STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Post Acute Rehabilitation	4450 E Jewell Ave Denver, CO 80222

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196 Based on observations, record review, and interviews, the facility failed to ensure residents were free from physical restraints imposed for staff convenience and not required to treat medical symptoms for one (#80) of two residents reviewed for restraints out of 33 sample residents. Specifically, the facility failed to: -Obtain a consent from the resident prior to the use of an alarm restraint; -Re-evaluate the resident for the appropriateness of the use of the restraint; and -Reassess and care plan the resident's history of inappropriate sexual behavior which originally led to the initiation of the restraint. Cross-reference to F838, facility assessment: the facility assessment failed to identify the use of wander guard alarms. Findings include: I. Facility policy and procedures The nursing home administrator (NHA) provided a copy of the facility's restraint policy on 2/26/2020 at 11:13 a.m. The policy, last revised in November 2017, documented in pertinent part: Restraints are implemented in accordance with State and Federal regulations. If indicated, the least restrictive restraint is used for the least amount of time. Restraints are not used as a disciplinary action or for the convenience of the facility to control behavior. If the resident and / or the resident's representative agree to the use of a physical restraint, a physical restraint consent form ([NAME]) is completed, signed and placed in the medical record under the consent tab. Consents are required to be updated at least annually, with any changes to the device being used. If a resident's unanticipated behavior places the resident or others in imminent danger, the use of a restraint is permitted and must not extend beyond the immediate episode. (continued on next page)

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

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	II. Resident status Resident #80, under age 55, was admitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included dementia in other diseases classified elsewhere with behavioral disturbance, other frontotemporal dementia, other specified depressive episodes and bipolar disorder, unspecified. The 1/8/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident did not exhibit physical behavior symptoms such as hitting, kicking, pushing, scratching, grabbing, or sexual abuse directed towards other residents. The resident did not wander. The resident required assistance with set-up for most activities of daily living (ALDs). However, he required one person physical assistant with personal hygiene. The resident utilized a wheelchair for mobility. The assessment did not document the resident utilized a wander guard restraint. III. Record review A. Elopement risk assessments Elopement risk assessments completed for the resident on 1/5/19, 4/5/19, 7/5/19, 10/5/19 and 1/5/2020 all documented the resident had no history of elopement within the past six months, such as walk-away attempts from home, another facility, or the current facility. B. Physician orders The 10/23/17 CPO documented, Wander guard on at all times. C. Care plans The resident's care plan, initiated 10/23/17 and revised 9/25/19, documented Resident #80 was an elopement risk/wanderer related to significantly intrudes on the privacy of others or activities. It further documented Resident #80 refused to wear the wanderguard even though he had been informed about the safety risk of not wearing it. The goal of the care plan documented the resident's safety would be maintained through the review date. The intervention portion of the care plan documented nursing staff were to check the placement and function of the safety monitoring device every shift, observe the resident's location at regular and frequent intervals, and document wandering behavior and attempted diversional interventions. There was no care plan which addressed the sexual behavior the facility was worried about the resident exhibiting. IV. Resident observations (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/24/2020 at 10:55 a.m., the resident sat in a wheelchair in the common area on the 4th floor hallway. The resident had a wander alarm on his person. On 2/25/2020 at 8:57 a.m., the resident was seated in his wheelchair watching television in his room. He had a wander alarm on his person. V. Interviews Resident #80 was interviewed on 2/25/2020 at 2:20 p.m. The resident stated he was placed on a wander guard because he had an encounter with another female resident a very long time ago. He said he had questioned the continuous use of the wander guard and nursing staff made him understand it was his guarantee of continued residency at the facility. Specifically, the resident stated, The nurses told me I cannot live here if I refuse to wear the wander alarm. A restorative aide (RA) was interviewed on 2/25/2020 at 2:26 p.m. The RA said Resident #80 was placed on a wander guard because he talks to other female residents inappropriately and harrasses them also. She said when nursing staff observed the behavior, they would document in behavior monitoring sheets and also report to the nurse on duty. She said she had not observed the resident exhibit the behavior for some months now. Certified nurse aide (CNA) #7 was interviewed on 2/25/2020 at 2:34 p.m. CNA #7 said Resident #80 was placed on a wander guard because he touched another female resident inappropriately. She said Resident #80 was relocated to the fourth floor of the facility which predominantly housed male residents, to prevent him from further encounters with female residents. She added that the resident was escorted to and from activities by nursing staff to curtail his potential of sexually harassing other residents. CNA #7 said she did not recall the last time the resident was involved with such behavior. CNA #7 also reviewed the behavior sheet which documented Resident #80's behavior and stated it was blank for several months. The admission/customer care (ACC) representative was interviewed on 2/25/2020 at 2:41 p.m. The ACC said a background was done prior to admission to see if a resident was on the sex offender registry or any type of criminal background. She said the essence of the record was to help with placement of the resident within the facility. She said the information was not to be used to discriminate or unnecessarily segregate the resident. The ACC added that the facility would still admit him regardless of the background record but reiterated the information was to be used only for placement awareness purposes. The ACC indicated the resident was listed in the registry. On 2/26/2020 at 11:38 a.m., the minimum data set coordinator (MDSC) #1 was interviewed. She said the 1/8/20 MDS did not code the resident as utilizing any restraints. She said she did not know why the wander alarm was not coded as a restraint. She said the wander alarm was always on the resident. She said the resident's care plans revealed the wander alarm was used for the resident's safety, and acknowledged there were no interventions for the removal or elimination of the wander alarm. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 2/25/2020 at 3:08 p.m. The SSD said, If the facility's assessment of a resident indicates the use of a restraint, then it is important to use the less restrictive means possible. He listed situations that might be indicative of the use of restraints, which included concerns that a resident might leave the building. The SSD said he did not participate in risk assessments at this time due to being recently employed. He said risk assessments were completed by nursing at this time and an IDT meeting was held once a week. He reviewed Resident #80's medical record and stated the resident does not necessarily need to be placed on a wander guard because of being a sexual predator. Specifically, the SSD said, We would have utilized other less restrictive means such as staff monitoring. He concluded the interview by stating he would educate nursing staff going forward. The director of nursing was interviewed on 2/25/20 at 2:38 p.m. The DON said the use of a wander guard at the facility was compelled by a resident's risk for elopement. She said it was important to have a matching diagnosis, tracked behavior, physician order, consent and continuous reassessment indicative of the use of a wander guard. The DON said Resident #80 has been on a wander guard prior to her employment with the facility. She said Resident #80 was on the sex offender list with the State. She reviewed the resident's medical record and verified that the resident had not been at risk for elopement or sexual behavior for the past one year. She also verified that there was no consent of file from the resident. The DON said it was important to re-evaluate the resident for behaviors which were indicative of use of a wander guard and also to have a consent form filled out by the resident or representative as deemed appropriate. VI. Facility follow-up The nursing progress note, dated 2/25/2020 (after survey was underway) at 4:27 p.m., documented in part: IDT risk note - elopement score of 1/5/2020 is a 10. Although elopement score shows no risk identified, IDT reviewed and determined resident continues to be at risk for elopement from unit due to diagnosis of TBI (traumatic brain injury), dementia resulting in decreased safety awareness, disorientation and the inability to verbalize his place of residence if he was outside the facility. Resident is also at risk to others given his history of inappropriate behaviors to females. As per (company name) nurse practitioner (NP) note on 1/23/202 . (Resident's) family member gave consent for wander guard, NP aware as well as Medical Director. The DON was interviewed on 2/26/2020 at 10:17 a.m. She acknowledged the consent referenced in the note above was not on the resident medical record. The SSD was interviewed on 2/26/2020 at 9:07 a.m. The SSD clarified that though Resident #80 might have a medical durable power of attorney (MDPOA), the resident had to be deemed unfit to make a decision before the MDPOA kicked in. The SSD reviewed Resident #80's last BIMS and said he was still his own person. The facility failed to acquire resident consent; assess, document and ensure the wander guard was necessary; and failed to attempt less restrictive measures when no sexually inappropriate behavioral issues were exhibited.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, record review and interviews, the facility failed to ensure two (#73 and #10) of six residents reviewed, who were unable to carry out activities of daily living, received the necessary services to maintain grooming, and personal hygiene, out of 33 sample residents. Specifically, the facility failed to provide and assist Residents #73 and #10 with showers. Findings include: I. Facility policy and procedure The Routine Resident Care policy, revised September 2011, was received from the business office manager on 2/27/2020 at 2:04 p.m. The policy documented in pertinent part, Residents receive the necessary assistance to maintain good grooming and personal hygiene. Showers, tub baths, and/or shampoos are scheduled twice weekly and more often as needed. II. Resident #73 A. Resident status Resident #73, age 86, was admitted on [DATE] and readmitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included diabetes, polyosteoarthritis, chronic pain and macular degeneration. The 1/9/2020 minimum data set assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance with bed mobility, transfers, dressing, personal hygiene, toileting and bathing. She had frequent complaints of pain. B. Resident interview Resident #73 was interviewed on 02/24/2020 at 10:17 a.m. She said she was told her showers would be on Wednesday and Saturday. She said not only did she not get the showers, but no one even asks me if I want a shower most of the time. She said if she did not want to take a shower because she was in pain she would ask to have help with a shower on a different day. She said, That does not do any good; the staff are too busy, they said. She said she did not get a shower last Saturday on her scheduled day. She said, I asked them about it, but it didn't do any good. (Cross reference F725, sufficient nursing staff.) C. Observations On 2/24/2020 at 10:24 a.m, Resident #73 was observed in her room in a wheelchair. Her hair was oily and clumped together. Her clothes had food on them and dry brown fluid. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/2020 at 10:00 a.m., Resident #73 was observed in her room in a wheelchair. Her hair was oily and clumped together. On 2/26/2020 at 9:13 a.m., Resident #73 was observed in her room in a wheelchair. Her hair was oily and clumped together. D. Record review The certified nurse aide (CNA) task sheets were reviewed in the electronic medical record (EMR). The record documented the resident's showers were scheduled for Monday and Thursday. The record documented Resident #73 had only one shower during February, on 2/20/19. There was no documentation indicating why there were no other showers given. There was no documentation that the showers had been refused. The care plan initiated 3/6/18 was reviewed. The care plan for activities of daily living did not document the resident refused showers. E. Staff interviews The nursing home administrator (NHA) was interviewed on 2//27/2020 at 9:02 a.m. He said he had looked into the missing shower documentation. He said he had no documentation on paper or in the EMR that indicated the resident had refused showers. He said, Even if she had refused, we should have tried again, or had another staff member approach her. The director of nursing (DON) was interviewed on 2/27/2020 at 9:24 a.m. She said she looked through a binder at the nurses' station which the staff used to document refusals of showers, but there were no refusals documented for this resident. She said the staff should have documented in the CNA task documentation the reason showers were not given to Resident #73. The DON said if the resident refused her showers, the staff should have approached her again at a different time. She said she would have the staff shower her today. Licensed practical nurse (LPN) #4 was interviewed on 2/27/2020 at 10:02 a.m. She said Resident #73 did not refuse to take showers during the week that she knew of, but she didn't know what happened on the weekends. CNA #6 was interviewed on 2/27/2020 at 10:59 a.m. He said the resident refused showers because she had pain in her legs or was in a bad mood. He could not say where those refusals were documented or if the resident was reapproached to offer a shower at a later time. F. Facility follow-up (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The staff development coordinator (SDC) provided an undated document titled In-Service Report, Bathing and Showering on 2/27/2020 at 2:47 p.m. There were no signatures on the inservice document. The document outline revealed in pertinent part, All baths and showers must be documented in point click care (PCC). If a resident refuses a bath or shower, it must be documented on the plan of care as 'refused.' Please offer more than once before documented as refused. Notify the nurse that the resident refused. The nurse will follow up with the resident again to see if they will bathe. If they still refuse the nurse will document a behavior note with the reason for the refusal and multiple attempts. 40467 III. Resident #10 A. Resident status Resident #10, age 70, was admitted on [DATE], with an initial admitted [DATE]. According to the November 2019 computerized physician orders (CPO), diagnoses included spinal stenosis, cervical region, osteoarthritis, neuralgia and neuritis, chronic pain, and generalized muscle weakness. According to the 2/3/20 MDS assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out 15. He required extensive assistance of one for bed mobility. He required supervision for transfers, locomotion on the unit, dressing, toileting and personal hygiene. He needed physical help in part for bathing. B. Resident interview Resident #10 was interviewed on 2/24/20 at 11:42 a.m. He said he was supposed to receive three showers a week, preferably around 6:00 p.m. He said often he only received one shower a week, and had not received a shower in the past nine days. He said he had to try to clean himself up in the sink in his room. Resident #10 was interviewed on 2/26/20 at 1:32 p.m. He said he still had not received a shower and had not refused offered showers. Resident #10 was interviewed again on 2/27/20 at 1:35 p.m. He said he only received showers when CNA #4 was scheduled in the evenings and he had not seen him in several days. He said he never received a shower in the middle of the night or early morning. C. Record review According to the February 2020 staff schedule, CNA #4 was not scheduled on 2/20/20, 2/21/20, 2/22/20 and 2/27/20. He was scheduled on 2/23/20. The staff schedule indicated on 2/23/20, only two out three CNAs worked between 6:30 a.m. to 6:30 p.m. The staffing schedule revealed CNA #4 worked on 2/24/20 from 2:30 p.m. to 10:30 p.m. According to the schedule, the third CNA schedule CNA to work with CNA #4 was light duty, and not able to assist with most ADL cares, adding an increased workload to the two other CNAs. The schedule noted CNA #4 called off from work on 2/25/20 and 2/26/20 (cross-reference F725, sufficient nursing staffing). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's ADL care plan, revised 8/7/28, documented he had a self care deficit related to hemiplegia, spinal stenosis, and chronic pain. The care plan indicated his self care deficit affected his bathing, dressing, transferring in and out of bed and toileting. According to his ADL care plan, he should receive showers on Mondays, Wednesdays and Saturdays, but he may refuse these and choose other times; documentation was required. The shower book for documentation of refusals was reviewed 2/26/20 at 1:20 p.m., with LPN #1 and CNA #10. After reviewing the shower book, both staff members agreed that there was no documentation to indicate the resident refused showers during the month of February 2020. LPN #1 reviewed recent progress notes and said the notes did not include refusals of showers by Resident #10. The February 2020 ADL task record was provided on 2/27/20 by the DON. According to the record the resident received one shower between 2/16/20 and 2/27/20. The record indicated he received a shower on 2/22/20 at 6:39 p.m. The follow up question report was provided on 2/27/20 by the DON. According the report, the resident received a shower: -On 2/20/20 at 3:51 a.m. -On 2/21/20 at 4:33 a.m. -On 2/22/20 at 4:24 a.m. -On 2/23/20 at 1:58 a.m. -On 2/25/20 at 5:26 a.m. -On 2/27/20 at 1:52 a.m. According to the report, the resident received a shower almost daily. The report indicated he received showers in the middle of the night or early morning. The report did not reflect the one shower on 2/22/20 at 6:39 p.m., as indicated on the February 2020 ADL task record. There were no nursing progress notes regarding the resident's showers or shower refusals. D. Staff interviews LPN #1 was interviewed on 2/25/20 at 2:53 p.m. She said Resident #10 requested to have a shower on the evening of 2/24/20, which was his normal shower day. She said she told him that they only had two CNAs working and could not fit him in. She said sometimes there were just not enough CNAs scheduled. She said she told him that she did not know when his next shower would be. