STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065232	A. Building B. Wing	06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure the resident's right to receive services in the facility with reasonable accommodation of the resident needs and preferences for one (#7) of three residents out of 24 sample residents. Specifically, the facility failed to ensure Resident #7 was provided with a bed that was long enough to fit his height. Findings include: I. Resident status Resident #7, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2022 computerized physician orders (CPO), the diagnoses included type two diabetes mellitus (DM2), aphasia, and cellulitis of right lower extremity. The 5/19/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of nine out of 15. He required extensive assistance of two people for bed mobility, transfers, toileting; limited assistance of two people for dressing; set up assistance for eating; and extensive assistance of one person for personal hygiene. It indicated the resident was 189 pounds and 75 inches (six foot three inches). II. Observations and resident interview On 5/24/22 at 9:48 a.m. Resident #7 was lying in bed. His entire foot and ankle were hanging off the edge of the bed. -At 3:00 p.m. Resident #7 was observed with his left foot and ankle extended off the end of the bed. The resident's head was near the top of the bed. On 5/25/22 at 10:55 a.m. Resident #7 was lying in bed with his foot hanging off the end of the bed. -At 4:55 p.m. Resident #7 was lying in bed with his foot hanging off the end of the bed. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/26/22 at 11:03 a.m. certified nurse aide (CNA) #3 lifted the resident's blankets off his foot to confirm the left foot was hanging off the end of the bed. The resident stated his right foot and leg were amputated. B. Record review The skin integrity care plan, initiated on 6/17/21 and revised on 5/25/22, revealed the resident was at risk for skin breakdown related to immobility, motor vehicle accident with a traumatic brain injury, history of stroke, aphasia, weakness, and medication side effects. The interventions included, in pertinent part, to remove the bed footboard of the resident's bed for the resident's comfort and to prevent further skin breakdown. II. Staff interviews CNA #2 was interviewed on 6/1/22 at 1:07 p.m. She said when residents needed additional equipment, such as a walker or larger bed she would report it to nursing management. She said Resident #7's foot would often hang off the end of the bed. The director of rehabilitation (DOR) was interviewed on 6/1/22 at 1:30 p.m. She said therapy had recently evaluated Resident #7. She said the recommendation was to remove the board at the end of the bed, because the resident's foot was often pushed up against the board. She said they placed a cushion underneath his leg to reduce pressure. She said he would likely have benefited from a larger bed, since he was a tall man. The director of nursing (DON) was interviewed on 6/1/22 at 1:35 p.m. She said therapy was responsible for assessing equipment for residents, such as beds. She said Resident #7 was very tall. She said he had pressure wounds on the bottom of his left foot. She said the board at the end of the bed was often causing additional pressure to his foot, so therapy recommended removing the board. She said a long bed would be beneficial for the resident, if his foot was frequently hanging off the bottom of the bed.

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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 - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews, the facility failed to ensure four (#11, #6, #2 and #13) of seven out of 24 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to: -Ensure Resident #11, Resident #2 and Resident #13's fingernails were kept clean and trimmed; and, -Ensure Resident #11, Resident #6 and Resident #2 received bathing services as indicated in their plan of care. Findings include: I. Facility policy and procedure The ADL policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 6/1/22 at 2:02 p.m. It revealed, in pertinent part, Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the (facility) must provide the necessary care and services to ensure that a resident's ADLs are maintained or improved and do not diminish unless circumstances of the individual's clinical condition demonstrate that a change is unavoidable. ADLs include: hygiene (bathing, grooming, and oral care), mobility (transfers and ambulation), elimination (toileting), dining (eating) and communication. II. Failure to ensure resident fingernails were kept clean and trimmed A. Resident #11 status Resident #11, age younger than 65, was admitted on [DATE] and readmitted on [DATE]. According to the June 2022 computerized physician orders (CPO), the diagnoses included diffuse traumatic brain injury with loss of consciousness of unspecified duration (prolonged loss of consciousness beyond six hours), mild protein malnutrition and flaccid hemiplegia (paralysis) affecting the left non-dominant side. The 2/15/22 minimum data set (MDS) assessment revealed the resident had mild cognitive impairment with a brief interview for mental status score of 11 out of 15. He required extensive assistance of two people with bed mobility, transfers, dressing and toileting and extensive assistance of one person with personal hygiene. He required one person physical assistance with bathing. 1. Observations (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/25/22 at 11:30 a.m. Resident #11 was observed sitting in a high back wheelchair in the dining room, facing the television. The resident's fingernails on both hands were observed to be long, approximately a quarter to a half inch in length, and jagged. The resident's fingernails appeared yellowish in color with darkened matter near the cuticle of the middle finger and pointer finger of the resident's right hand. On 5/26/22 at 10:40 a.m. Resident #11 was observed in his room. His fingernails extended a half an inch past the tip of his fingers and were jagged. On 6/1/22 at 9:56 a.m. the resident's fingernails remained unchanged. 2. Record review The ADL care plan, initiated on 10/8/18 and revised on 10/26/2020, documented the resident was at risk for decreased ability to perform ADLs related to impaired balance, dizziness, limited mobility, change in the resident's cognitive status, a traumatic brain injury with a right sided craniotomy and left sided hemiplegia. It indicated the resident required extensive assistance of one person for grooming and personal hygiene. B. Resident #2 status Resident #2, age 77, was admitted on [DATE] and discharged on [DATE]. According to the May 2022 CPO, the diagnoses included dementia, type two diabetes mellitus (DM2) and a stage three pressure ulcer. The 3/24/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required extensive assistance of two people for bed mobility, transfers, dressing, toileting and extensive assistance of one person for personal hygiene. It documented that the resident required total physical assistance for bathing. 