewed on 8/19/21 at 1:37 p.m. and again on 8/26/21 at 1:01 p.m. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	She said the facility was going through potential ownership changes. She said that was the reason a nursing home administrator (NHA) had not been permanently assigned to the facility. She said the facility had been through eight changes in the DON position since October 2020. She said the DON had received two weeks of online onboarding training. She said the DON was scheduled to go to another facility to be trained in the corporate policies and systems, however that was cancelled. She said she was not aware if it was ever rescheduled or planned to happen in the future. She said she was aware ADON #1 did not have any wound training. She said the corporation did not have any plan to provide wound training for ADON #1. She said there was a complete breakdown in the system of wound care at the facility. She said the facility had a breakdown in the documentation of the resident's wounds. She said the wound nurse, who worked in the facility in April, had resigned suddenly and did not leave her notes. She said the wound tracking that was found was old and they did not know which residents needed to be seen by the wound physician. She said the facility had switched medical record systems and the notes were not put into the new wound portal. She said the change of condition evaluation should have been caught on the electronic medical record dashboard. She said there was a breakdown in that system because the nurse who completed the change of condition evaluation did not complete a risk management form. She said the risk management form would have alerted the nurse management team. She said the facility had a consistent problem with obtaining resident weights. She said the dietician wanted the weights to be completed on the same day and that was not possible. She said the dietician had brought up the concern of weights not being obtained in the management meeting on many occasions. She said they had the lab tech, unit managers and therapy assisting, however the weights were still not being obtained. She said the facility was unable to monitor weight loss and implement interventions timely without resident's weights being obtained. She said the lack of awareness of facility systems could have played a factor in the breakdown for pressure injuries, nutrition, bathing and staffing. The medical director (MD) and NHA were interviewed on 8/26/21 at 10:54 a.m. The NHA said he had started working at the facility as the NHA two months prior. He said he was at the facility on a contracted basis and his contract was over at the end of August 2021. He said the corporation was actively looking for an NHA to fill the position. He said he did not know how many DONs had been at the facility in the past year. He said he was unaware of facility systems that were in place. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said the QAPI meeting had been focused on the plan of corrections for previous citations during the survey that exited on 7/1/21. He said he could not remember the areas of concern being discussed. He said he was unable to locate the notes from the previous few QAPI meetings.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 38185 Based on record review and interviews the facility failed to have a system for identifying deviations in performance and adverse events, and develop and implement appropriate quality assurance and performance improvement (QA/QAPI) plans of action to correct identified quality deficiencies. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of care at harm level during the survey on 8/18/21 to 8/26/21. Findings include: I. Facility policy and procedure The Quality Assurance Performance Improvement (QAPI) Process policy and procedure, revised February 2017, was provided by the nursing home administrator (NHA) on 8/26/21 at 3:34 p.m. It revealed, in pertinent part, The Center is committed to incorporating the principles of WAPI into all aspects of the work processes, service lines, and departments. All staff and stakeholders are involved in QAPI to improve the quality of life and quality of care that our patients experience. To standardize the approach to QAPI culture and processes by implementing the following key elements: -The QAPI program is ongoing, integrated, data driven, and comprehensive, addressing all aspects of care, quality of life and patient centered rights and choice; -The center executive director leads the QAPI processes and involves all departments, staff, and stakeholders - balancing a culture of safety, quality, and patient centeredness; -The QAPI processes and improvements are based on evidence, drawing data from multiple sources, prioritizing improvement opportunities, and benchmarking results against developed targets; -Improvement activities and performance improvement projects (PIP) are the structure and means through which identified problem areas are addressed with data analysis, process improvements, and ongoing monitoring whenever necessary using an interdisciplinary team; -The learning through applied QAPI is continuous, systematic, and organized. II. Cross-references citations (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Cross-reference F686: The facility failed to prevent avoidable pressure injuries for four out of six residents. The facility failed to develop a comprehensive care plan to address the resident's risk in the development of pressure injuries along with interventions. The facility failed to conduct thorough assessments to include a description, measurements and staging of the pressure injury. The facility failed to ensure an appropriate treatment was in place timely to prevent the facility-acquired pressure injury from worsening. The facility failed to follow infection control measures during wound care. Cross-reference F692: The facility failed to consistently monitor weight loss by obtaining weights throughout the facility. The facility failed to conduct a root cause analysis and assessment of two out of three residents for a significant weight loss and put interventions into place. Cross-reference F725: The facility failed to provide sufficient staffing to ensure residents received the care and services required. Cross-reference F600: The facility failed to ensure one out of 36 sample residents received the care and services required to ensure the resident did not have significant weight loss and develop a facility acquired pressure injury which worsened to a stage 4. Cross-reference F676: The facility failed to ensure eight of eight residents received bathing in accordance with their plan of care. Cross-reference F835: The facility failed to ensure the facility provided sufficient administrative oversight to identify areas of concern to ensure each resident's highest practicable well-being. III. Interviews The NHA and medical director (MD) were interviewed on 8/26/21 at 10:54 a.m. The MD said the QAPI committee was only required to meet quarterly, however the committee tried to meet monthly. He said himself, the NHA, director of nursing (DON), assistant director of nursing (ADON), social services, dietary manager and pharmacist attended the meeting. The MD said each department presented a scheduled set of reports, which were provided ahead of the meeting so he could review. He said the facility attempted to identify the issues throughout the facility and discover trends. The MD said the DON being at the meeting has been a challenge because of staffing for that position. He said the other members of the nursing staff should present any concerns identified within the care being provided. The NHA said the QAPI meeting had been focused on the plan of corrections for previous citations during the survey that exited on 7/1/21. He said he could not remember the areas of concern being discussed. He said he was unable to locate the notes from the previous few QAPI meetings. The NHA said if new areas of concern were identified, performance improvement plans (PIP) would be developed and discussed during the next QAPI meeting. (continued on next page)

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said pressure injuries were discussed at every QAPI meeting. The MD said the discussion was regarding the number of current wounds in the facility, broken down by newly acquired and existing status. The MD said individual residents were not discussed, just the numbers along with any trends. He said along with the wounds, the registered dietician (RD) would discuss any numbers and trends regarding significant weight loss. The NHA said the facility did not have any current PIPs in place. He said the facility was in compliance from the previous two surveys, so there were no current PIPs the facility was working through. The NHA said he was not aware the facility had a concern about obtaining weights and therefore made it difficult to determine if residents were experiencing weight loss. The NHA said staffing had been a concern at the facility since he had been with the NHA for two months. The MD said sufficient staffing was in the eye of the beholder and he felt the facility had sufficient staff. He said he did not currently have any residents under his care. He said he had not spoken with the residents regarding how they felt their care and needs were being met. The NHA said the concerns identified during the survey process had not been previously identified by the facility staff and brought to the QAPI meeting.