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #1 was interviewed on 2/26/20 at 1:18 p.m. She said they did not have bathing aides in the facility and showers were a primary CNA's responsibility. CNA #1 said if a resident refused he should be given a second opportunity that day. She said shower refusals were documented in the shower book. She said CNA #1 said she had not provided Resident #10 a shower because he preferred to have a shower in the evenings. She said she did not know when he last received a shower. CNA #11 was interviewed on 2/27/20 at 3:10 p.m. He said CNA #4 was usually responsible for the showers of Resident #10. CNA #10 was unavailable for an interview. The DON was interviewed on 2/27/20 at 9:51 a.m., with the assistant director of nursing (ADON). The DON said residents should receive showers at least twice a week, on their shower days at or near their preferred time. She said staff should document all showers given and if the resident refused. She said the CNA should then report the refusal to the nurse and the nurse should document the refusal in a note. The nurse would encourage the resident to take a shower the shower and write a behavior note the resident still refused. The DON said she was not familiar with the shower book on the unit for refusals. The ADON requested CNA #6 to assist in review the given showers on the facility's software because only CNAs had access to that task. The record, reviewed on the software, listed the same dates as the follow up question report (above). CNA #6 said the program prompted a documented action by the CNA but it did not confirm the resident received the shower at that time. The DON said the shower documentation was a broken process and appreciated that the concern was identified so they could move forward in establishing a system that would clearly reflect when residents received or refused showers.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to provide a meaningful program of activities for one (#42) of three residents reviewed for activities of 33 sample residents. Specifically, the facility failed to: -Ensure the activity program was designed to meet the individual activity needs, interests, and abilities for Resident #42, a cognitively dependent and physically impaired resident; and -Invite and encourage group and individual activities of stated interest promoting socialization, and decreasing boredom. Finding include: I. Facility policy and procedure The activity program policy and procedure, dated February 2017, was provided by the business office manager (BOM) on 2/27/20 at 2:04 p.m. The policy read in pertinent part: The facility provides an activities program designed to meet the interests, preferences, and physical, mental, and psychosocial well-being of each resident as indicated on the comprehensive assessment and care plan.Individual (one-to-one) and group activities, plus on site activities are included in the activities program. II. Resident #42's status Resident #42, under the age of 60, was admitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included unspecified intracranial injury without loss of consciousness, anoxic brain damage, cognitive communication deficit, other specified depressive disorders, anxiety disorder and muscle weakness. According to the 12/27/19 minimal data set assessment (MDS), the resident's cognition was severely impaired with a brief interview for mental status (BIMS) score of seven out 15. The resident required extensive to total staff assistance for all of his activities of daily living (ADLs). III. Resident interview Resident #42 was interviewed on 2/25/20 at 3:24 p.m. The resident had some difficulty speaking but was able to state that he was bored. He said he used to play the guitar but did not have access to one. When asked if he enjoyed watching television, he shrugged his shoulders. When asked if he would like to attend group activities, he responded, "Where?" IV. Observations Resident #42 was observed on 2/25/20 between 8:30 a.m. and 10:15 a.m. He sat in the lounge; the television was off. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 8:40 a.m., he was given a cookie and water. -At 8:48 a.m., the television was turned on to a romantic comedy. -At 9:03 a.m., the activity director (AD) greeted the resident as she walked past him. -At 9:18 a.m., the resident watched the staff work and interactions. He was not focused on the television. -At 9:34 a.m., the AD offered him Mardi Gras beads. The resident declined. She offered him nail care, he declined. -At 9:35 a.m., he was taken to his room for ADL care. -At 9:54 a.m., the certified nurse aide (CNA) brought him out of his room and placed him in front of the television. -At 9:59 a.m., the resident looked around the room, he was not focused on the television. -At 10:01 a.m., the AD provided him water and a quesadilla snack. The resident was not offered group or individualized activities other than food and television. Resident #42 was observed on 2/25/20 between 1:10 p.m. and 3:30 p.m. -At 1:10 p.m., the resident lay in his bed awake. The television or radio was not on. -At 2:23 p.m., the resident slept as male residents played poker with the BOM in the dining room. -At 3:00 p.m., a Mardi Gras party was scheduled on the calendar. The resident was not invited to participate. -At 3:24 p.m., the resident watched television in his room.The male residents continued to play cards in the dining room. The resident was not offered to join them. Resident #42 was observed on 2/26/20 between 1:00 p.m. and 3:30 p.m. in the lounge, alone. The television was on. He was not offered group activities with peers. -At 3:06 p.m., the resident attempted to answer game show questions on the television. The resident showed interest in the game show. -At 3:30 p.m., the February birthday party was scheduled on the calendar. The resident was not invited to participate. V. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 7/29/19 interview for daily and activity preferences assessment identified it was important to the resident to do activities that were meaningful to him. The assessment of the resident's preferences for customary routine and activities revealed it was very important to the resident to listen to music he liked; participate in religious services or practices; be around animals; spend time outdoors; and participate in groups. According to the assessment, it was important for the resident to participate in his favorite activities. The 7/30/19 activities initial review identified the resident was a musician who spent much of his time in a studio making music. Resident #42 also enjoyed spending much of his leisure time engaging in physical fitness and outdoor walks. He was Christain and his family wanted him to have opportunities to attend services. The initial review did not identify that the resident needed activities to be modified to accommodate his cognitive and communication deficit. The review did not identify the resident needed assistance to participate in activities. The 12/10/19 quarterly activity note read the resident had difficulty communicating but was able to make his needs known. The activity note indicated the resident liked independent activities with assistance, three or more times a day. He watched television, movies and sports. He listened to music and liked to sit in the common area. According to the note, the resident did not have interest in group activities but would benefit from encouragement and a one to one program three times a week for socialization and sensory stimulation. The individual activity participation record for December 2019, January 2020 and February 2020, recorded the resident watched television, movies or listened to the radio daily. He had some form of conversation daily and relaxed daily. The January participation record revealed the resident attended one group activity program. According to the record, he participated in a New Year's holiday party or social event. According to the February participation record, he listened to music daily. The participation records did not indicate refusal to attend groups, or attempts made to offer group activities that were identified on his activity initial review. The attendance record revealed the resident independently listened to music. It did not identify how the resident received music other than the radio. The record did not indicate the resident was offered music in any other form. The activity record did not indicate the resident was offered and encouraged to participate in religious services, received pet visits, or opportunities with animals. The record did not indicate the resident had opportunities outside on warmer winter days or was invited to outings outside of the facility targeting some of his identified interests. The 12/11/19 complementary therapies progress note identified the resident received a 20 minute aromatherapy session. According to the note, the resident was attentive, relaxed, smiled and nodded his head. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The one to one activity program documentation for December 2019, January 2020 and February 2020, was reviewed with the AD and her activity assistant (AA). The documentation identified the resident received television or movies, sensory stimulation, conversation, relaxation and exercise or sports. The AA clarified that the identified exercise or sports was marked because he received physical therapy or was on a restorative program, seperate from the activity program. The AA identified the resident was marked for relaxation based on observation of him, not as a therapeutic relaxation program. The January and February one to one documentation did not identify if the marked music entry was different than a radio in his room. The one to one documentation did not identify a specific one to one program that focused on his past leisure interests and or how the one to one program met or attempted to meet those interests or goals. The care plan for activities, revised on 8/23/19, identified his needs were to be anticipated, he liked to watch people, and he had limited mobility and needed assistance to and from places. According to the care plan, he would benefit from the one to one program for sensory and socialization. Interventions included an activity calendar and individual activity materials would be provided to him. He would receive daily hydration and receive praise for activity participation. The care plan did not identify what individual activity materials would be provided. The care plan did not identify what assistance would be required for him to engage in an individual activity. The activity care plan did not identify how the group activity program and individualized program would target his past interests othen a visits offering conservation and general sensory stimulation. The care plan did not include any modifications needed to adapt the program to meet his communication and cognitive deficit. The care plan did not identify that he was younger then many residents at the facility and may benefit from a socialization program with peers of similar age and/or like interest. The review of the February 2020 activity calendar revealed a variety of outings were available throughout the month. The outings also included trips outside to the botanical gardens and to the zoo to see animals. The calendar revealed opportunities to listen to a nature program discussing birds and their habitats, and listen to live music with entertainers. According to the calendar, group activity programs also included religious services, and food related socials and parties. The activity calendar did not include physical exercise or sports related programs, a specific men's group or a program designed for younger adults. VI. Staff interviews Registered nurse (RN) #5 was interviewed on 2/27/20 at 2:41 p.m. She said staff had to set up the resident's ipad, for him to be able to listen to music on it. CNA #7 was interviewed on 2/27/20 at 2:42 p.m. She said Resident #42 did not like to lay in his room for long periods at a time. She said he prefered to sit in the common area, around people. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AD was interviewed on 2/27/20 at approximately 8:45 a.m., with the AA. The AD said Resident #42 did not regularly attend activities. He watched television or listened to music on his ipad. The AA said he liked to look out the window and sit in the common area, (dining room/lounge). She said she would give him juice and talk to him. She said she sometimes offered him a car magazine to look at. The AD said he was on a one to one program three times a week, usually offering snacks, lotion on his hands, or nail filing if he allowed. She said she knew he liked music and to go outside. She said she brought him a sweater to keep warm during cooler weather, but he had not been taken outside in several months. The AD was informed that the resident said he was bored, she said he told her he was hungry during one to one visits, so she offered snacks. She said Resident #42 usually dozed off to sleep when he was provided nail care or hand lotion rubs. She said she was not sure if hand and nail care were important to him. The AD confirmed that she did not offer a one to one program that focused on his past leisure interests or provided prefered activities that were adapted to his current needs and abilities. She was not sure how often he was offered activities that were identified on his assessment. She said he attended a superbowl party that he liked but could not confirm other recent activities that he was invited to, or participated in. The AD said she made sure he had access to his ipad or radio when he was in bed but did not offer to set it up for the last few days because he had changed rooms temporally. She identified he liked jazz and rhythm and blues. She said he used to play the guitar but no longer had strong use of his hands. The AD said she felt there was a need for Resident #42 to have more programming offered to him that focused on meaningful activities targeting his interests and were adapted to his abilities. She said she could incorporate one of the guitars she had as a sensory and reminisce activity. She said she could create a program for younger adults to provide more peer socialization. She said she was interested in purchasing a video game station, and would see how he responded. The AD said she would need the support and financial corporation from management to reach some of her goals for Resident #42 and other residents with similar interests and abilities. She said she saw the potential benefits in expanding a program of activities designed to meet the needs and interests of Resident #42. The director of Nursing (DON), was interviewed on 2/27/20 at 10:42 a.m. She said she felt Resident #42, would benefit from activities that targeted his interests and abilities. She said she and the nursing staff would support a strong program of activities to meet the needs of Resident #42. The DON said she had some activity ideas she would like to share with the AD.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196 Based on observations, record review and interviews, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for five (#31, #198, #73, #58 and #54) of nine out of 33 sample residents. Specifically, the facility failed to ensure: -A timely orthopedic consultation was provided as ordered by the physician to follow up on Resident #31's admitting diagnosis of fractured left clavicle; -A physician order was sought and obtained prior to removing Resident #31's sling and performing range of motion (ROM) and resistance (weight) exercises to the affected left upper extremity (LUE); -The admitting diagnosis of fractured clavicle, and the proper care and precautions, were reflected in Resident #31's care plan. These failures resulted in Resident #31 experiencing increased, severe pain and potentially delayed healing of a fractured clavicle. The facility further failed to ensure: -Neurological assessments were completed per instructions, and abnormal vital signs assessments were reported and followed up on, for Resident #198; -Medications were available for administration for Resident #73; -Neurological assessments was initiated immediately after an unwitnessed fall for Resident #58; -Resident #54's vital signs were taken prior to the administration of a hypertensive medication to ensure the resident was within the physician-ordered parameters. Findings include: I. Failure to ensure proper care for Resident #31's fractured clavicle Cross-reference F697 pain management: the facility failed to prevent increased pain during range of motion (ROM) services by therapy which resulted in the resident experiencing severe pain. A. Resident #31's status (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #31, less than [AGE] years old, was readmitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included headache, osteoarthritis of knee (unspecified), muscle weakness (generalized), unspecified lack of coordination, history of falling, and cervicalgia. The resident diagnosis of fractured clavicle was not included in the list of diagnoses until 2/26/2020, during the survey. The 11/26/19 minimum data set (MDS) assessment coded the resident as cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had sustained a fracture resulting from falls in the past six months prior to this assessment. No pain experience was recorded. The resident received an opioid for seven days prior to this assessment. The resident did not reject evaluation or care. The resident required one person physical assistance with transfer, walking, locomotion, dressing and personal hygiene. B. Resident status on admission A review of the referral comment portion of the referral note by the referring physician, dated 11/16/19 at 7:43 a.m., reported Resident #31 failed at home. She's had 5 falls with the last fall being last evening. She now has a clavicle fracture. Her family member cannot care for her as she is unable to assist with any of her daily needs. C. Observation Resident #31 was observed on 2/24/2020 at 9:45 a.m. while the resident sat in her bed. The resident had a red/pinkish protrusion around her left clavicle (collar) bone. This protrusion was not observed on the resident's right collar bone. The resident was not wearing a sling. D. Resident interview Resident #31 was interviewed on 2/24/2020 at 9:56 a.m. The resident stated she discharged home in November of 2019 and had a fall at home which resulted in her fractured left clavicle. Specifically, the resident stated, I blacked out and fell in November of 2019 and fractured my collar bone in the process. My family member took me to the emergency room (ER) and I was under observation for three days. An X-ray of the left collar bone was conducted which indicated a fracture. The ER doctor recommended that I follow-up with an orthopedic surgeon. Furthermore, the resident stated, I got readmitted back at the facility, and there has been no ortho follow-up. I have been in constant pain since re-admitting to the facility. She expressed that her most excruciating pain was during range of motion exercises with occupational and physical therapy (OT and PT). Specifically, the resident stated she could feel her bones grinding against each other (referring to her fractured clavicle) and it caused a sensation she described as tormenting and horrible. The resident stated, I have not been spoken to about my orthopedic consultation or appointment since I readmitted . In fact, I had to look for a business card of a spine surgeon I have used in the past and provided the same to the DON about three days ago in an attempt to speedily ensure that a consultation with the orthopedic surgeon was made as it does not seem the facility was doing anything to make that happen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The progress note further documented that the resident participated in facilitation of crossing midline and weight shifting with BUE activity. Complexities/barriers impacting the sessions were identified as resident complaint of left shoulder pain. b. PT notes The PT treatment encounter note dated 2/24/2020 documented Resident #31's pain at rest was three out of 10, The frequency was intermittent; the location was her left shoulder. She also reported neck pain and described the pain as aching to sharp. The pain with movement was rated at six out of 10. The frequency of the resident's pain with movement was described as hourly and the location was the resident's shoulder with active range of motion (AROM) like gleno-humeral flexion, abduction or extention beyond comfortable range identified as the cause of pain. The resident also reported neck pain, which was reported as usually worse in the morning. The PT treatment encounter notes documented a pattern of pain descriptions on the following dates: -2/5/2020 resident reported pain at rest and with movement as 0/10 and 5/10 consecutively; -2/12/2020 resident reported pain at rest and with movement as 3/10 and 7/10 consecutively; -2/17/2020 resident reported pain at rest and with movement as 0/10 and 5/10 consecutively; -2/18/2020 resident reported pain at rest and with movement as 3/10 and 7/10 consecutively; -2/19/2020 resident reported pain at rest and with movement as 3/10 and 6/10 consecutively; -2/21/2020 resident reported pain at rest and with movement as 2/10 and 5/10 consecutively. Documented pain levels on the medication administration records (MARs) were significantly below documented pain levels by therapy. There was no evidence if the resident was pre-medicated for pain prior to the physical or occupational therapy sessions. Therapy notes did not specify the time frame that they worked with the resident. 