1. Observations On 5/25/22 at 3:45 p.m. Resident #2 was lying in bed with his lunch meal in front of him. All of the resident's fingernails were a half of an inch extended past the tip of his finger. Six of his nails had a black built-up substance underneath them. Further observations were not conducted during the survey, as the resident was sent to the hospital for medical attention after becoming unresponsive. 2. Record review The infection care plan, initiated on 4/8/21 and revised on 3/23/22, revealed the resident had a fungal infection to his fingernails. The interventions included, in pertinent part, educating the resident on hand hygiene to prevent the spread of infection. C. Resident #13 status (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13, age 88, was admitted on [DATE]. According to the May 2022 computerized physician orders (CPO), diagnoses included Parkinson's disease and dementia. According to the 4/26/22 minimum data set (MDS) assessment, the resident had memory impairments and decision making skills were moderately impaired. The resident required extensive assistance with activities of daily living. 1. Observations and interviews On 5/26/22 at 11:22 a.m., the resident was in his wheelchair in the common area. The resident was attempting to use his right index finger nail and clean his left index finger nail. The resident's nails were approximately a quarter to half an inch over his nail bed. The resident said that he needed to have his nails cut. He said his nails were longer than what he preferred. He asked the surveyor to help him cut the nails. Licensed practical nurse (LPN #1) was interviewed on 5/26/22 at 11:30 a.m. LPN #1 said he had noticed the resident's nails were long earlier in the morning. He said he heard the resident say his nails were too long and went over during the interview to cut his nails. The LPN said the resident's nails should be cut as needed and during showers. 2. Record review The care plan last updated on 5/2/22 identified the resident as having a decreased ability to perform grooming needs related to Parkinson's disease. The care plan directed staff to anticipate his activities of daily living. III. Failure to ensure bathing services were provided to residents in accordance with their plan of care A. Resident #11 1. Observations On 5/25/22 at 11:30 a.m. Resident #11 was observed sitting in a high back wheelchair in the dining room facing the television. The resident was wearing a hospital gown with dark sweatpants. The resident's hair was on his shoulders and appeared wet. The resident had a strong musky odor. 2. Record review The ADL care plan, revised on 10/26/2020, documented the resident required total staff assistance with bathing. The April 2022 certified nurse aide (CNA) ADL documentation revealed the resident received one shower (4/8/22) and two bed baths (4/10/22 and 4/18/22) during the entire month. It did not indicate the resident had refused any bathing opportunities. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The May 2022 CNA ADL documentation indicated the resident received one bed bath (5/30/22) from 5/19/22-5/31/22. It did not indicate the resident had refused any bathing opportunities. -The facility did not provide the March 2022 CNA ADL documentation as requested during the survey process that was exited on 6/1/22. B. Resident #6 status Resident #6, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the June 2022 CPO, the diagnoses included Parkinson's disease, muscle weakness, difficulty walking and cognitive communication deficit. The 4/29/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing and toileting and extensive assistance of one person with personal hygiene. 1. Resident interview and observations Resident #6 was interviewed on 6/1/22 at 12:55 p.m. She said she had not received a shower or bath in over two weeks. She said she felt like her hair was greasy and smelled. Resident #6's hair was observed sticking up in many directions and appeared wet. 2. Record review The ADL care plan, initiated on 2/14/22 at revised on 2/15/22, documented the resident required assistance from staff with ADLs, including bathing. The April 2022 CNA ADL documentation revealed the resident did not receive bathing services from 4/1/22 to 4/10/22 and 4/25/22 to 4/30/22. It did not indicate the resident had refused any bathing opportunities. The resident was in the hospital from 4/11/22 and readmitted on [DATE]. The May 2022 CNA ADL documentation documented the resident received two bed baths (5/2/22 and 5/7/22) and one shower (5/29/22). It did not indicate the resident had refused any bathing opportunities. -The facility did not provide the March 2022 CNA ADL documentation as requested during the survey process with exit on 6/1/22. C. Resident #2 1. Record review The activities care plan, initiated on 9/25/22 and revised on 3/23/22, revealed the resident said it was important for him to have the opportunity to engage in his normal daily routine. The interventions included, in pertinent part, Resident #2 wanted a bed bath daily and a shower once per week. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activities of daily living (ADL) care plan, initiated on 9/16/2020 and revised on 4/19/22, revealed the resident required assistance with ADLs related to impaired cognition, weakness, impaired mobility, pressure wounds, diabetes, and refusals in care. The interventions included, in pertinent part, Resident #2 frequently declined showers, but staff would continue to offer showers as scheduled and as needed. The March 2022 shower documentation revealed Resident #2 received bathing on 3/1/22, 3/10/22, 3/24/22, and 3/31/22. Resident #2 refused bathing on 3/6/22 and 3/29/22. -It indicated Resident #2 was provided bathing four out of 31 opportunities. He refused two offered opportunities to bathe. The April 2022 shower documentation revealed Resident #2 received bathing on 4/3/22, 4/5/22, 4/10/22, and 4/12/22. Resident #2 refused bathing on 4/14/22, 4/19/22, and 4/21/22. -It indicated Resident #2 was provided bathing four out of 30 opportunities. He refused three opportunities to bathe. The May 2022 shower documentation revealed Resident #2 received bathing on 5/3/22 and 5/17/22. Resident #2 did not refuse bathing in May. He was discharged to the hospital on 5/25/22. -It indicated Resident #2 was provided bathing on two of 25 opportunities. IV. Staff interviews Certified nurse aide (CNA) #4 was interviewed on 6/1/22 at 9:37 a.m. She said the CNAs were responsible for trimming the resident's nails on their shower days and as needed. She said the nurses were responsible for trimming residents' nails who were diabetic. She said the point of care electronic system notified the CNAs of the resident's shower days. LPN #3 was interviewed on 6/1/22 at 10:05 a.m. She said the licensed nurses were responsible for cutting Resident #2's nails, since he was diabetic. She said Resident #2 had a fungal infection underneath his nails. She said the licensed nurses provided a topical ointment to his nails. She said the resident often ate with his hands, which caused food debris to build up underneath his nails. She said she often found Resident #2 with long dirty fingernails when she worked. She said she would soak Resident #2's nails to clean and trim them as needed. CNA #1 was interviewed on 6/1/22 at 1:10 p.m. He said showers and bed baths should be given according to the bathing schedule which was kept at the nursing station and documented in point of care (POC). He said each resident received bathing services according to their preference, which was typically twice per week. He said each resident should receive bathing at least once per week. He said showers and baths were documented in POC electronic records for each resident. He said not applicable was documented in POC when bathing was not provided to the resident. He said any refusals were documented in POC. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said Resident #6 and Resident #11 were scheduled to receive bathing twice per week. He said he could not remember when their showers were scheduled. He said he did not know the last time they received a shower or a bath. He said fingernails were typically cut by the CNAs unless the resident had a diagnosis of diabetes. He said each resident's fingernails should be checked on their shower day. He said Resident #6 required assistance to cut his nails. He said hand hygiene should be provided in the morning and before every meal. He said the CNAs were able to cut the resident's nails. He said he would cut the resident's nails after he was done assisting residents with lunch. The director of nursing (DON) was interviewed on 6/1/22 at 1:27 p.m. She said bathing should be provided to the resident according to the bathing schedule. She said the bathing schedule was developed based on the resident's preference. She said she was not aware that residents were not receiving bathing services. She said audits that had been completed recently had shown a lot of POC documentation indicating not applicable. She confirmed the not applicable meant the resident was not provided bathing. She said the fingernails should be observed by the CNA on the residents shower days. She said the CNA was able to cut resident fingernails if the resident did not have a diagnosis of diabetes. She said resident fingernails should be kept short to prevent injury from scratching, unless it was the resident's preference. She said the resident's preference should be documented on the plan of care. The director of nursing (DON) was interviewed again on 6/1/22 at 2:28 p.m. She said Resident #11 should have short trimmed nails as he often scratched himself due to involuntary movements. She said the resident recently had a tear in his percutaneous endoscopic gastrostomy (PEG) tube and the intervention the facility put into place was to ensure the resident had trimmed nails. She said Resident #2 had a fungal infection underneath his nails. She said the licensed nurses were responsible for ensuring Resident #2's nails were trimmed and clean. 46022 20287

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to prevent pressure injuries from occurring and worsening for three (#12, #6, and #2) of five out of 24 sample residents. Specifically, the facility failed to ensure Resident #12's pressure injury to the coccyx/sacrum did not worsen. Resident #12, who was at high risk for developing pressure injuries, was admitted to the facility with a healing stage 2 pressure injury to the sacrum/coccyx. The facility failed to encourage the resident to reposition and follow physician orders for ensuring the resident was not up in the wheelchair for extended periods of time. The facility failed to ensure treatments were provided as ordered by the physician and develop a person-centered care plan for the resident's pressure injury to the sacrum/coccyx. Resident #12 was admitted to the facility with a stage 2 pressure injury to her sacrum. The facility's failure contributed to the worsening of Resident #12's pressure injury worsening from a healing stage 2 to her sacrum/coccyx to an unstageable wound on 3/23/22. The resident was sent to the hospital on 4/20/22 due the fever and possible sacral wound infection. When the resident return from the hospital on 4/25/22, the sacral/coccyx wound was debrided and classified as a stage 4. Additionally, the facility failed to: -Ensure treatments were provided as ordered by the physician for Resident #6's pressure injury to the sacrum; and, -Ensure Resident #2 was repositioned timely. Findings include: I. Facility policy and procedure The Skin Integrity Management policy and procedure, revised June 2021, was provided by the nursing home administrator (NHA) on 6/1/22 at 11:39 a.m. It revealed, in pertinent part, The implementation of an individual patient's skin integrity management occurs within the care delivery process. Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Identify the patient's skin integrity status and need for prevention intervention or treatment modalities through review of all appropriate assessment information. Perform skin inspection on admission/readmission and weekly. Document on the treatment administration record (TAR) or in Point Click Care (PCC). Perform wound observations and measurements and complete a skin integrity report upon initial identification of altered skin integrity, weekly, and with anticipated decline of the wound. Perform daily monitoring of the wounds or dressings for presence of complications or declines and document. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. Implement pressure ulcer prevention for identified risk factors. Determine the need for support surface for bed and chair. Determine the need for heel protectors and heel lift devices and utilize per manufacturer's guidelines. Implement skin/wound care guidelines as applicable. Implement special wound care treatments/techniques, as indicated and ordered. Document daily monitoring of ulcer site, with or without dressing. For wounds that do not require a daily dressing change, monitor: the status of the dressing, status of the tissue surrounding the dressing and adequate control of wound pain. For wounds that require a daily dressing change or wounds without a dressing, monitor for signs of decline in wound status. If unanticipated decline in wound, surrounding tissue, or new or increased wound, and complete the skin integrity report and notify the physician. II. Resident #12 A. Resident status Resident #12, age less than 65, was admitted on [DATE]. According to the May 2022 computerized physician orders (CPO), diagnoses included functional quadriplegia, unspecified severe protein calorie malnutrition, and pneumonia. According to the 4/28/22 minimum data set (MDS) assessment, the resident had minimal cognitive impairment with a score of 14 out of 15 on the brief interview for mental status (BIMS). The resident required total assistance with activities of daily living. The MDS coded the resident as having an unhealed stage 4 pressure ulcer. She was at risk for pressure ulcers. The MDS coded the resident as not having any behaviors or refusal of care. The physician progress note dated 5/6/22 documented the primary care physician had a plan discussed with the resident to only be up in the wheelchair for no more than 30 minutes for smoke breaks and then to return to bed. The note further documented this was discussed with licensed practical nurse (LPN) #1. B. Observations On 5/23/22, during a continuous observation which started at 10:30 a.m. and ended at 12:30 p.m. Resident #12 was sitting in her wheelchair, outside in the supervised smoking area. -At 11:45 a.m. the resident's position remained unchanged. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-At 12:15 p.m. the resident's position remained unchanged. The facility staff did not encourage the resident to lie down in bed to offload the pressure to the resident's sacrum/coccyx. On 5/26/22, during a continuous observation which started at 9:41 a.m. and ended at 12:30 p.m., Resident #12 was not offered or encouraged to lie down after smoking and after 30 minutes of sitting up in the wheelchair. -At 9:41 a.m. Resident #12 was observed being assisted out of bed by two unidentified staff members. -At 10:18 a.m. certified nurse aide (CNA #2) assisted the resident out of her room with the wheelchair to the dining room, waiting for her smoking break. -At 10:50 a.m. CNA #2 was assisted back into the dining room from the supervised smoking area. CNA #2 remained in the dining room, however did not provide education to Resident #12 about lying down in bed after her smoke break. -At 10:54 a.m. CNA #2 wheeled the resident back to her room and poured her a soda. She did not offer to lay the resident down in bed or reposition the resident. -At 11:08 a.m. LPN #1 entered the resident's room to answer a question for her roommate. While in the room, he made a joke to the resident and then exited the room. He did not offer to lay the resident down or provide education to the resident on repositioning. -At 11:25 a.m. CNA #2 asked her if she wanted another drink of the soda. She provided her a drink, but did not ask the resident to lie down or provide education about lying down. -At 11:45 a.m. the resident remained in the same position, with no offer to offload, reposition or lie down. -12:10 p.m. the resident remained in the room sitting in her wheelchair. The resident had not been offered to lie down for the past two hours. On 5/31/22 at 9:30 a.m. the coccyx/sacral wound was observed with the resident's primary care physician (PCP) and the wound physician. The wound to the coccyx/sacrum was observed to have beefy red tissue at the bottom with well defined edges. The wound physician said the wound was smaller than the previous week when he had observed the wound. The wound physician replaced the wound vac treatment (a machine used to treat wounds) and said the wound was healing. He reinforced education with the resident to only remain up in the wheelchair for 30 minutes at a time and the important of offloading the coccyx/sacrum. C. Resident interview (continued on next page)

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Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #12 was interviewed on 5/25/22 at 6:25 p.m. The resident said that she did have a pressure ulcer injury on her coccyx. She said she had recently returned from the hospital. She said that she was unable to move on her own and that a hoyer mechanical lift was utilized to move her from the chair to the bed. She said that she stayed in her chair for the day, and that she was not always offered to go to lie down. She said she liked to go out to smoke. She said the pressure ulcer injury would hurt at times when she had been sitting on the wound for too long. D. Worsening of the coccyx/sacral pressure injury The 2/9/22 admission assessment documented the resident was admitted to the facility with a stage 2 pressure injury to the sacrum measuring 2 cm (centimeters) x 2 cm x 0.1 cm. The 2/23/22 admission Braden scale for predicting pressure injuries revealed the resident was at a high risk for developing pressure sores. The assessment revealed the resident had no sensory perception impairment, her skin was constantly moist, she was bedfast, was completely immobile, had adequate nutrition, and had a problem for friction or shear which indicated she required moderate to maximum assistance in moving. The 3/12/22 wound report documented the pressure injury on the sacrum was a stage 2 with 15% slough. The wound tracker dated 3/23/22 report documented the coccyx pressure injury was unstageable and had worsened with 10% granulation, 30% slough and 60% eschar. The drainage was moderate seropurulent drainage. The wound tracker dated 3/29/22 report documented the coccyx pressure injury was unstageable with 40% granulation, 20% slough, and 40% eschar. The wound was noted as better from previous week. The 4/5/22 wound tracker documented the coccyx wound as unstageable with 30% granulation, 30% slough and 20% eschar with moderate serous drainage. The wound was noted to show improvement. The wound tracker dated 4/12/22 documented the coccyx wound as unstageable with 100% eschar. The wound was documented as worsened. The drainage was moderate and malodorous (smelling very unpleasant). The wound tracker dated 4/19/22 documented the coccyx wound had worsened and it was 50% granulation, 30% slough, and 20% eschar. The drainage was significant seropurulent and malodorous. On 4/20/22, Resident #12 was sent to the hospital for a possible infection due to the resident having a fever and a foul smelling sacral pressure injury. The 4/21/22 history and physical from the hospital showed the resident was admitted for a sacral decubitus ulcer. The note further documented the decubitus ulcer with necrotic tissue noted, malodorous. CT of the abdomen and pelvis showed the midline sacral decubitus ulcer is deepening with new posterior cortical erosion of the first coccygeal segment and displaced fracture of second coccygeal segment for which early osteomyelitis could not be excluded. Continue ceftriaxone and vancomycin. Irrigation and debridement of sacral pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #12 returned to the facility on [DATE] from the hospital. The resident returned with a wound vacuum. The wound was debrided. The 4/26/22 wound tracker documented that the stage 4 pressure ulcer injury was 100% granulation with moderate serous drainage. The wound was showing improvement. Continued with the wound vacuum. The 5/2/22 PCP progress note documented that the wound physician had concerns about the stage 4 pressure injury on the sacrum. It did not include the measurements of the wound. The wound had an odor. The physician had told the resident to turn every two hours, however, the resident said that staff did not offer it. The care plan, last updated on 4/25/22, revealed the resident had actual skin breakdown to the sacrum. Interventions included: -Pressure redistribution surface to bed as per guideline -Utilize positioning devices as appropriate to prevent pressure over bony prominences; and, -Provide wound treatment as ordered. -The care plan failed to address that the wound physician was following the resident, and that the resident was to be up in the wheelchair for only 30 minutes three times a day. E. Resident refusals of care Although the resident had