3. Care plans The resident's pain care plan, initiated on 3/31/16 and last revised on 4/19/18, during her prior admission to the facility, documented the resident was at risk for pain due to diagnoses of chronic pain and Parkinson's disease. The resident's pain was not care planned when she was readmitted to the facility on [DATE] after she suffered a fractured clavicle. The readmitting diagnosis of fractured left clavicle was also not listed as part of the resident's diagnosis and was also not care planned. The care plan also did not document treatment for pain prior to therapy sessions. F. Staff interviews (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	B. Resident #198 status Resident #198, age 70, was admitted to the facility on [DATE]. According to the December 2019 computerized physician orders (CPO), diagnoses included congestive heart failure, chronic obstructive pulmonary disease, diabetes, shortness of breath and difficulty walking. The 10/24/19 minimum data set (MDS) assessment documented the resident had short term memory loss, moderately impaired cognitive skills for daily decisions, disorganized thinking and inattention. He required limited one assist with bed mobility, supervision for transfers, dressing, eating, toileting, and personal hygiene. The assessment documented he had no falls since admission. However, the resident had fallen on 10/20/19. He was occasionally incontinent of bowel and bladder, and used a walker for mobility. His balance was unsteady. C. Record review The progress notes were reviewed. On 10/20/19 at 11:25 p.m. the licensed practical nurse (LPN) documented that around 10:15 p.m., the resident was found on the floor in a sitting position, close to the bathroom door. The registered nurse (RN) supervisor was notified and performed a head to toe assessment. There was no noted injury. On 10/21/19 at 12:22 a.m. the RN documented further, Resident was found sitting on the floor with his back resting on his wheelchair, both legs stretched out in front of him. He stated that he tripped over his nasal cannula (oxygen) line while walking to the bathroom by himself. Physical assessment from head to toe completed with no visible injury nor bruises at this time of assessment. Active range of motion (ROM) to both upper and lower extremities completed by this nurse. Resident is verbally responsive to nurse, assisted to standing position and he walked over to his bed without any assistance, at the presence of nurses and staff. Neuro checks started, physician and family were notified by the nurse. Denies any pain. The neurological check assessments dated 10/20/19 at 10:15 p.m. were reviewed. The instructions at the top of the form documented to complete the neurological assessment every 30 minutes times four, then every one hour times four, then every four hours for 24 hours, then every eight hours for the remaining 72 hours. The neurological assessment included checking the vital signs (blood pressure, temperature, respirations, and pulse), level of consciousness, pupil reaction and eye signs, eye, motor and verbal response. The neurological checks were incomplete. The documentation revealed the following: -On 10/20/19 at 10:15 a.m. through 10/21/19 at 4:45 a.m. there was no assessment documented of the residents eye response; -10/21/19 at 2:45 a.m., the resident's vital signs were not checked because he was sleeping; -10/21/19 7:45 p.m., the neurological checks did not include vital signs, pupil reaction or eye signs, or motor response; (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-10/21/19 at 11:45 p.m., the neurological checks did not include the eye, motor or verbal response; and -10/22/19 at 3:45 a.m., the neurological checks did not include the level of consciousness, pupil or eye signs, eye, motor or verbal response. There were no neurological checks for: -10/22/19 from 3:00 p.m. to 10:00 p.m.; -10/22/19 10:00 p.m. to 6:00 a.m. (except for eye, motor and verbal response); -10/23/19 6:00 a.m. to 2:00 p.m.; -10/23/19 2:00 p.m. to 10:00 p.m.; and -10/23/19 10:00 p.m. to 6:00 a.m. The neurological checks documented multiple low blood pressures. On 10/20/19 at 10:15 at the time of the fall, the resident's blood pressure was 85/51 (older adult normal range 120/80). On 10/21/19 at 1:45 a.m., the blood pressure was 76/43, and at 3:45 a.m. the blood pressure was 69/39. The nurses' progress notes were reviewed. There was no documentation that addressed the resident's low blood pressure. D. Staff interviews The DON was interviewed on 2/27/29 at 9:17 a.m. She reviewed the neurological checks initiated 10/20/19. She said they were not done correctly. She said the neuro checks should have been done even if the resident was sleeping. The DON said the staff should have awakened the resident to complete the assessment and ensure there were no changes to his neurological status. She said it looked as if the resident's blood pressure and pulse were running low and there should have been follow up, including notifying the physician. She said the nurses didn't complete this at all, they did not do a good job. She said, They didn't even do anything from 10/22/19 to 10/23/19. The DON said she did not like the current form they used for neurological checks because it only checked the status every 30 minutes in the beginning. She said she would be ordering a new form. III. Failure to ensure medications were available for administration for Resident #73 A. Facility policy and procedure The Medication Administration policy, revised June 2008, was received from the DON on 2/26/2020 at 3:15 p. m. The policy documented in pertinent part, Resident medications are administered in an accurate, safe, timely and sanitary manner. Begin new medication orders timely. Begin routine orders on the same day ordered. B. Resident #73 status (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident #73, age 86, was admitted on [DATE] and readmitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included diabetes, polyosteoarthritis, chronic pain and macular degeneration. The 1/9/2020 MDS assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required extensive assistance with bed mobility, transfers, dressing, personal hygiene, toileting and bathing. She had frequent complaints of pain. C. Resident interview Resident #73 was interviewed on 2/24/2020 at 3:52 p.m. She said the nurses frequently did not have her medications and she had to go without them. She said she had missed her eye drops for macular degeneration many times because they ran out of them. She said she had not received her eye vitamins and blood pressure medications several times. Resident #73 said they had even run out of insulin and her dilaudid pain medication. She could not recall the dates she missed medications but said it had happened multiple times in the last year. D. Record review The nurse progress notes, medication administration records (MARs), and controlled drug count sheets were reviewed and documented the following: -The resident had orders for Dilaudid 2 mg (milligrams) every eight hours for pain. The controlled drug sheets for January 2020 and MARs were reviewed. The MAR indicated the Dilaudid was scheduled every eight hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m. On 1/17/2020, the controlled drug sheet documented that the nurse only signed out doses for 5:00 a.m. and 1:11 p.m. There were no further doses signed off the narcotic count sheet for the 10:00 p.m. dose. On 1/22/19, the 6:00 a.m. dose of Dilaudid was not signed off the controlled drug sheet. In addition, the controlled drug count sheet for the Dilaudid doses administered from 11/28/19 through 12/8/19 was requested three times from the DON, and not received. -On 2/25/2020 at 10:23 a.m, the nurse progress notes documented, Timolol Maleate solution 0.5% eye drops for optic atrophy, was not given because the nurse was waiting for pharmacy to deliver. -On 2/20/2020 at 10:20 a.m, the nurse progress notes documented, Dorzolamide HCL solution 2% eye drops, for optic atrophy, was not given because the nurse was waiting for pharmacy to deliver. -On 1/29/2020 11:04 a.m., the nurse progress notes documented, Ocular vitamins, eye health supplement, was not given because the nurse was waiting for supply. -On 1/28/2020 10:21 a.m., the nurse progress notes documented, Ocular vitamins, eye health supplement, was not given because the nurse was waiting for supply. -On 1/27/2020 10:52 a.m., the nurse progress notes documented, Ocular vitamins, eye health supplement, was not given because the nurse was waiting for supply. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-On 1/23/2020, 12/26/19, 12/16/19, 12/9/19, 12/8/19, 12/2/19, the nurse progress notes documented, Icy Hot Patch to the left knee at bedtime for knee pain was not administered because it was on order. -On 11/26/19, 11/25/19, 11/22/19 to 11/20/19, the nurse progress notes documented, PreserVision vitamins for supplemental eye health were not given because the nurse was waiting for supply. -On 10/11/19 at 10:19 p.m., the nurse progress notes documented, Novolin insulin 15 units subcutaneously at bedtime for diabetes. Notify physician if the fasting blood sugar is less than 70 or greater than 400. The insulin was not given because the medication was not available, called the pharmacy to order, will be coming after midnight. There was no blood glucose level documented. There was no follow up documentation that the resident received the insulin that night. -On 10/5/19 through 6/21/19 there were more than 10 nurse progress notes documenting that the resident's Cosopt Solution 22.3-6.8mg/ml (milligrams per milliliter) eye drops, for optic atrophy, were not given because it was not available. -On 4/14/19 at 10:37 a.m., the nurse progress notes documented, Novolin insulin 10 units subcutaneous in the morning was not given because the nurse was waiting for the pharmacy to deliver the medication STAT. The blood glucose level was 203. The nurse notified the physician and received orders to check a fasting blood glucose level before dinner and call the physician if the results were over 250 mg/dL (milligrams per decilitre). E. Staff interviews Registered nurse (RN) 31 was interviewed on 2/25/2020 at 10;31 a.m. She said sometimes medications were unavailable. She said medications could be reordered through the computer or by pulling the label on the medication card and faxing it to the pharmacy. She said if medications were not available in her cart, she would check the facility backup supply and call the pharmacy. She did not indicate the physician would be notified. Licensed practical nurse (LPN) #1 was interviewed on 2/26/2020 at 11:32 a.m. She said if she did not have a medication available she would notify the physician and call the pharmacy to get the medication. She said she would also try to get it out of the facility backup supply. She could not answer if medications were frequently unavailable. The DON was interviewed on 2/26/2020 at 11:32 a.m. She said the nurse should notify the physician when medications were not available, call the pharmacy, and attempt to get it from the facility's backup supply. She said she would investigate the omitted medications noted. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed again on 2/27/2020 at 9:29 a.m. She said the resident's Timolol Maleate and Dorzolamide HCl eye drops had not been delivered from the pharmacy because it had been ordered too soon and could not be sent sooner than 30 days from the last supply. She said the nurses could have filled out a form for the facility to cover the cost of ordering the medication early, but they had not done that. The DON said she could not figure out what happened with the missed Novolin insulin doses, but he would be educating the nurses to notify the physician and the DON in this situation. The DON further said there was no reason for the resident to have missed the eye vitamins because the facility had them in house stock. She said Icy Hot was not part of the facility formulary and therefore they did not carry the medication in their house stock. She said she had called the physician today to get the order changed to Biofreeze. The DON said she was still looking for the controlled drug sheet for Diluadid doses 11/28/19 through 12/8/19. She said she was the nurse on duty 1/22/2020 and the resident refused the medication. She said she did not document it properly. The DON said she was still investigating the missed dose from 1/17/2020. 19262 IV. Failure to start neurological assessments timely after an unwitnessed fall for Resident #58 A. Resident status Resident #58, age 66, was admitted on [DATE]. According to the February 2020 CPO, diagnoses included metabolic encephalopathy, chronic obstructive pulmonary disease, heart failure, paroxysmal atrial fibrillation, epilepsy, myocardial infarction, acute and chronic respiratory failure. The 12/21/19 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. The resident did not exhibit any behaviors. The resident required extensive staff assistance for bed mobility, dressing, eating, toileting and personal hygiene. B. Record review The care plan for falls, revised on 4/5/19, revealed the resident was at high risk for falls related to muscle weakness and a history of falls. Some of the interventions revealed to anticipate the resident's needs. Place the resident's call light within reach and encourage the resident to use the call light for assistance as needed. Provide prompt response to the resident's use of the call light for assistance. The fall risk assessment, performed on 12/7/19 at 7:43 p.m., revealed the resident had a score of 12 or high risk. The situation, background, assessment, recommendations (SBAR) summary dated 12/29/19 at 7:33 a.m., by a licensed practical nurse (LPN) revealed the resident was assessed by a registered nurse (RN). The resident walked from her bed into the bathroom and fell . The resident's wheelchair was by the closet door in her room. The resident's bed was in the lowest position and the call light was within reach. The fall was unwitnessed and no injuries were observed. The fall risk assessment, performed on 12/29/19 at 6:41 p.m., revealed the resident had a score of 17 or high risk. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The interdisciplinary (IDT) post fall review, dated 12/29/2020 at 6:43 p.m., revealed the resident had an unwitnessed fall with no injuries on this date at 7:30 a.m. The location of the fall was in the resident's bathroom. The resident performed an unassisted transfer from her bed. The resident had an unsteady gait, cognitive deficits and a history of falls. The resident wore socks at the time of the fall. The resident was encouraged to use the call light for assistance. The Neurological Record (NR) revealed the facility started the neurological assessments for the fall on 12/29/19 at 3:30 p.m. The fall occurred at 7:33 a.m. There was an eight hour delay in starting the assessments for this unwitnessed fall. The facility nursing staff did not follow the frequency listed on the NR. A nurse note dated 12/30/19 at 3:40 a.m. by an RN revealed the resident fell while coming out of the bathroom. The resident had no complaints of pain and there were no post fall injuries observed. Neurological assessments were at the resident's baseline. A nurse note dated 12/31/19 at 12:40 p.m. by an RN revealed the resident continued to be monitored for a previous fall. The resident was stable and was at her baseline for the day. C. Staff in[TRUNCATED]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196 Based on observations, record review and interviews, the facility failed to ensure pain management services for one (#31) of four residents reviewed out of 33 sample residents. The facility failed to prevent increased pain during range of motion (ROM) services by therapy for Resident #31 who had a fractured left clavicle. The facility was aware the resident had a history of chronic pain and during a previous admission had required pain medications. However, the facility failed to assess, document, report to the physician and respond to the resident's pain. The nursing staff failed to communicate with therapy and implement a plan to premedicate the resident for pain in preparation for therapy sessions. The occupational and physical therapists performed range of motion and weight-bearing exercises although the resident had a fractured clavicle and verbalized pain during therapy sessions. The resident's pain during therapy sessions was not communicated by therapy to nursing staff or the physician. The facility further failed to develop a comprehensive, person-centered pain management care plan for Resident #31. As a result, the resident stated during interview that she could feel and hear her bones grinding during therapy sessions, and she experienced increased, severe pain, which she described as excruciating, tormenting and horrible. Cross-reference to F684, highest practicable quality of care: the facility failed to ensure a timely orthopedic consultation was provided as ordered by the physician, ensure a physician order was sought and obtained prior to removing Resident #31's sling and performing range of motion (ROM) and resistance (weight) exercises to the resident's affected left upper extremity (LUE), and ensure the resident's fractured clavicle and related pain management issues were included in the resident's care plan. Findings include: I. Facility policy and procedure The nursing home administrator (NHA) provided a copy of the facility's pain policy on 2/26/2020 at 11:13 a.m. The policy, last revised in July 2017, documented in pertinent part: The facility recognizes the inter-relationship between uncontrolled pain and the decline in functional abilities, leading to an impaired quality of life. The facility will evaluate and identify residents experiencing pain; evaluate the existing pain and the cause(s); determine the type and severity of the pain; and develop a care plan for pain management consistent with the comprehensive care plan and resident's goal and preferences. The care plan is implemented and evaluated for its effectiveness. Acute pain, also known as warning pain, is a discomfort or signal that alerts you something is wrong in your body. Pain results from any condition that stimulates the body's sensors, such as infections, injuries, hemorrhages, tumors, and metabolic and endocrine problems. Acute pain usually abates as the underlying problem is treated. Early management of acute pain may hasten the recovery of the causative problem and reduce the length of treatment. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	II. Resident #31's status Resident #31, less than [AGE] years old, was readmitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included headache, osteoarthritis of knee (unspecified), muscle weakness (generalized), unspecified lack of coordination, history of falling, and cervicalgia. The fractured clavicle was not included in the list of diagnoses until 2/26/2020, during the survey. The 11/26/19 minimum data set (MDS) assessment coded the resident as cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had sustained a fracture resulting from falls in the past six months prior to this assessment. No pain experience was recorded. The resident received an opioid for seven days prior to this assessment. The resident did not reject evaluation or care. The resident required one person physical assistance with transfer, walking, locomotion, dressing and personal hygiene. III. Resident status on admission The comment portion of the referral note by the referring physician, dated 11/16/19 at 7:43 a.m., reported Resident #31 failed at home. She's had 5 falls with the last fall being last evening. She now has a clavicle fracture. Her family member cannot care for her as she is unable to assist with any of her daily needs. IV. Resident observation and interview Resident #31 was observed on 2/24/2020 at 9:45 a.m. while she sat in her bed. The resident had a red/pinkish protrusion around her left clavicle (collar) bone. This protrusion was not observed on the resident's right collar bone. The resident was not wearing a sling. Resident #31 was interviewed on 2/24/2020 at 9:56 a.m. The resident was grimacing and almost tearful throughout the interview. The resident stated she discharged home in November of 2019 and had a fall at home which resulted in her fractured left clavicle. The resident stated, I got readmitted back at the facility . I have been in constant pain since re-admitting to the facility. She expressed that her most excruciating pain was during range of motion exercises with occupational and physical therapy (OT and PT). Specifically, the resident stated she could feel her bones grinding against each other (referring to her fractured clavicle) and it caused a sensation she described as tormenting and horrible. She added that her pain experience was different every day. V. Record review A. History and physical A review of the admitting physician history and physical completed with Resident #31 on 11/19/19 revealed the resident was admitted to a hospital and was diagnosed with left clavicle fracture. There was documentation of no surgical intervention at the hospital, however, the facility was instructed to manage the resident's fracture with a sling and follow-up with ortho. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	B. Medication administration records A review of the resident's October 2019 (pre-clavicle fracture) through February 2019 (post clavicle fracture) medication administration records (MARs) revealed a lidocaine patch was the only additional pain medication Resident #31 received after she sustained the fracture to her left clavicle Specifically, the MARs (before and after the clavicle fracture) revealed the resident continued to be on the same pain medication which included: -Aspirin tablet 81 mg, give 1 tablet by mouth in the evening for supplement; -Diclofenac Sodium tablet Delayed Release 75 mg, give 1 tablet by mouth two times a day for inflammation; -Oxycodone-Acetaminophen tablet 10-325 mg, give 1 tablet by mouth three times a day for pain; -Acetaminophen tablet 325 mg, give 2 tablets by mouth every six hours as needed for pain; and -Observation: Pain - Observe every shift. If pain present, complete pain flow sheet and treat trying non-pharmacological interventions prior to medicating if appropriate. Document in the progress notes every shift per protocol. Lidocaine Patch 4%, apply to left shoulder topically one time a day for pain, added to the resident's pain management regimen on 11/19/19 at 2:01 p.m., and discontinued on 2/19/2020 at 1:36 p.m. The MAR demonstrated timelines which were not consistent with the timelines during which Resident #31 was receiving therapy which exacerbated her pain. C. Pain assessment The resident's pain assessment, dated 11/22/19, on admission, reported that Resident #31 had in the last five days been on a scheduled pain management regimen, received as-needed (PRN) pain medications, and also received non-medication interventions for pain. The assessment also documented that Resident #31 reported she had frequent pain or hurting during the last 5 days prior to the assessment. Her pain was located in her left fractured clavicle and she described the pain as sharp. It also documented that Resident #31 had a history of generalized pain. The resident rated her pain at a five on a scale of zero through 10. Resting and medication were what relieved her pain. The assessment only listed Percocet 10-325mg three times a day as the medication the resident's pain was being managed with. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	There was no documentation of an assessment to determine the effectiveness of the lidocaine patch with reference to addressing the resident's pain with her fractured clavicle. There was no documentation of the resident's acceptable level of pain. There was no documentation of whether or not the resident's pain interfered with her daily activities or her sleep. The pain scale documentation of the resident's verbalized pain rating did not reflect her expressed pain concern during the survey. D. Failure to schedule orthopedic consultation and evaluate sling use A review of the resident's medical record revealed no consultation was made with ortho since the resident readmitted in November 2019 and would not be until 2/27/2020, after the survey was initiated. There was no evidence or observation (see above) of the facility providing a sling to support the resident's affected left arm/clavicle. Likewise, there was no order to initiate or discontinue a sling to the resident's affected arm. E. Therapy notes Review of the resident's physical and occupational therapy (PT and OT) notes revealed the precautions/ contraindications portion of the exercise sessions documented: Status post (s/p) left clavicle fracture (fx), fall risk (history of falls) and seizure. 1. OT notes The OT progress note dated 2/13/2020 documented that Resident #31 participated in a graded therapeutic exercise to increase strength, endurance and ROM to LUE for functional performance of ADLs. During the session, Resident #31 performed resistance exercise with a theraband to the LUE (there was no order for the resident to partake in such exercise). The pain at rest and pain with movement recorded for this session was zero and four consecutively out of 10. Complexities/barriers impacting the session were identified as history of left clavicle fracture, unhealed properly. The document also revealed Resident #31 reported that her LUE remaining still was what helped with her pain. According to the OT progress note dated 2/20/2020, Resident #31 participated in a guided therapeutic exercise to increase strength, endurance and ROM to bilateral upper extremities (BUE) for performance of activities of daily living (ADLs). During the session, Resident #31 performed BUE bicep curls, chest presses, internal/ external rotations and overhead presses using three-pound weights for LUE and five-pound weights for RUE (there was no order for the resident to partake in such exercise).The pain at rest and pain with movement recorded for this session was zero and four consecutively out of 10. The document also revealed that Resident #31 reported that her LUE remaining still was what helped with her pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The progress note further documented that the resident participated in facilitation of crossing midline and weight shifting with BUE activity. Complexities/barriers impacting the sessions were identified as resident complaint of left shoulder pain. 2. PT notes The PT treatment encounter note dated 2/5/2020 documented Resident #31's pain at rest was zero out of 10, The frequency was intermittent; the location was her left shoulder. She also reported neck pain and described the pain as aching to sharp. The pain with movement was rated at five out of 10. The frequency of the resident's pain with movement was described as hourly and the location was the resident's shoulder with active range of motion (AROM) like gleno-humeral flexion, abduction or extention beyond comfortable range identified as the cause of pain. The resident also reported neck pain, which was reported as usually worse in the morning. The PT treatment encounter note documented a pattern of pain description similar as that reported for the following days: -2/12/2020 resident reported pain at rest and with movement as 3/10 and 7/10 consecutively -2/17/2020 resident reported pain at rest and with movement as 0/10 and 5/10 consecutively; -2/18/2020 resident reported pain at rest and with movement as 3/10 and 7/10 consecutively -2/19/2020 resident reported pain at rest and with movement as 3/10 and 6/10 consecutively; -2/21/2020 resident reported pain at rest and with movement as 2/10 and 5/10 consecutively -2/24/2020 resident reported pain at rest and with movement as 3/10 and 6/10 consecutively F. Shift by shift nursing pain assessments Documented pain levels on the medication administration records (MARs) were significantly below documented pain levels by therapy, and in many cases indicated zero pain. There was no evidence the resident was pre-medicated for pain prior to the physical or occupational therapy sessions. Therapy notes did not specify the time frame that they worked with the resident or that they requested pain medication prior to therapy. The resident was still receiving therapy services during the survey, mostly for lower extremity exercises and balancing. There was no documentation in therapy or nursing notes that the resident's physician was notified of her pain during therapy sessions. G. Care plans The resident's pain risk care plan, initiated on 3/31/16 and last revised on 4/19/18 during her prior admission to the facility, documented the resident was at risk for pain due to diagnoses of chronic pain and Parkinson's disease. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The resident's pain was not care planned when she was readmitted to the facility on [DATE] after she suffered a fractured clavicle. The readmitting diagnosis of fractured left clavicle was also not listed as part of the resident's diagnosis and was also not care planned. The care plan also did not document treatment for pain prior to therapy sessions. VI. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 2/26/2020 at 2:05 p.m. He said he was familiar with the resident. He said Resident #31 was independent with most of her care but that pain affected her independence with activities of daily living (ADLs) sometimes. CNA #10 said when the resident was in a lot of pain from her chronic pain and the pain from her fractured clavicle she could not sleep well sometimes. The CNA said he recalled calling the nurse one day not long ago when Resident #31 was moaning and making sounds and appeared to be in a lot of pain. CNA #10 said, I walked to the nurses' station to get the nurse on duty to address the resident's pain. Registered nurse (RN) #2 was interviewed on 2/26/2020 at 3:30 p.m. She said when a resident was in pain, she would have the resident rate her pain and medicate accordingly. She said nurses did not have access to the computer program the therapists used in documenting their treatment of the residents. She also said that the therapists (referring to OT and PT) did not ask when residents were last given pain medication. She reviewed Resident #31's medication administration record and verified that the Lidocaine patch was the only additional pain treatment the resident got when she compared her medication regimen before and after the incident of her fractured clavicle. The hospital discharging physician was interviewed on 2/26/2020 at 10:23 a.m. via telephone. The physician stated it was important to provide timely follow-up consultation with orthopedics as the resident needed to be evaluated by an expert (referring to the orthopedic surgeon) who then made the decision to address the next line of treatment of the fractured bone and the pain associated with it. The OT and PT were interviewed on 2/27/2020 at 9:37 a.m. The OT said she had done some therapeutic exercises to Resident #31's left upper extremity (referring to the ROM and resistance exercise). She reviewed the resident's medical record and agreed that there was no order from the physician to do so. The OT verified that it was important to obtain a physician order prior to discontinuing Resident #31's use of the sling because the sling helped hold the resident's fractured clavicle in place and required the orthopedic surgeon's review to determine whether or not it was safe to discontinue the resident's use of the sling. The OT acknowledged that she instructed the resident to discontinue her use of the sling without having an order to do so. She also verified she did not document that decision and her rationale for doing so. The PT verified that though Resident #31 had an order for OT and PT, the order was to address the balancing related to the resident's December 2019 fall Resident #31 experienced while at the facility. The PT said there was no order to perform a range of motion exercises to the resident's LUE and that the standard practice was to ensure there was an order in place before conducting any therapeutic exercise. He verified that not having an order for therapeutic exercise could result in doing things that were not beneficial to the resident. The PT stated, Before working on a fractured bone, I would like to see a sign of healing on the fractured bone. The PT however verified that there was no follow-up x-ray on file since Resident #31's re-admission in November 2019. He stated it was important to have an x-ray to guarantee that the bone had healed. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The PT agreed that pain could result from moving a body part with a fractured bone. The DON was interviewed on 2/25/2020 at 10:28 a.m. She said when a resident was in pain, the information was communicated to the nurse who documented the location of the pain, the intensity and the frequency of the pain and would medicate or provide non-pharmacological intervention as necessary. The DON stated resident pain management was discussed at weekly interdisciplinary team (IDT) meetings and changes to the pain management regimen were made as necessary, and the initial interventions remained if it was determined that they had proven effective. The DON said the PT and OT were not included in the IDT team who reviewed Resident #31's pain management regimen. She denied being aware that the resident complained of pain during therapy sessions. The DON said it was important for the therapy and nursing department to communicate information pertinent to the resident's care in order to improve the quality of care the resident received from the facility. She concluded the interview stating she would initiate an all inclusive IDT, to ensure all departments responsible for the resident's health care management were included.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews the facility failed to ensure dialysis services were consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals and preferences for one (#16) of one resident reviewed out of 33 sample residents. Specifically, the facility did not obtain all the necessary information from the dialysis center to ensure there were no complications or concerns related to the resident's dialysis treatments. Findings include: I. Facility policy and procedures The Hemodialysis, Care of Residents policy, revised July 2014, was provided by the director of nursing (DON) on 2/26/2020 at 2:53 p.m. The policy revealed the facility provided residents with safe, accurate, appropriate care, assessments and interventions to improve resident outcomes. -A Dialysis Communication Record (DCR) would be initiated and sent to the dialysis center for each appointment. The staff were to ensure the DCR was received upon the resident's return to the facility. The policy did not direct nursing staff to review the DCR to ensure the dialysis center's information section of the form was completed for accuracy. The policy also did not direct nursing staff to call the dialysis center when the DCR was incomplete and lacked pertinent information regarding the resident's dialysis treatment. II. Resident status Resident #16, age 90, was admitted on [DATE]. According to the February 2020 computerized physician's orders (CPO), diagnoses included end stage renal disease, essential hypertension, heart failure, and dependence on renal dialysis. The 11/11/19 minimum data set (MDS) assessment revealed the resident had severe impairment in cognitive skills for daily decision making. The resident had both short and long term memory problems. The resident required extensive staff assistance for bed mobility, transfers, dressing, eating, toileting, and personal hygiene. The resident received dialysis services. III. Resident interview The resident was interviewed on 2/25/2020 at 12:53 p.m. She said she received dialysis treatments but was unsure of the specific days of the week. IV. Record review (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order (PO), dated 6/7/19 at 11:34 a.m., revealed the resident received dialysis treatments on Monday, Wednesday and Friday. The order also revealed the resident utilized a stretcher for transport on each dialysis day for comfort. The care plan (CP) for dialysis related to end stage renal disease was revised on 12/11/19. The plan revealed the resident received dialysis treatments on Monday, Wednesday and Friday. The plan also revealed the resident utilized a stretcher for transport on each dialysis day for comfort. One of the interventions was the DCR would be sent to the dialysis center with each appointment and to ensure the DCR was returned to the facility after each appointment. -The CP did not direct nursing staff to review the DCR to ensure the dialysis center's information section of the form was completed for accuracy. -The CP also did not direct nursing staff to call the dialysis center when the DCR was incomplete and lacked pertinent information regarding the resident's dialysis treatment. The January 2020 DCRs were reviewed and the following concerns were observed: -1/1/2020: no post dialysis weight information. The yes or no box was not checked to inform the facility if any laboratory work was completed. -1/3/2020: no pre or post dialysis weight information. The yes or no box was not checked to inform the facility if the dialysis treatment was completed without an incident. The yes or no box was not checked to inform the facility if there was a problem with the access graft/catheter. The yes or no box was not checked to inform the facility if any laboratory work was completed. The section for medications administered during dialysis was not completed. The dialysis nurse did not sign or date the form. -On 1/6/2020, 1/8/2020, 1/10/2020, 1/13/2020, 1/15/2020, 1/17/2020, 1/20/2020, 1/22/2020, 1/24/2020 and 1/27/2020: no post dialysis weight information. -On 1/29/2020 and 1/31/2020: no post dialysis weight information. The yes or no box was not checked to inform the facility if any laboratory work was completed. The February 2020 DCRs were reviewed and the following concerns were observed: -On 2/3/2020, 2/10/2020, 2/12/2020, 2/19/2020 and 2/24/2020: no post dialysis weight information. -On 2/7/2020, 2/14/2020 and 2/17/2020: no pre or post dialysis weight information. The yes or no box was not checked to inform the facility if the dialysis treatment was completed without an incident. The yes or no box was not checked to inform the facility if there was a problem with the access graft/catheter. The yes or no box was not checked to inform the facility if any laboratory work was completed. The section for medications administered during dialysis was not completed. The dialysis nurse did not sign or date the form. -2/21/2020: no post dialysis weight information. The yes or no box was not checked to inform the facility if there was a problem with the access graft/catheter. The section for medications administered during dialysis was not completed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's clinical record notes from 1/1/2020 through 2/26/2020 were reviewed. The record did not contain any information regarding dialysis treatments to supplement the missing information in the DCRs. V. Staff interviews Registered nurse (RN) #7 was interviewed on 2/26/2020 at 4:21 p.m. She said the resident received dialysis treatments three times a week and was taken to the dialysis center by an ambulance. She said the ambulance staff took the DCR notebook and all the necessary forms to the dialysis center and returned the notebook to a nurse when the resident returned to the facility. She reviewed and agreed there was missing documentation on multiple January and February 2020 DCRs. RN #7 said the night nurse filled out the general information to be completed by the facility section of the DCR, the night before a dialysis treatment. She said prior to the resident leaving the facility, a nurse would complete the resident specific pre-dialysis information section of the DCR. She said a dialysis nurse would fill out the information to be completed by the dialysis center at the bottom portion of the DCR. RN #7 said when the notebook returned to the facility after each dialysis treatment, a nurse should review the current DCR to make sure it was complete. She said if the DCR was not completed, the nurse should call the dialysis center and get all the necessary information to complete the record. She said the DCRs often did not contain post dialysis weights. She said the resident was not weighed at the facility after a dialysis treatment. RN #7 said the pre and post dialysis weights let the facility nursing staff know how much fluid was removed from the resident during the treatment. She said it was important to know both weights in the event the resident experienced dizziness, became light headed, appeared dehydrated, hypotension, postural hypotension or needed more assistance with their cares by staff. The licensed practical nurse (LPN) #4 was interviewed on 2/27/2020 at 2:06 p.m. She said the resident went to dialysis on Monday, Wednesday and Friday. She said prior to the resident going to dialysis she would complete the top and middle sections of the DCR. She said the dialysis center nurse filled out the bottom section of the DCR. She said the DCR was kept in the yellow notebook entitled dialysis communication log (DCL). She said the DCL was given to the paramedics each time the resident went to the dialysis center. She said the notebook was handed to a nurse by the paramedics when the resident returned back to the facility. She said the bottom section of the DCR should be filled out completely by the dialysis nurse. She said if she received an incomplete DCR she would call the dialysis center and fax the DCR to the center for them to complete. LPN #4 said the dialysis treatment cleaned the resident's blood, it also removed fluids from the resident's body. She said the facility needed to know the post dialysis weight, so that the facility would know how much total fluid was removed from the resident. She said it was also important for the facility to know if the resident received any medications during the treatment in the event the resident experienced a change of condition. She said the dialysis nurse should sign and date each DCR after its completion. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 2/26/2020 at 2:53 p.m. She said the facility sent a packet with the resident that included a face sheet, medication list and a DCR each time she went to dialysis. She said the ambulance driver was given the packet to deliver to the dialysis center staff. She said the driver returned the packet to a facility nurse when the resident returned to the facility after each dialysis treatment. The DON reviewed and agreed there was missing documentation on many of the January and February 2020 DCRs. She said the dialysis center nurses did not fill in all of the required information in the section to be completed by the dialysis center on the aforementioned DCRs. She said the dialysis nurses should have filled out this section completely for each of the DCRs. The DON said when each DCR was returned to the facility, a nurse should have reviewed the DCR for completeness. She said this was not done. She said if the DCR had missing information, the nurse should have called the dialysis center, requested the missing information and wrote it on the DCR. She said this was not done. The DON said it was important for the resident's post dialysis weight to be documented so that the facility knew how much fluid the resident had drawn off (removed) during the dialysis treatment. She said the post weight was also important for the facility to know how much fluid weight the resident gained prior to the next treatment. She said it would be very important to know if there were any incidents or concerns during the dialysis treatments and if there were any problems with the resident's access graft/catheter. She said it would also be very important for the facility to know if any medications or additional fluids were administered to the resident. She said the dialysis nurse should have provided all of the necessary information and signed/dated the DCR for every dialysis treatment. She said the information obtained from the dialysis center on the DCR would be extremely beneficial to the facility nursing staff, if the resident experienced shortness of breath, became dehydrated, had onset of a heart arrhythmia, experienced hypotension, lethargy or confusion.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on record review and interviews, the facility failed to provide sufficient nursing staff to ensure the residents received the care and services they required to achieve their highest practicable physical, mental, and psychosocial well-being. Specifically, the facility failed to ensure enough staff were available to adequately care for the residents, as residents felt and expressed their activities of daily living (ADLs) of toileting assistance, transferring, showers, and overall call light response, were not met and addressed in a timely manner. Cross-reference: F604 restraints, F677 ADLs, F684 quality of care, F689 falls/accidents, F697 pain management, F698 dialysis services, F742 psychosocial well-being, and F758 unnecessary medications. Findings include: I. Resident interviews Residents, who per facility assessment were cognitively independent and interviewable, made the following comments about nursing staffing. Resident #81 was interviewed on 2/24/20 at 8:58 a.m. She said call light response time needed much improvement. Resident #81 said there was not enough staff to help everyone in a timely manner. She said she sometimes had to wait over an hour in the morning and 45 minutes to two hours to lie down at night. She said staff either ignored her or just did not have the staff available to assist her. She said she required two female staff to assist her with ADL care. Resident #73 was interviewed on 2/24/20 at 10:09 a.m. She said she preferred to get up at 7:00 a.m., but that did not always happen. She said recently she woke up at 7:20 a.m. and turned on her call light. According to the resident, no one answered the call light. She said she waited 15 minutes then decided to get herself out of bed. The CNA then came into her room, turned off the call light, and left. The resident said she had to take herself to the nurses' station to ask for help. She had to cover herself with a gown that had a broken snap, her hair was clumped together, she had shoes on with no socks, and needed a new brief. She said the CNA approached her and told her that he could not assist because he needed to feed another resident and did not have the time to help her. Resident #73 expressed her frustration and said she wanted to leave the facility. Resident #10 was interviewed on 2/24/20 at 11:42 a.m. He said he recently had his catheter bag overflow and leak on his clothes and his bedding in the middle of the night. He said he called for help but no one came. He said he had to clean himself up the best he could. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #51 was interviewed on 2/24/20 at 1:35 p.m. She said there was not enough staff to help on the 2:30 p.m. to 10:30 p.m. evening shift or sometimes on the overnight shift. She said they usually had only two CNAs working. She said call lights routinely took a 15 to 30 minute response with three CNAs. She said when there were only two CNAs available, the call light response time jumped up to 45 minutes. Resident #51 said the CNAs just could not handle everyone's needs without long waits. She said she had experienced weekend nights where she waited all night for assistance, and no one came. Resident #44 was interviewed on 2/24/20 at 2:49 p.m. He said call light response time had been a big concern for him. He said he was able to provide most of his own care but at night he would have a lot of pain and needed more assistance. He said it would take 30 to 45 minutes for someone to check on him after he pushed the call light. Resident #44 said there were sometimes only one to two CNAs at night. He said he felt that the staff did the best they could to assist everyone but they just needed more help, and the nurse did not usually answer the call lights. II. Group interview A group interview was held on 2/25/20 at 10:00 a.m. with five alert and oriented residents selected by the facility for participation. The residents represented all three units. The residents said they felt the CNAs worked hard but were short handed, resulting in long waits for care and services. They said they had not had consistent staff coverage. They said they were also aware that some staff were let go and some staff quit. One resident said she had to go to bed sometimes 45 minutes to two hours past her preferred bedtime because she had to wait for CNA availability. One resident said they need to hire more staff to meet everyone's needs. He said he was independent but other residents needed a lot of help. The group said they addressed their concerns in resident council but had not seen much change. One resident said she had to wait a long time for even simple requests such as getting ice. She said the staff was just too busy, CNAs tried to meet everyone's needs but they just did not have enough help. One resident said he had to wait for 45 minutes in pain at night because no one answered his call light, so he took himself to the nurses' station to request pain medication. Another resident said dinners were sometimes late because there was not enough staff to help. According to the group, they felt their biggest concern was that the facility needed to ensure there was enough staff to be able to answer call lights to check to see if there were serious problems with the residents, even if the staff could not meet all their needs right away. III. Record review A. Resident council meeting minutes (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The resident council minutes for January 2020 and February 2020 were reviewed. According to the January minutes, residents felt there was a shortage of CNAs available related to staff turnover and staff on vacation. According to the February minutes, residents felt they were short a CNA over weekends between 6:30 p.m. and 9:00 p.m. The residents also identified a shortage of nursing staff on the 3rd floor unit between 7:30 a.m. and 8:00 a.m. Specific details of dates were not provided. B. Staffing schedules The February 2020 staff schedule was reviewed. The schedule revealed the following: The weekend schedule for the 6:30 p.m. to 6:30 a.m. shift on 2/1/20 for the second floor unit indicated only two CNAs worked between 6:30 p.m. and 10:30 p.m. The 6:30 a.m. to 2:30 p.m. shift for the second floor unit had only two CNAs on 2/2/20, 2/5/20, 2/3/20, 2/4/20 , 2/9/20, 2/11/20, and 2/27/20. The 2:30 a.m. to 10:30 p.m. shift for the second floor unit had only two CNAs on 2/9/20, 2/10/20, 2/11/20, and 2/22/20. The 6:30 a.m. to 2:30 p.m. shift for the second floor unit indicated the third CNA scheduled was in training and shadowed the second CNA on the unit on 2/10/20 and 2/11/20. The 2:30 p.m. to 10:30 p.m. shift for the second floor unit, indicated a third CNA was on restricted light duty from 2:30 p.m. to 6:30 p.m. on 2/13/20, 2/14/20, 2/17/20, 2/18/20, 2/20/20, 2/21/20, 2/24/20. The 6:30 p.m. to 6:30 a.m. schedule for the second floor unit for 2/15/20 and 2/16/20, revealed the unit had only two CNAs from 6:30 p.m. to 10:30 p.m The weekend 6:30 a.m. to 6:30 p.m. shift for the second floor unit on 2/15/20 had only two CNAs scheduled. According to a note on the schedule, no coverage was found. The third CNA on the third floor unit had to rotate between the two floors. The 6:30 a.m. to 2:30 p.m. shift on 2/19/20, for the second floor unit, had only one CNA scheduled on the unit between 6:30 a.m. and 8:30 a.m. The weekend 6:30 a.m. to 6:30 p.m. shift for the second floor unit on 2/23/20 had only two CNAs scheduled. According to a note on the schedule, no coverage was found. The 6:30 a.m. to 2:30 p.m. shift for the second floor on 2/24/20, indicated only two CNA's were scheduled between 12:00 p.m. and 2:30 p.m The 6:30 a.m. to 2:30 p.m. shift for the third floor unit had only two CNA's on 2/1/20 and 2/11/20. The weekend schedule for the 6:30 p.m. to 6:30 a.m. shift on 2/1/20 for the third floor unit indicated only one CNA worked between 6:30 p.m. and 10:00 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The 6:30 p.m. to 6:30 a.m. schedule for the third floor unit for 2/16/20 revealed the unit had only two CNAs from 6:30 p.m. to 10:30 p.m. The 2:30 p.m. to 10:30 p.m. shift for the third floor unit had only two CNAs on 2/18/20 and 2/20/20. The 6:30 a.m. to 2:30 p.m. shift on 2/19/20, for the second floor unit and third floor unit, indicated only two CNAs worked on the second floor. The third CNA on the third floor worked on the second floor between 8:30 a.m. and 11 a.m., leaving the third floor with only two CNAs. The 6:30 a.m. to 2:30 p.m. shift for the third floor on 2/24/20, indicated only two CNAs were scheduled from 6:30 a.m. to 9:45 a.m. The 2:30 p.m. to 10:30 p.m. shift for the third floor on 2/24/20, indicated only two CNA's worked between 6:30 p.m. and 10:30 p.m. C. Resident census and conditions The census and conditions of residents form, provided by the facility on 2/24/20, revealed 97 residents resided in the facility. Care needs of the residents were documented as follows: -14 residents were dependent on staff for bathing and 80 residents needed the assistance of one or two staff to bath; -Five residents were dependent on staff for dressing and 91 residents needed the assistance of one or two staff to dress; -Eight residents were dependent on staff for transferring and 81 residents needed to the assistance of one or two staff to transfer; -Six residents were dependent on staff for toileting and 84 residents needed the assistance of one or two staff to use the toilet; - Four residents were dependent on staff for eating and 69 residents needed the assistance of one or two staff to eat; -22 residents were frequently or occasionally incontinent of bladder; -20 residents were frequently or occasionally incontinent of bowel; -Five residents were bedfast all or most of the time; -39 resident were in their wheelchairs all or most of the time; -19 residents had a diagnosis of dementia; -Four residents had current pressure injuries and 53 residents received preventative skin care; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two residents recieved dialysis services; -Three residents received intravenous therapy, nutritions, and/or blood transfusion -23 residents recieved respiratory care; -Nine residents had contractures; -Three residents received tracheostomy care; -Nine resident has a indwelling or external catheter; -Three residents received ostomy care; -Five residents received suctioning; -Six residents were tube fed; -11 residents received therapy services; -Nine residents received antibiotic therapy; -11 residents had behavioral healthcare needs; -44 residents were on psychoactive medication; and -74 residents were on a pain management program. D. Facility assessment The facility assessment was provided on 2/25/20 by the facility. The facility assessment indicated the facility had 3 units. The assessment revealed: -44 or more residents lived on the second floor unit; -46 or more residents lived on the third floor unit; and, -16 or more residents lived on the fourth floor unit. According to the facility assessment, staffing was determined by census and acuity. According to the assessment, the facility should adapt staffing levels based on resident needs and preferences, including activity of daily living assistance, (ADLs). The assessment indicated staff shortages should be replaced