a history of refusal of repositioning and wound care treatment, the resident's medical record failed to show that the resident was educated on the side effects of refusal of treatment until after the hospitalization of the worsening pressure injury. The progress notes were reviewed from 2/9/22 to 5/6/22 and failed to show the resident was encouraged and educated on the importance of relieving the pressure on her coccyx. The April 2022 and the May 2022 behavior log did not show that the resident had any behaviors and refusals. The care plan last updated on 5/17/22 identified the resident was resistive to care, specifically insisting on being in her mobile wheelchair for extended amounts of time and refused to be repositioned in her bed to decrease the amount of time on high pressure areas. Pertinent approaches were to explain care, and to continue to provide education to Resident #12 about the health risks of remaining on high pressure areas for extended amounts of time. F. Failure to ensure physician ordered treatment was completed The March 2022 treatment administration record (TAR) showed the resident was to have a dressing changed daily on the sacrum but it was not completed on 3/19/22 and 3/27/22. The April 2022 TAR showed the resident was to have a dressing change daily on the sacrum but it was not completed on 4/6/22, 4/7/22 and 4/20/22. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident's medical record failed to show any evidence of the reason for the missed dressing changes. G. Interviews CNA #5 was interviewed on 5/25/22 at 6:32 p.m. The CNA said the resident required a hoyer mechanical lift for all transfers. He said she was cooperative and did not refuse care. He said that she had a call light that she could request to lie down. He said that she would let him know when she was ready for bed, otherwise she stayed in her chair and watched television with her roommate. Licensed practical nurse (LPN) #1 was interviewed on 5/26/22 at 12:15 p.m. The LPN said Resident #12 had an unstageable pressure injury on her coccyx/sacrum which had worsened. He said she had returned recently from the hospital as she had an infection in the wound. She returned with a wound vacuum. He said that the wound physician followed the resident. He said the dressing was changed every 72 hours, however, he did not change the dressing. He said he assessed the dressing to ensure there were no leaks from the wound vacuum. He said the assistant director of nurses, the wound nurse or the wound physician was responsible to change the dressing every 72 hours or as needed. The LPN said the physician had placed an order that the resident was to only be up in the wheelchair for 30 minutes at a time. He said that in the beginning he would encourage the resident of the importance of lying down, however, she would refuse to lie down. He said that in the beginning he had kept encouraging the resident to lie down, however he had given up on consistently telling her the importance of lying down, as she always refused. He said that was why the wound worsened. He said that she was afraid of missing her smoking opportunities. The assistant director of nurses (ADON) was interviewed on 5/2/22 at 2:00 p.m. The ADON said she was familiar with the resident's sacral pressure injury. She confirmed the documentation referred to the sacral pressure injury as also the coccyx pressure ulcer. She said that the wound became large enough that it was over both the sacral and coccyx area. The ADON said the resident was admitted to the facility with a stage 2 pressure injury to the sacrum. She said that the resident was not followed by the wound physician for the stage 2. She said the nursing management were not aware the resident was non-compliant with turning and repositioning before the pressure injury worsened to unstageable. She said the resident was unable to move independently and required total assistance. She said the resident refused to lie down, as she did not want to miss her smoking breaks. She said the resident was to be repositioned in bed every two hours, and that she was to be up for only 30 minutes up to three times a day for smoking breaks. She said the resident needed to be offered and encouraged to lie down after 30 minutes. If the resident refused, then it should be documented and the resident should be provided education on the importance of relieving the pressure on her sacrum/coccyx. The ADON said the wound had shown improvement for the past two weeks. She reviewed the physician order and said the licensed charge nurse on the unit was responsible for changing the dressing. She said if the TAR had holes, then the treatment was not completed. The charge nurse was responsible to notify the nursing administration that the dressing was not changed, so a plan could be made. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The wound physician was interviewed on 5/26/22 at 2:15 p.m. The wound physician said he had been following the resident for the pressure injury since 4/2/22. He said the wound was unstageable because the depth of the pressure injury could not be seen. He said that the wound was debrided as 80% of the wound was necrotic and 20% slough. He said on 4/19/22 it started to smell and she went to the hospital. The hospital debrided it and it was now a stage 4. He said when she came back from the hospital the wound was debrided again. He said since the debridement of the sacral pressure injury and the wound vacuum, it was beginning to heal. He said that she did need to relieve the pressure by lying down. He was aware that she was not compliant, however the staff needed to provide education to the resident. LPN #1 was interviewed a second time on 5/26/22 at 2:57 p.m. LPN #1 confirmed he did not change the dressing on the resident's sacrum pressure injury. He said when he had signed off on the May 2022 treatment administration record (TAR) it was signing off that the wound physician or the ADON had changed the dressing. III. Failure to ensure treatments were administered as ordered by the physician A. Resident status Resident #6, age 73, was admitted on [DATE] and readmitted on [DATE]. According to the June 2022 CPO, the diagnoses included Parkinson's disease, stage four pressure injury, muscle weakness, difficulty walking and cognitive communication deficit. The 4/29/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing and toileting and extensive assistance of one person with personal hygiene. It indicated the resident had a stage 4 pressure injury. B. Record review The skin integrity care plan, initiated on 2/15/22 and revised on 4/25/22, documented the resident was at risk for skin breakdown due to poor mobilization. It indicated the resident had an actual skin breakdown of a stage 4 pressure injury to the sacrum. The interventions included turning and repositioning the resident every two hours, encouraging the resident to consume all fluids of choice during meals, observing the resident's skin condition with care, pressure redistribution to the bed and chair and providing wound treatments as ordered by the physician. The 5/24/22 wound physician progress notes documented