quickly, with the assistance of PRN (as needed) staff, the scheduler, the health information manager (HIM), and certified nursing aides (CNA's). IV. Staff interviews (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensed practical nurse (LPN) #4 was interviewed on 2/24/20 at 8:59 a.m. She revealed the third floor unit had 41 residents and needed to have three CNAs to provide care on the 6:30 a.m. to 2:30 p.m. shift. She said they currently had only two CNAs working on the morning shift of 2/24/20. LPN #1 was interviewed on 2/25/20 at 2:53 p.m. She said Resident #10 requested to have a shower on the evening of 2/24/20. She said she told him that they only had CNAs working and could not fit him in. She said there were just not enough CNAs sometimes. The scheduler (SCH) was interviewed on 2/26/20 at approximately 10:00 a.m., with the director of nursing. According to the SCH, the second and third floor unit required two nurses, three CNAs for the day and evening shift, and one nurse and two CNAs overnight. According to the DON, she recently increased staffing from one to two nurses and one CNA for the day and evening shift. The SCH said the facility currently used an agency CNA to help fill in the holes when possible. She said they had some CNAs on leave. She said she had had to place a CNA on the second floor who was on restricted light duty. The SCH said the light duty CNA could not turn, push, pull or transfer residents, and was limited to nail care and taking meal orders and vitals. The light duty CNA had been in place of a third CNA on the unit but could not do most of the ADL needs that CNAs without restrictions could do. The SCH said she tried to replace the holes in the schedule. She said, when possible, she used an agency CNA when she could not find anyone else to work the needed shifts. The DON was interviewed on 2/27/19 at 10:42 a.m. She said she wished she could hire five more staff. She said she had several open positions and had staff turnover related to poor attendance. CNA #6 was interviewed on 2/27/20 at 2:25 p.m. He said he had experienced coverage shortages recently but as a seasoned CNA, he could handle the extra workload. He said it seemed difficult for the new staff to keep up with the heavier resident load. CNA #2 was interviewed on 2/27/20 at 2:31 p.m. She said she has been a CNA for [AGE] years. She said she had had to work short for several weeks. She said it was related to a high staff turnover. She said it was too difficult for only two CNAs to have to tend to the high acuity needs of 45 residents. CNA #11 was interviewed on 2/27/20 at 5:15 p.m. He said staff shortages were frequent and put too much burden on the staff who worked to provide care for the residents. The SCH was interviewed again on 2/27/20 at 11:41 a.m. with the human resource corporate consultant (CSC). She said she tried to accommodate the needs of residents but staffing coverage had been a challenge. The SCH said a light duty CNA should not count as a third CNA on the second floor. She said she was aware that she needed more staff. The SCH said she recently lost three staff members, had two CNAs out on medical leave, and had open positions on every shift. She said she had three open positions on the day shift, two open positions on the evening shift, and two open overnight positions. The CSC said the facility was always trying to improve its staffing coverage but struggled to get qualified staff to apply. He said they encouraged the use of agency staff, and with help from the corporation, were looking into the possibility of increasing the wage scale to meet the current market value of the positions. He said all efforts were being made to recruit staff. He said increasing staff would reduce the stress of the staff, and better meet the needs of the residents.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 31820 Based on record review and interviews, the facility failed to ensure registered nurses (RNs) were able to demonstrate competencies in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Specifically, the facility failed to complete staff competencies for two RNs for a peripherally inserted central catheter (PICC) line care and total parenteral nutrition (TPN) administration for Resident #59. Findings include: I. Competency records The facility did not have competency records for RN #3 and #4 specific to PICC and TPN. II. Interviews The staff development coordinator (SDC) was interviewed on 2/26/2020 at 3:56 p.m. She said RN #3 and RN #4 had not completed return demonstrations for PICC line care and TPN formula administration. She said she had orally talked through the steps with the nurses, but had not completed the return demonstration. She said going forward any nurse working with a PICC line and/or TPN would need to provide return demonstration prior to working with residents that required those services. The director of nursing (DON) was interviewed on 2/27/2020 at 9:20 a.m. She said the facility could not locate the current competencies of the RNs providing care with the PICC line and TPN formula. She said the facility was going to ensure RN #3 and RN #4 completed the competencies before working with the PICC line and TPN formula. She said going forward every RN scheduled to work with Resident #59 would complete return demonstration competencies.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interview, the facility failed to ensure a resident with a history of trauma and/or post-traumatic stress disorder, received appropriate treatment to attain the highest practicable mental and psychosocial well-being for one (#81) of six residents reviewed for accommodations out of 33 sample residents. The facility was aware the resident requested female caregivers but failed to routinely schedule female staff to assist Resident #81 with her activities of daily living (ADLs), resulting in the feelings lack of self worth. The resident had a past trauma that left the resident paralyzed and fearful of male caregivers. The resident required extensive assistance of two or more female staff for bed mobility and transferring. The facility was also aware that the resident's need for female staff was frequently not honored, causing the resident anxiety and stress. The facility's failure to accommodate the resident's needs and preferences resulted in extended waits to go to bed, which induced the resident's feelings of stress, anxiety, tearfulness and lack of self worth. The facility was aware of the resident's past trauma, but considered the preferences of staff unit placement over the needs and preferences of the resident. Cross reference to F725, sufficient nursing staff Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, dated February 2017, was provided by the business office manager on 2/27/20 at 2:04 p.m. The policy read in pertinent part: The facility protects and promotes the rights of each resident. The resident has the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside of the facility. The facility staff will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes the maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.The facility provides equal access to quality care regardless of diagnosis, severity of condition, or payment source. II. Resident #81 status Resident #81, under age 60, was admitted on [DATE], with an initial admitted [DATE]. According to the February 2020 computerized physician orders (CPO), the resident's diagnoses included unspecified injury at unspecified level of cervical spinal cord, muscle spasms, chronic pain, other specified depressive episodes and muscle weakness. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	According to the 1/10/20 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS), score of 15 out 15. She required extensive assistance of two or more staff with ADLs for bed mobility, and transfering. She required extensive assistance of one for toileting, dressing, and personal hygiene. III. Resident interview Resident #81 was interviewed on 2/24/20 at 8:56 a.m. She said she was not comfortable with male certified nurse aides (CNAs), providing care to her because of a past trauma with a man, resulting in paralysis. She said the facility was aware that she wanted only female CNAs. Resident #81 said there were usually not enough female aides on her unit to assist her to bed. She said her unit was often staffed with male CNAs and she had to wait for a CNA from another unit to assist her to bed, resulting in long waits to go to bed. She said the lack of female aides available for her care caused her anxiety and frustration. She said she often had to worry that she would have increased pain the following morning because she had to sit in her chair for long periods at a time and not be able to lie down at her preferred bed time. She said she preferred to lie down between 9:00 p.m. and 9:45 p.m. Resident #81 was interviewed on 2/25/20 at 10:33 a.m., during a resident group interview. She said on the night of 2/25/20, she had to wait until 11:00 p.m. for a female CNA to leave their assigned unit and assist her. She said she required a lot of assistance to go to bed, and was not able to lie down until 11:45 p.m. She said she felt it was unfair to her she could not go to bed near her preferred bedtime, because not enough female CNAs were staffed on her unit constantly at night. Resident #81 said the facility knew why she could not have male CNAs. She said the lack of female CNAs scheduled on her unit made her feel that her needs did not matter, causing her to cry out in frustration. The resident was interviewed on 2/27/20 at 1:39 p.m. She said the female nurse would help her sometimes in the morning to get out of bed, but seldom would female nurses help her lie down at night. IV. Record review The social service note on 9/16/19 read Resident #81 discussed with social services that she was in a domestic violence situation that led to her paralysis. The care plan for behavior, revised on 10/22/18, read the resident could become demanding with her cares, had a diagnosis of depression and should be monitored for sadness and worried facial expressions. Interventions included to allow choices and modify environment, situations, and/or treatment to minimize episodes. According to the behavior care plan, the resident needed to accept staffing limitations, and her preferences were identified as a behavior. The care plan further read: This resident chooses only those who she wants within the building to care for her and to turn her. She will not take an alternative solution and she has none (solutions) herself, just does what she wants. I explained that I (unidentified writer) have to staff with those we have to help her. The resident's care plan did not include her preference for female CNAs or how to accommodate those needs. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The February 2010 staffing schedule was provided by the staffing scheduler (SCH) on 2/25/20 at 2:19 p.m. The February staffing schedule revealed the 2:30 p.m. to 10:30 p.m. shift on the unit where Resident #81 lived was frequently staffed with male CNAs. According to the schedule, either two male CNAs were assigned to the unit or two male CNAs and one female CNA. The schedule and the SCH indicated the female CNA scheduled was on restricted light duty. The following dates were without a scheduled female CNA able to assist Resident #81 to bed: -2/5/20 -2/10/20 -2/11/20 -2/14/20 -2/17/20 -2/18/20 -2/19/20 -2/24/20 -2/25/20 According to the 2/19/20 schedule, the facility had an opportunity to staff three CNAs in addition to the light duty female CNA. However, the three CNAs were all male. D. Staff interviews The social service director (SSD) was interviewed on 2/27/20 at 8:39 a.m. He said he was new to the facility and still learning the needs of each resident. He said care plans should reflect individual resident needs, be dynamic (ever changing), and person-centered. The SSD reviewed the behavior care plan documented in the medical record of Resident #81. He said the care plan was demeaning towards her and her needs. He said staff needed to treat everyone as an individual, listen and respond to the resident's needs. The resident should not feel that her needs were less than, or be told that this was just how things were going to be, without consideration or accommodation. The SSD said staff should be sensitive to resident needs, especially when the resident had needs related to past trauma. He said staff should honor her wishes, and think outside the box to meet her needs. He said she should have female staff assistance without undue stress or waiting. He said staffing should be adjusted on her unit to meet her needs and preferences. He said he would meet with the resident and advocate for her request. The SSD said the facility needed to improve their practice of handling resident needs related to past trauma. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 2/27/20 at 10:42 a.m. The DON said she was aware of the past trauma of Resident #81, and knew she was not comfortable with men providing care. She said the unit was staffed with one female CNA and a female nurse. The nurse should assist if needed. She said the female CNA assigned should not be a CNA on restricted or light duty. The DON said they had limited female staff available to work on the unit of Resident #81, but the SCH made provisions for another female CNA to leave her assigned unit to attend to Resident #81. She said the provision should not interfere with the time the resident was able to get ready and go to bed. The DON said she would have to move staff from their preferred units to accommodate Resident #81. The DON said moving staff could cause problems and frustrations with the staff. The DON said she instructed the SCH to accommodate by having a female CNA provide resident cares on her preferred assigned unit and also assist Resident #81 who lived on a different unit. The DON said a resident should not have to wait over a half an hour to receive assistance. The DON said Resident #81 had told her that she had to wait over a half hour for staff to assist her to bed which caused her to hurt the following day. The DON said the resident was often anxious about who was going to care for her at night. The DON said her anxiety resulted in the resident exhibiting behaviors such as repeated calls to the SCH and attempting to modify the staffing schedule. The SCH was interviewed on 2/27/20 at 11:41 a.m. with the human resource corporate consultant (CSC). The SCH said she was aware of the past trauma and preferences of Resident #81. She said the resident should always have two female staff available to provide care, one of which should not be a light duty CNA. She said the female light duty CNA identified on the staff schedule could not push, pull, turn or lift the resident due to her restrictions. The SCH said Resident #81 was difficult to assist because of her extensive care needs. The SCH said female staff had complained that she was too hard and turning her hurt their back. The SCH said the resident and the staff would benefit from having the assistance of three female staff to assist the resident to bed. The SCH said she did not have the staff on the unit to have a consistent supply of two to three CNAs to be staffed on the resident's unit. She said she tried to accommodate the needs of Resident #81, by asking a CNA from another unit to assist the resident when she needed to go to bed. The SCH said Resident #81 would frequently call her to ask who was scheduled to assist her at night. The SCH said the resident was directed to contact the DON and/or reach out to the charge nurse for staffing concerns related to who was scheduled to work on her unit. The SCH agreed that lack of female CNAs on the unit caused the resident anxiety. She said the male aides on the unit of Resident #81 were scheduled on that unit because that unit was part of their set assignment. The SCH said the unit was often staffed with more male staff than female staff to allow consistent staff schedules and staff unit preferences to reduce staff stress. She said she usually had more female CNAs available but currently two were out on medical leave. The SCH also said she had several open positions and recently lost some staff related to poor attendance. She said she recently added a female CNA to the unit from a staffing agency. The SCH said the staffing challenges and sometimes residents, including Resident #81, caused residents to have to wait for care because staff were handling other residents' needs. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	The human resource corporate consultant (CSC) said the facility staff challenges should not cause a resident undue stress or make her have to wait for care. He said the facility needed to provide care that best suited the resident. He said staff needed to accomodate the needs of all residents. The CSC said the staffing schedule should have been modified to ensure Resident #81 had female staff available on a consistent basis. The SCH said resident needs should be the facility's number one priority and residents should not have to feel stressed related to staffing challenges. A licensed practical nurse (LPN) who provided care for Resident #81 was interviewed on 2/27/20 at 1:35 p. m. She said she was aware of the resident's preference for female staff. She did she helped get Resident #81 up in the morning when she was available but did not work on the evening shift to help the resident go to bed. She said the resident had expressed to her that she had to wait awhile for staff to assist her to bed at night. She said the resident expressed pain and frustration in the morning when her time preferences to lie down in the 9:00 p.m. hour and get up out of bed at or shortly after 7:00 a.m. were not met. She said Resident #81 frequently complained of pain at a level of seven out of 10 (severe pain) in the morning. The SSD and the SCH were interviewed again on 2/27/20 at 1:45 p.m. The SCH said she and the SSD met with the resident and determined that a lot of the resident's stress was related to the fear of the unknown in regards to who was going to provide her care. The SCH said she had met with staff and adjusted the schedule to ensure the resident had more female staff scheduled on her unit seven days a week to limit the resident's anxiety and provide consistent female staff to help her needs without undue waiting and frustration. She said a staff schedule identifying who was scheduled to work with Resident #81 each day would be provided to the resident in her room. The SSD said he would also provide any needed supportive assistance and frequent visits with her, to make sure she felt her needs were met. He said he would continue to assist her and staff to work towards a solution. He said the facility needed to improve communication with her so she felt safe, comfortable and heard. The nursing home administrator (NHA) was interviewed on 2/27/2020 at 2:15 p.m. The NHA said he was aware Resident #81 preferred only female staff. The NHA said she only wanted the people she wanted. He said he was working on other solutions. He said he was not aware of her associated signs of distress or related behaviors. He said the resident did not self seclude, hide in her room, or avoid participating in community activities. The NHA said he spoke with Resident #81 daily and felt she tried to control things that no one could control. The NHA said he tried to meet her needs as best as he could.

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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** 31820 Based on record review and interviews, the facility failed to ensure one (#59) of five residents reviewed for unnecessary medications of 33 sample residents was free from unnecessary drugs. Specifically, the facility: -Failed to ensure psychotropic medications had a signed consent form that identified education, targeted behaviors, and dosage were provided, -Failed to track behaviors associated with the psychoactive medications, and -Failed to care plan the use of psychoactive medications. Findings include: I. Resident status Resident #59, age 63, was admitted on [DATE]. According to the February 2020 computerized physician orders (CPO), diagnoses included insomnia, depressive disorder, and anxiety. The 12/25/19 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. He had no behaviors or rejections of care. II. Record review The care plan did not address the use of psychoactive medications. The February 2020 CPO included: -Aripiprazole (Abilify, an antipsychotic) tablet 2 milligrams (mg), give one tablet by mouth one time a day for depression. -Quetiapine Fumarate (Seroquel, an antipsychotic) tablet 100 mg, give one tablet by mouth at bedtime for depression. -Trazodone HCL (an antidepressant) tablet 50 mg, give one tablet by mouth at bedtime for insomnia. The electronic medication administration record (eMAR) included: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observation: AntiDepressant Medication - Observe for behavior(s) of: withdrawal from socialization and sadness. Observe for side effects: GI upset, insomnia, fatigue, dizziness, dry mouth, headache. Document Y if resident is free of side effects. Document N if the resident is NOT free from side effects (SE). If N document SE in the progress notes (PNs).' -Observation: Antipsychotic Medication - Observe for behavior: mood swings, outbursts, hallucinations. Observe for side effects:dry mouth, constipation, blurry vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin, nausea and vomiting (N&V), lethargy, drooling, extrapyramidal symptoms (EPS) side effects (S/X) (tremors, gait issues, agitation, restlessness, involuntary movement of mouth/tongue.) Document:Y if resident is free of side effects. N if the resident is not free of side effects. If N document SE in the PNs. The facility did not track behaviors associated with the psychoactive medications. The psychoactive medication consent form for Aripiprazole and Quetiapine Fumarate did not identify the dosage, did not identify if the resident gave consent for the medication, did not identify specific targeted behaviors, nor did it identify if education on the potential side effects was explained to the resident. The forms only identified the medication, had the resident's signature, and a date of 12/18/29 on the forms. The resident did not have a social services (SS) progress note. III. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 2/25/2020 at 2:21 p.m. She said Resident #59 did not have any behaviors. She said he was a very nice man who just kept to himself. Registered nurse (RN) #1 was interviewed on 2/25/2020 at 2:24 p.m. She said he had not displayed any behaviors. She said SS tracked his behaviors in their assessments. SS was interviewed on 2/26/2020 at 12:36 p.m. He said he was new to his position and had not completed a consent form yet. He said the form should have been completed. He said there should have been a care plan to address the use of psychoactive medications. The director of nursing (DON) was interviewed on 2/26/2020 at 1:11 p.m. She said the consent form should have included identified behaviors to monitor, dosages of the medications given, had evidence of education on the potential side effects of each psychoactive medication, and a care plan developed to address the use of psychoactive medications.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41172 Based on observations, interviews and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards, in one out of two medication rooms and three out of three medication carts. Specifically, the facility failed to: -Ensure medication carts were clean and sanitary; -Date medications when opened; and -Discard expired medications. Findings include: I. Professional references According to Sanofi-Aventis (November 2019) Lantus Storage instructions, retrieved 2/28/2020 from: http://products.sanofi.us/Lantus/Lantus.html#section-16.2 Lantus insulin is good for 28 days after opening. According to Novo Nordisk (2019) How to store Levemir, retrieved 2/28/2020 from: https://www.levemir.com/levemir-flextouch-and-vial.html Levemir insulin pens, dispose after 42 days, even if there is insulin left in it. II. Facility policy and procedure The Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles policy, revised 10/28/19, was received from the director of nursing (DON) on 2/26/2020 at 3:15 p.m. The policy documented in pertinent part, the facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding. -Once any medicton or biological package is opened, the facility should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-If a multi-dose vial of an injectable medication has been opened or accessed, the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial. -When ophthalmic solutions and suspensions are opened, the bottle should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial. -Facility staff should check the temperature of vaccines twice daily. III. Record review The Recommended Minimum Storage Parameters document from the facility pharmacy, revised 3/31/16, was received from registered nurse (RN) #1 on 2/25/2020 at 10:00 a.m. The document revealed in pertinent part: -Refer to manufacturer for recommendations on insulin pen, -All insulin vials should be dated when opened and discarded in accordance with manufacturer's recommendations, -Tubersol (tuberculin test), date when opened and discard unused portion after 30 days, -Anoro inhalation powder, date the inhaler when removed from the foil pouch and discard six weeks after opening the foil pouch, -Flovent Diskus, date diskus when removed from foil pouch and discard 6 weeks (for 50mcg) strength or two months (for 100mcg and 250mcg strengths) after removal from foil pouch. -Combivent Respimat inhalation spray, after initial priming, discard after 120 sprays or three months after first use, -Incruse Ellipta inhalation powder, date product when opened and discard six weeks after opening foil tray. IV. Medication cart #1 Observation and interview On 2/25/2020 at 11:50 a.m., medication cart #1 was observed with RN #2. The following were observed in the cart: -Levemir insulin pen, opened, no date; -Flovent Diskus, opened, no date; -Combivent Respimat inhalation spray, opened, no date; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Incruse Ellipta inhalation powder inhaler, opened, no date. In the second drawer, under the medications, were multiple medications/pills loose in the bottom of the drawer. Medications in the bottom of the drawer included: two white oval tablets, two pink round tablets, one large white oval capsule, and one round light blue tablet. The drawer also contained hair, small pieces of paper from the medication cards, tan crumbs, and small white balls from a medication capsule that had opened. RN #2 was observed to date the inhalers and insulin with a marker, adding the date 2/25/00. She said the inhalers and insulin should have been dated when opened. RN #2 said she assumed the medications were all opened recently and that was why she added the current date to them. RN #2 said she did not know whose responsibility it was to clean the carts. She did not know what the loose pills were in the cart. V. Medication cart #2 Observation and interview On 2/25/2020 at 10:45 a.m., medication cart #1 was observed with licensed practical nurse (LPN) # 4. The following were observed in the cart: -Lantus insulin pen, opened, no date; -Latanoprost ophthalmic (eye) drops, opened, no date; -Dorzolamide ophthalmic (eye) drops, opened no date. The middle drawer of the cart contained multiple (16) medications pills loose in the bottom. There were three white caplets, six and one half white round tablets, one white capsule, two round blue tablets, one round pink tablet, one half round pink tablet, and one large orange tablet. LPN #4 said the nurses should have cleaned the carts when they worked them. She said the insulin and eye drops should have been dated when opened. She said the insulin was good 28 days after opening, and eye drops 30 days after opening. She removed the insulin and eye drops from the cart for destruction. VI. Medication cart #3 Observation and interview On 2/25/2020 at 10:31 a.m. medication cart #3 was observed with RN #1. In the top drawer of the cart was a Lantus insulin pen, opened, no date. RN #1 said she did not know when the insulin was opened but it was good until the expiration date. She returned the insulin to the top drawer and locked the cart. VII. Medication room [ROOM NUMBER] (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication room [ROOM NUMBER] was observed with LPN #4 on 2/25/00 at 10:50 a.m. The medication room refrigerator contained a vial of Tubersol (tuberculin skin testing) dated 1/13/2020. The vial had been open for 43 days. LPN #4 said the Tubersol was used for resident tuberculosis skin testing. She said the Tubersol was past the expiration date and she removed it to dispose of it. The medication room refrigerator temperature log was reviewed. The temperatures were checked one time daily. There were no temperature checks documented on 2/2/2020, 2/10/2020, 2/16/2020, or 2/23/2020. LPN #4 said the night shift checked the temperatures. VIII. DON interview The director of nursing (DON) was interviewed on 2/25/2020 at 3:26 p.m. She said she had been working on a checklist of items for the night shift nurses to do which would include cleaning the medication carts. She said she had not rolled out the new checklist yet, and the nurses should be cleaning the carts when they used them. The DON said the night shift nurse checked the refrigerator temperatures and the temperatures should be checked daily. She said she could not recall how long a vial of Tuberculin skin testing solution was good after opening. She said the inhalers were good for 30 days after opening, and insulin was good for 28 days after it was opened. IX. Facility follow-up The staff development coordinator (SDC) provided a copy of an inservice on 2/27/2020 at 2:00 p.m. The inservice, titled One to One Education, dated 2/25/2020, documented that RN #1 had been educated on dating Lantus when it was opened. It revealed Lantus was good 28 days after opening. In addition, RN #1 was educated that the medication cart binder had an expiration guide for medications. The SDC provided a copy of an inservice on 2/27/2020 at 2:00 p.m. with LPN #4. The inservice titled One to One Education, dated 2/25/2020, documented that LPN #4 had been educated to date all eye drops, insulins, and inhalers when opened. In addition, the inservice documented the LPN had been educated on proper medication storage and cleanliness of the cart and to look for loose pills and spilled medications and liquids.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41196 Based on observations, record review and staff interviews, the facility failed to ensure food items were stored and served under sanitary conditions for one of one serving areas. Specifically, the facility failed to ensure: -Opened food items were labelled and dated; -Dented canned food items were not put in the rotation, ready to be used and served; and -Cooking utensils were stored appropriately. Findings include: I. Facility policy and procedure The Receiving policy, revised in September of 2017, was provided by the certified dietary manager (CDM) on 2/27/2020 at 1:30 p.m. The policy read in part, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery and subsequent storage of all food items. II. Opened and unlabelled food items A. Observation During the initial tour of the kitchen on 2/24/2020 at 8:36 a.m. opened food items which had no labels/dates were observed. The food materials included: -Two packs of plain bagels; -Three packs of [NAME] whole grain bagels; -Two containers of Wholesome Farm liquid whole eggs with citric acid; -A bowl of lettuce and tomatoes in the refrigerator; -Two packs of corn tortillas; -One box of Sysco classic complete mashed potatoes; -One pack of egg noodles; -Two packs of durum wheat semolina pasta; (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two containers of Sysco Imperial brown gravy mix; and -Two containers of Sysco Imperial country style gravy B. Interview The CDM was interviewed on 2/27/2020 at 8:52 a.m. The CDM said it was important to label/date stamp opened food items to track how long they had been opened and also to know if they were usable. She said the best practice was to toss unlabelled/ dated food items. The CDM tossed the aforementioned food items. She stated she would educate dietary staff on the need to date stamp open food items going forward. III. Dented food cans A. Observation During the initial tour of the kitchen on 2/24/2020 at 8:36 a.m., canned foods which were dented around the seams were observed on the shelf and ready to be served. The canned food items included: -one can of applesauce; -one can of sliced pears; and -one can of mandarin oranges. B. Interview The CDM was interviewed on 2/27/2020 at 8:52 a.m.The CDM verified that the facility cared for vulnerable individuals and that it was essential to ensure foods served to such a population were free from contaminants. Specifically, the CDM verified that the three identified cans were dented enough to have raised a red flag for dietary staff not to have shelved them ready to serve. In addition, the CDM stated the risk associated with canned food dented around the seam was that the dents could result in pinhole-size openings and that the mixture of air and moisture from the food within the can had the potential to spur bacteria growth hence contaminating the food. She reported that the standard was to store dented cans separately and request credit for them from the suppliers. The CDM concluded the interview stating she would provide education to dietary staff going forward. IV. Failure to ensure utensils were stored in sanitary manner A. Observation During observations of the afternoon meal on 2/26/2020 beginning at 12:00 p.m., (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the pizza cutter, measuring spoons, spatulas, tongs and whisks were observed in the kitchen cabinets. The cabinets which housed the aforementioned items had a mixture of oily and black dustlike particles at the bottom which were consistent with long standing dirt. There were also tiny particles which the CDM described as crumbs. The cabinets had no mats in them, thus the cooking utensils were sitting directly on the dirty surfaces as described above. The CDM examined the cabinets using her finger to gather the particles and agreed that they were indeed dirty. B. Interview The CDM was interviewed on 2/26/2020 at 8:52 a.m. The CDM stated resident safety is a top priority and that proper cleaning and sanitizing was how the goal of keeping residents safe could be met. The CDM said what she thought was wrong with the cabinets was that dietary staff were just wiping the cabinets without putting the drawers through the dishwasher. She added that she believed the crumbs observed in the cabinets were from the cabinet drawers being left ajar and the piles of crumbs kept making their way into the cabinets. She concluded that education would be provided to dietary staff on the need to clean and sanitize the kitchen more effectively. V. Follow-up The CDM provided copies of in-service attendance records for the topics: -Dented cans; -Food storage and labelling; and -Cleaning and sanitizing. The in-service attendance reported a start date of 2/27/2020. The document further reported an identified solution which read: Dented cans cannot be stored on the can rack and cannot be used in food preparation. All canned goods will be appropriately inspected for dents, rust or bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate. The document further read: All food preparation areas, food services areas and dining areas will be maintained in a clean and sanitary condition. The in-services document itemized the procedures through which kitchen sanitation was to be achieved and it read as follows: The dining services director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls ceilings, lighting and ventilation; -The dining services director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces; -All food contact surfaces will be cleaned and sanitized after each use; -The dining services director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas and surfaces; and -All dining areas will be cleaned and sanitized after each use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The CDM was interviewed on 2/27/2020 at 1:16 p.m. The CDM verified that the facility conducted the above mentioned in-service because they were informed during survey of the above observations.