that the resident had a stage 4 pressure injury with a status of not healed. The measurements were documented as 6 cm (centimeters) length x 6.5 cm width x 6.5 cm width x 1 cm depth. It indicated the wound had a moderate amount of serous drainage with a wound bed with 100% granulation. It indicated the wound was improving. The March 2022 treatment administration record (TAR) documented the following: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	To sacrum: cleanse with wound cleanser, pat dry with 4x4 gauze. Paint the periwound with betadine solution. Apply a nickel thick layer of santyl to the wound base. Apply bactroban to the wound base, lightly fill the wound to remove all dead space, including in undermining with calcium alginate. Cover with a foam dressing every day shift for wound care-ordered 2/28/22 and discontinued on 3/21/22. -According to the March 2022 TAR, there were blanks on the treatment record to indicate the wound treatment had not been provided as ordered by the physician from 3/1/22 to 3/7/22 and 3/18/22. To sacrum: cleanse with wound cleanser, pat dry with 4x4 gauze, paint periwound with betadine solution and allow to dry. Paint the macerated periwound skin with skin prep and allow to dry. Apply silver alginate to the wound base and fill all dead space including undermining and cover with a foam bandage every day shift for wound care-ordered 3/21/22 and discontinued on 4/25/22. -According to the March 2022 TAR, there were blanks on the treatment record to indicate the wound treatment had not been provided as ordered by the physician on 3/23/22, 3/24/22 and 3/28/22. The April 2022 TAR documented the following: To sacrum: cleanse with wound cleanser. Pat dry with 4 x 4 gauze. Paint periwound with betadine solution and allow to dry. Paint macerated periwound skin with skin prep and allow to dry. Apply silver alginate to the wound base and fill all dead space including undermining. Cover with foam bandage every day shift for wound care-ordered 3/21/22 and discontinued on 4/25/22. -According to the April 2022 TAR, there were blanks on the treatment record to indicate the wound treatment had not been provided as ordered by the physician on 4/5/22, 4/6/22, 4/8/22 and 4/11/22-4/25/22. The May 2022 TAR documented the following: To coccyx-Cleanse with skintegrity wound cleanser, pat dry with 4 x 4 gauze. Apply betadine 10% solution to periwound and allow to dry. Lightly fill wound space with silver alginate. Cover with dry dressing. May secure with tape every day shift for wound care-ordered 4/29/22 and discontinued 5/18/22. -According to the May 2022 TAR, there were blanks on the treatment record to indicate the wound treatment had not been provided as ordered by the physician on 5/8/22 and 5/12/22. C. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 6/1/22 at 1:25 p.m. She said all treatment orders should be administered according to the physician orders. She said when a treatment order was provided, the nurse should sign off on the TAR to indicate it was completed. She said if a resident refused the treatment, after attempting another time, the nurse should select the code that indicated refusal and sign off on the TAR. LPN #3 said Resident #6 had a stage 4 pressure injury to the coccyx/sacrum. She confirmed there were multiple blank spots on the TAR for Resident #6's treatment to the sacrum and coccyx. She said it appeared as though the treatments were not provided according to the physician orders. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 6/1/22 at 1:27 p.m. She said treatments should be administered according to physician orders. She said each treatment should be signed off on the TAR once the treatment had been administered. She said if a resident refused a treatment, there was a specific code the nurse should choose to indicate the refusal along with the nurse's initials. She said a blank on the TAR could mean missed documentation, omission or a missed treatment. 46022 IV. Failure to reposition timely A. Resident status Resident #2, age 77, was admitted on [DATE] and discharged on [DATE]. According to the May 2022 CPO, the diagnoses included dementia, type two diabetes mellitus (DM2) and a stage three pressure ulcer. The 3/24/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required extensive assistance of two people for bed mobility, transfers, dressing, toileting; extensive assistance of one person for personal hygiene and set-up assistance for eating. It documented he had one facility acquired stage 4 pressure wound. B. Observations During a continuous observation on 5/25/22 beginning at 11:00 a.m. and ending at 3:45 p.m., Resident #2 was lying in bed in a supine position. -At 11:16 a.m. an unidentified CNA placed an isolation cart and signs on Resident #2's door. The CNA said the resident had tested positive for COVID-19 and shut the resident's door. -At 11:22 a.m. two unidentified CNAs entered Resident #2's room and provided incontinence care. Upon exiting the room Resident #2 remained in a supine position. -At 1:01 p.m. CNA #3 delivered Resident #2's lunch tray. Upon exiting the room Resident #2 was observed lying in a supine position. CNA #3 did not reposition the resident. -At 3:45 p.m. staff had not entered the resident's room since 1:01 p.m. On 5/25/22 at 5:15 p.m., Resident #2 was sent to the hospital due to a change of condition, therefore no further observations were able to be conducted during the survey process. C. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The skin care plan, initiated on 3/29/22 and revised on 4/18/22, revealed the resident had a history of redness and moisture associated skin damage to the buttocks, multiple abrasions to his toes, an unstageable pressure wound to his left foot, and a fungus infection to his nails. He was at risk for skin breakdown related to weakness, decreased mobility, dementia, and incontinence. The interventions revealed, in pertinent part, to provide wound treatment as ordered, to off load/float heels while in bed, and complete weekly wound assessments. The 5/24/22 wound physician note documented that the resident had a stage 4 pressure injury to the left distal foot that measured 1 cm length x 1 cm width x.3 cm depth. The current treatment was to cleanse with wound cleanser and paint betadine once a day and as needed. The May 2022 CPO revealed the following physician orders for wound treatments: Wound left distal foot and toe without nail - paint peri wound and wound base with betadine 10% solution. Leave open to air. Okay to wear sock-ordered on 5/4/22; and, Encourage (to get) out of bed once a day every shift-ordered on 8/21/21. -A review of the May 2022 TAR revealed the resident did not receive two (5/7/22 and 5/18/22) out of 22 treatments. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 6/1/22 at 1:15 p.m. She said Resident #2 had a physician's order to encourage the resident to get out of bed for meals. She said Resident #2 frequently refused to get out of bed, but the staff should encourage him to reposition every few hours. She said Resident #2 did not typically refuse to be repositioned when offered. The director of nursing (DON) was interviewed on 6/1/22 at 1:28 p.m. She said Resident #2 should have been offered or encouraged to be repositioned every two hours.