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 31820 Based on record review and interview, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. Specifically, the facility failed to have a comprehensive facility assessment. Cross-reference F604, restraints Findings include: I. Facility assessment The facility assessment (FA) was reviewed and revealed it was not a comprehensive assessment of the facility's resources necessary to provide daily care to the resident population. The FA was updated 9/1/19, and reviewed by the quality assurance (QAA) committee on 9/26/19. The FA failed to identify the use of wanderguard alarms. II. Interview The nursing home administrator (NHA) was interviewed on 2/27/2020 at 2:15 p.m. He said he did not think the wanderguards needed to be identified. He said he understood why the use of wanderguards should have been identified in the FA.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to ensure the following areas were free from multiple environmental concerns observed during repeated tours of the facility: -13 of 66 resident rooms/bathrooms; -Three of nine hallways; -One of four dining rooms; -One of one activity room; -One of three common areas; and -One of three nurses' stations. Findings include: I. Facility policies and procedures The Physical Plant Interior Maintenance policy, revised March 2008, was provided by the nursing home administrator (NHA) on 2/27/2020 at 11:30 a.m. The policy revealed all interior areas of the building were inspected within a one-month period to ensure proper condition and function. Interior maintenance of the physical plant was an essential function of the preventive maintenance program to assure employee and resident safety. -Daily inspect all halls and exits for obstructions. -Check cove base for cleanliness and tightness. Replace or re-glue loose areas of the cove base. Report cleaning issues to housekeeping for additional cleanliness. -Check all areas of ceramic/vinyl flooring for repairs and cleanliness. Repair/report all damaged areas. Report cleaning issues to housekeeping for additional cleanliness. The Common (Public) Areas Cleaning policy, revised April 2005, was provided by the NHA on 2/27/2020 at 11:30 a.m. The policy revealed day rooms and lounges were cleaned daily to provide clean, odor-free and neat appearing public areas. -Check walls and spot wash as necessary. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Dry mop, then wet mop hard surface floors daily with a disinfectant solution. Move furniture to clean underneath, per schedule. II. Observations Two environmental tours of the facility were conducted on 2/25/2020 at 1:05 p.m., and on 2/26/20 at 9:00 a. m. Observations revealed: room [ROOM NUMBER]: dirty (covered or marked with an unclean substance) room cove base, chipped paint on one red accent wall, dirty room corners, missing piece of laminate on the dresser, one missing towel holder, one broken towel holder, loose laminate under the sink, chipped paint on the closet doors, chipped paint on the door frame, multiple dirty floor tiles, dirty closet floor. room [ROOM NUMBER] bathroom: chipped paint on the door frame, chipped paint on the door, dirty caulk around the toilet base, two unfinished sheetrock patches on one wall, dirty linoleum floor, dirty room corners, dirty bathtub, dirty caulk at the bathtub base, three small holes in one wall, mismatched paint on one wall, chipped paint on the metal heater cover. room [ROOM NUMBER]: black marks on the wall by the window, dirty room cove base, dirty room corners, dirty plastic window heater cover, two missing floor tiles under the sink, one missing towel bar, several adhesive remnants on the sink countertop surface, chipped paint on the closet doors, chipped paint on the entrance door frame, dirty wall under the sink, sheetrock damage on two walls, chipped paint on one entrance wall nightlight cover, four cracked floor tiles, missing wood strip on one dresser drawer. room [ROOM NUMBER] bathroom: dirty linoleum floor, dirty room corners, dirty caulk around the toilet base, chipped paint on the metal heater cover, dirty bathtub, dirty caulk at the bathtub base, chipped paint on the wall behind the toilet, chipped paint on the door, chipped paint on the door frame. room [ROOM NUMBER]: sheetrock damage around the hand soap dispenser, dirty room cove base, dirty room corners, four cracked floor tiles, two unfinished sheetrock patches, chipped paint on the closet doors, dirty room floor tiles, chipped paint on the entrance door, chipped paint on the door frame. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, dirty linoleum floor, dirty room corners, dirty caulk around the toilet base, chipped paint on the door, chipped paint on the door frame, chipped paint on the metal heater cover, loose metal heater cover, dirty cove base, dirty room corners. room [ROOM NUMBER]: dirty room cove base, dirty room corners, chipped paint on the closet doors, dirty closet floor, missing cove base, dirty laminate under the sink, missing wood on one drawer at the sink. room [ROOM NUMBER] bathroom: dirty tub, dirty caulk at the bathtub base, dirty floor, chipped paint on the door, chipped paint on the door frame, dirty room corners, one water damage ceiling tile, dirty brown stain around the toilet base. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER]: missing cove base, dirty cove base, dirty room corners, multiple dirty floor tiles, loose metal baseboard wall heater, chipped paint on the entrance door frame, one broken entrance floor tile. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, yellow caulk around the toilet base, dirty metal heater cover, dirty linoleum floor, dirty room corners, chipped paint on the wall behind the toilet, chipped paint on the door frame. room [ROOM NUMBER]: dirty room cover base, dirty room corners, chipped paint on the closet doors, chipped paint on the entrance door, chipped paint on the door frame, chipped paint on the ceiling above the window, chipped wood on the corner of the sink counter, one hole in the wall behind the headboard of bed one, water damage on the ceiling above the window. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, dirty linoleum floor, dirty room corners, chipped paint on the door, chipped paint on the door frame, chipped paint on the metal heater cover, two dirty walls. room [ROOM NUMBER]: dirty cove base, dirty room corners, dirty plastic on the window heater cover, multiple dirty floor tiles, brown water stain on the ceiling above the window, bubbled paint on two walls by the window, multiple chipped paint areas on one wall, chipped paint on the door frame, dirty entrance floor tiles, black marks on the door, chipped paint on the closet doors, chipped ceiling paint in the middle of the room, long unused coaxial television cable along one wall. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, dirty floor, yellowed caulk around the toilet base, chipped paint on the door, chipped paint on the door frame, chipped paint on the metal heater cover, chipped paint on the wall above the heater. room [ROOM NUMBER]: dirty room cover base, dirty room corners, loose laminate on the sink counter, loose wood on the sink counter, chipped paint on the closet doors, dirty clothes closet floor, chipped paint on the door, chipped paint on the door frame, multiple dirty floor tiles, sheetrock damage around the hand soap dispenser, lint in the front plastic cover of the window heater. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, chipped paint on the wall around the bathtub water faucets, chipped paint on the wall behind the toilet, chipped paint on the metal heater cover, chipped paint on the door, chipped paint on the door frame, loose cove base, dirty room cove base, dirty room corners. room [ROOM NUMBER]: one hole in one closet door, dirty room cove base, dirty room corners, chipped paint on the door, chipped paint on the door frame, multiple dirty floor tiles, chipped paint on the red accent wall, dirty entrance floor tiles. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, loose metal heater cover, dirty floor corners, dirty caulk around the toilet base, chipped paint on the door, chipped paint on the door frame. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065230	A. Building B. Wing	02/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Valley Post Acute Rehabilitation	4450 E Jewell Ave Denver, CO 80222

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER]: dirty room cover base, dirty room corners, loose laminate at the sink countertop, chipped laminate at the sink countertop, sheetrock damage around the hand soap dispenser, chipped paint on one wall behind the headboard, chipped paint on the door fame, black marks on the entrance door. room [ROOM NUMBER] bathroom: dirty bathtub, dirty caulk at the bathtub base, dirty linoleum floor, dirty caulk around the toilet base, loose metal heater cover, chipped paint on door, chipped paint on the door frame. room [ROOM NUMBER]: dirty cove base, dirty room corners, multiple dirty floor tiles, chipped paint on the wall by the window, missing room cove base, five pieces of loose/missing laminate on the dresser, missing laminate on the edge of the dresser. room [ROOM NUMBER] bathroom: one large hole in the wall, chipped paint on the metal heater cover, loose metal heater cover, chipped paint on the door, chipped paint on the door frame, loose caulk around the toilet base, loose caulk at the sink, chipped paint on one wall, two bathroom lights containing electrical outlets without evidence of a connection to a ground fault circuit interrupter. room [ROOM NUMBER]: dirty room cove base, dirty room corners, loose wall heater cover, multiple dirty floor tiles, one missing floor tile, four missing sections of laminate on the dresser, one torn/loose window screen, chipped paint on the closet doors, chipped paint on the door frame, black mark on the door, missing cove base by the closet doors, dirty personal floor fan, large roll of wall insulation lying on the ledge outside the room window. room [ROOM NUMBER] bathroom: yellowed linoleum floor, chipped paint on the metal heater cover, chipped paint on the door, chipped paint on the door frame, yellowed caulk around the toilet base, cracked caulk at the sink, two bathroom lights containing electrical outlets without evidence of a connection to a ground fault circuit interrupter. room [ROOM NUMBER]: dirty room cove base, dirty room corners, missing cove base, multiple dirty floor tiles, loose laminate on the dresser, two missing dresser door handles, two holes in the wall at the window, dirty plastic heater cover at the window, chipped paint on the door, chipped paint on the door frame, chipped paint on the closet doors, chipped paint on one wall. room [ROOM NUMBER] bathroom: dirty floor, missing caulk around the toilet base, chipped paint on the door, chipped paint on the door frame, chipped paint on one wall, chipped paint on the toilet riser, chipped paint around the hand soap dispenser, seven small holes in one wall, dirty entrance transition area, two bathroom lights containing electrical outlets without evidence of a connection to a ground fault circuit interrupter. Hallway for resident rooms 301 to 308: eight metal handrails (boxed shaped with a top, bottom, and two sides) with chipped paint on all rails, multiple areas of dirty cove base, multiple dirty floor tiles, dirty transition area at entrance to hall, dirty corners behind fire doors. Hallway for rooms 309 to 316: eight metal handrails with chipped paint on all rails, multiple areas of dirty cove base, multiple dirty floor tiles, dirty hall corners, sheetrock damage on the wall to the left of the hand sanitizer adjacent to the elevator, mismatched paint on the wall around the computer kiosk, multiple black marks on the restroom door and door frame. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hallway for rooms 317 to 323: eight metal handrails with chipped paint on all rails, multiple areas of dirty cove base, multiple dirty floor tiles, dirty hallway corners, eight broken floor tiles, black marks on the elevator door frame, multiple areas of chipped paint on the walls, chipped paint on the spa room door and door frame. Third floor dining room: chipped paint on three walls, large area of unfinished sheetrock damage over one one window, loose/sagging paint from water damage on one wall in the corner, dirty cover base throughout the room, dirty room corners, two broken five wheeled chairs, chipped paint on three room wall metal heater covers, missing room cover base, one loose metal wall heater cover, multiple black marks on one wall, multiple dirty floor tiles. Activity room: dirty cove base, dirty cover base on the pole in the middle of the room, dirty room corners, dirty floor tiles at entrance to the room, dirty floor tiles adjacent to the cover base throughout the room, one dirty electrical outlet, missing laminate edge of the sink counter, dirty cove base under the sink cabinets, chipped paint on the stove, dirty stove base, dirty floor around the stove/refrigerator, chipped paint on two wall metal heater covers, chipped paint on one room corner edge, two loose floor tiles near the windows, missing cove base at the ramp by the sliding doors, chipped paint over the sliding doors near the ceiling, two sliding plastic folding doors to the activity office off the track. Third floor common area adjacent to the nurses' station: multiple areas of chipped paint on three walls, dirty area cove base, dirty room corners, multiple dirty floor tiles, one broken floor tile, chipped paint on two fire door frames, chipped paint on two sets of fire doors, sheetrock damage on the wall beside the elevator, black marks on the elevator door frame, one section of a metal handrail with chipped paint on all rails. Third floor nurses' station: multiple areas of chipped paint all along the wall surface of the desk, multiple areas of chipped laminate along the top portion of the desk, dirty cove base at the bottom of the desk, chipped paint on the eye wash station door, dirty plastic laminate on the eye wash station door, dirty floors tiles at the entrance of the eye wash station room, dirty floor tiles at the entrance to the medication storage room room, dirty cove base adjacent to the eye wash station and the medication storage room entrance doors, dirty cove base in the nurse station area, missing cove base in the nurse station area, dirty floor in the nurse station area, unfinished wall patch behind the metal record rack, four protruding screw heads on one wall, four unused anchors on one wall. III. Resident council minutes The resident council minutes dated 1/4/2020 and 2/7/2020 revealed that residents had expressed concerns with the cleanliness in the facility and in their rooms. IV. Resident group interview A resident group interview was conducted on 2/25/2020 at 10:15 a.m. According to residents #27, #81 and #95 the second floor did not receive housekeeping services on Sundays and Mondays. The residents said their rooms received inadequate cleaning procedures such as wiping down items, scrubbing and mopping. V. Staff interviews (continued on next page)

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