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46370 Based on observation, record review, and interviews, the facility failed to ensure residents were as free from accident hazards as possible for three (#12, #14, and #4) of four out of 24 sample residents. Specifically, the facility failed to ensure safe smoking evaluations were completed timely for Residents #12, #14 and #4. Findings include: I Facility policy The Smoking policy for Residents, not dated, was received on 5/25/22 at 5:53 p.m., from the social service director (SSD) and read in pertinent part, supervised smoking is defined as the observer must be in the direct area of the smoker, within eye contact, and able to respond to emergency situations. A patient's smoking status will be documented in the care plan. Center leadership will consider special circumstances on an individual basis for example the need for smoking apron and/or flame retardant clothing). II. Resident #12 A. Resident status Resident #12, age less than [AGE] years old, was admitted on [DATE]. According to the May 2022 computerized physician orders (CPO) diagnoses included, functional quadriplegia (paralysis from neck down), unspecified severe protein calorie malnutrition and pneumonia. The 4/8/22 minimum data set (MDS) assessment showed the resident had minimal cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident required total assistance with activities of daily living. The resident had impairment in both upper extremities. B. Observations On 5/25/22 at 10:37 a.m., the resident was in the supervised smoking area. The resident did not have a smoking apron on. The resident held the cigarette between her lips. The resident was unable to use her hands to manipulate the cigarette. On 5/25/22 at 1:45 p.m., the resident was in the smoking area. Certified nurse aide (CNA) #1 lit her cigarette. The resident did not have a smoke apron on. The resident smoked the cigarette. The CNA used his thumb and index finger to remove the ash and throw it on the ground, since the resident was unable to use her hands. C. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/6/22 smoking evaluation documented the resident was unable to light the cigarette, she was unable to hold the cigarette, she was unable to dispose of the ash safely and she was not allowed to smoke without a smoke apron. The care plan last updated on 4/7/22 identified the resident was able to smoke cigarettes with supervision. -The care plan failed to show the resident required a smoke apron. III. Resident #14 A. Resident status Resident #14, age [AGE] years old, was admitted on [DATE]. According to the May 2022 computerized physician orders (CPO) diagnoses included, weakness, unspecified dementia without behavioral disturbance, schizophrenia, muscle weakness, unspecified lack of coordination and reduced mobility. The 5/5/22 minimum data set (MDS) assessment showed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. No mood or behavior symptoms or rejection of care was noted. He required extensive assistance for bed mobility, grooming and toilet use. The resident had impairments on both upper and lower extremities. B. Observations On 5/25/22 at 1:45 p.m., the resident was in the smoking area. CNA #1 lit his cigarette. The resident did not have a smoke apron on. The resident smoked the cigarette. The CNA used his thumb and index finger to remove the ash and throw it on the ground, since the resident was unable to use his hands. C. Record review The 5/322 smoking evaluation documented the resident was unable to light the cigarette, he was unable to hold the cigarette, he was unable to dispose of the ash safely and he was not allowed to smoke without a smoke apron. The resident required supervised smoking. The care plan last updated on 5/5/22 identified the resident was able to smoke cigarettes with supervision. -The care plan failed to show the resident required a smoke apron. IV. Resident #4 A. Resident status Resident #4, age under [AGE] years old, was admitted on [DATE] and readmitted on [DATE]. According to the May 3022 computerized physician orders (CPO), diagnoses included quadriplegia, local infection of the skin and subcutaneous tissue, unspecified dependence on wheelchair; osteomyelitis (bone infection), and type 2 diabetes mellitus with diabetic polyneuropathy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the 5/12/22 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. No mood or behavior symptoms or rejection of care was noted. He required extensive assistance for bed mobility, grooming and toilet use. He utilized a Foley catheter, and was always incontinent of bowel. B. Observations On 5/24/22 at 10:38 a.m. to 10:54 a.m. an unidentified resident was helping Resident #4 smoke. Resident #4 would hold the cigarette in his mouth and would puff on it. The unidentified resident took the cigarette out of Resident #4's mouth and flicked the ash then placed it back in his mouth. Staff sat in a chair on the side and would periodically come over and check on Resident #4. The staff took the cigarette out of his mouth twice to flick the ash and put it back in mouth. An unidentified CNA washed her and Resident #4's hands when finished. The resident did not have a smoking apron on. On 5/25/22 at 10:44 a.m., the resident was brought out to the smoking patio by unidentified staff. The resident was not wearing a smoking apron. The staff monitored the resident's smoking by taking the cigarette out of the resident's mouth and flicking ash as needed. On 5/25/22 at 1:45 p.m., the resident was assisted with lighting a cigarette. The resident did not have a smoking apron on. C. Record review The 3/8/22 smoking evaluation documented the resident was unable to light the cigarette, he was unable to hold the cigarette, he was unable to dispose of the ash safely and he was not allowed to smoke without a smoking apron. The resident required supervised smoking and the resident was unable to safely smoke without assistance. The care plan last updated on 5/12/22 identified the resident was able to smoke cigarettes with supervision. -The care plan showed the resident required a smoking apron. V. Staff interviews CNA #1 was interviewed on 5/25/22 at 2:00 p.m. He said that he was the CNA assigned to supervise the residents. He said that he was responsible to light the cigarettes and to ensure that the residents were safe when smoking. He said that smoking aprons were only used if they were on the resident's care plan. He said was not aware if Resident #12, #14 and #4 were to wear the aprons when smoking. The social service director (SSD) was interviewed on 5/25/22 at 5:53 p.m. The SSD said each resident was assessed for their smoking abilities. She said that when a resident required supervision, the cigarettes were kept at the nurses station. She said aprons were available and to be used when the resident was not safe while smoking. The SSD reviewed the resident care plans and confirmed the care plans needed to be individualized and include the smoking aprons.

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Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure two (#11 and #2) of four out of 24 sample residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being. Resident #11 was admitted to the facility for long term care on 9/24/22 with diagnosis of a traumatic brain injury, aphasia (loss and ability to understand speech), gastroparesis (delayed gastric emptying), depression, mild protein-calorie malnutrition, cognitive communication deficit and post-traumatic stress disorder. Following a hospital stay due to sepsis from 4/21/22 to 5/19/22, the resident was readmitted to the facility with a physician order that he was unable to consume anything by mouth (NPO) and was to receive all nutrition, fluid, and medications via a percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube in the stomach). Upon the resident's readmission to the facility on [DATE], the facility failed to obtain a readmission weight and an annual height to estimate the resident's normal body weight as part of the nutritional monitoring for the resident. The facility failed to accurately calculate Resident #11's bolus enteral feeding (means of providing nutritional formula directly through g-tute) which led to the facility providing 560 calories less per day than the recommended amount based on the resident's estimated nutritional needs. Due to the facility's failure to adequately monitor the resident's nutritional status and to ensure Resident #11's nutrition and hydration needs were met, the resident sustained a significant weight loss of 19.7 pounds (lbs.) in 11 days, which was 9.8%. Additionally, the facility failed to adequately monitor Resident #2's nutritional status by ensuring weight discrepancies were clarified and nutritional interventions were put into place and re-evaluated to prevent a significant weight loss. Based on observations, during the survey process, the facility failed to ensure Resident #2 received the nutritional interventions put in place by the registered dietitian (RD), such as double portions and set up assistance with his meals. The facility failed to re-weigh the resident as requested by the RD timely (from 5/13/22 to 5/25/22 when the resident was sent to the hospital for a change of condition) to determine if the resident had sustained actual weight loss and determine if additional interventions should be put into place. Findings include: I. Facility policy and procedure The Weight policy and procedure was provided by the RD on 6/1/22 at 11:15 a.m. It revealed, in pertinent part, Residents are weighed upon admission, weekly x4 weeks, then monthly unless their treatment plans dictate differently. Weights are obtained on all residents by the 7th of the month. This facilitates the weight monitoring process by the dietician. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Any resident with a 3-pound change +/- (weight gain or weight loss) will have a re-weight to verify weight change. Unit manager/designee brings the names and records of residents with weight loss to the interdisciplinary team meeting weekly. Weekly weights will be implemented on residents experiencing weight changes of three or more pounds in a week. These residents will remain on weekly weights until the weight is stabilized. The Enteral Management policy and procedure was provided by the RD on 6/1/22 at 11:28 a.m. It revealed, in pertinent part, Gastrostomy tube (G-tube): A tube that is placed directly into the stomach through an abdominal wall incision for administration of foods, fluids, and medications. The most common type is a percutaneous endoscopic gastrostomy (PEG) tube. An assessment of the patient;s nutritional status which may include usual food and fluid intake, pertinent laboratory values, appetite, and usual weight and weight changes. The Fluid Balance policy and procedure was provided by the RD on 6/1/22 at 11:28 p.m. It revealed, in pertinent part, The Center will provide the patients/residents (hereafter 'patient') with sufficient amounts of fluids based on individual needs. Patient's hydration status will be determined through routine nursing evaluation. II. Resident #11 A. Resident status Resident #11, younger than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2022 computerized physician orders (CPO), the diagnoses included traumatic brain injury, contracture of the left hand, aphasia (loss of the ability to understand or express speech), depression, gastroparesis (delayed gastric emptying), mild protein-calorie malnutrition, dysphagia, cognitive communication deficit, and post-traumatic stress disorder. The 2/15/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of 11 out of 15. He required limited assistance of two people for bed mobility, personal hygiene and extensive assistance of two people for transfers, dressing, and toileting. It documented the resident had a diagnosis of malnutrition or was at risk for malnutrition and did not have any recent significant weight changes. According to the 5/19/22 nutrition progress note the resident was readmitted to the facility with a diagnosis of severe sepsis. It indicated the resident would remain NPO and had a PEG tube placed for enteral feedings. B. Observations (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 5/26/22 at 10:40 a.m.licensed practical nurse (LPN) #2 entered Resident #11's room with one carton (237ml) of Jevity 1.5 (enteral nutrition formula) and the supplies to provide Resident #11 with an enteral bolus feeding. LPN #2 asked the resident if he was hungry. Resident #11 responded yes. LPN #1 said Resident #11 always reported he was hungry when she administered his enteral feedings. LPN #1 checked the residual of the PEG tube and then administered 30 ml (milliliters) of water through the PEG tube. She began pouring the enteral formula through the PEG tube until all 237 ml were administered. She then flushed the tube with 30ml of water. -However, the physician's order read to provide 255 ml Jevity 1.5 four times a day (see orders below). On 6/1/22 at 9:56 a.m. LPN #4 and certified nurse aide (CNA) #1 weighed Resident #11 with a mechanical lift. The resident's weight read 182.3 lbs and was confirmed by LPN #4 and CNA #1. -While LPN #4 and CNA #1 were positioning Resident #11 to be weighed in the mechanical lift, the resident requested water four times. Resident #11 said he was very thirsty. LPN #4 did not address the resident was thirsty by communicating to the physician for additional water flush or mouth swabs for comfort. Resident #11 was observed with white build up in the cracks of his lips, on his tongue and corner of his mouth. C. Record review 1. Hospital admission from 4/21/22 to 5/19/22 A review of the hospital medical record on 5/31/22 at 9:00 a.m. documented: Resident #11 was admitted to the hospital on 4/21/22 with severe sepsis. The resident required intubation (a process where a healthcare provider inserts a tube through a person's mouth or nose, then down into their airway). Resident #11 was extubated on 5/7/22, which was 17 days after he was admitted to the hospital. On 5/17/22 a PEG tube was placed to begin enteral feedings as the resident was unable to swallow safely. The physician ordered for the resident not to consume anything by mouth (NPO). The physician attempted to place a feeding tube through the resident's nose several times throughout the resident's hospital stay, however the resident continued to pull the tube out. The hospital RD recommended the resident receive Pivot 1.5 formula at 55 ml per hour to meet his estimated nutritional needs. On 5/19/22, the hospital RD documented that the resident weighed 202 lbs (91.8 kilograms). She estimated the resident needed 1836 to 2295 calories or 25 to 30 calories per kilogram (kg) and one ml of fluid per calorie or per physician order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident #11 was readmitted to the facility on [DATE] with the following nutritional recommendations: Pivot 1. 5 at 15 ml per hour for 24 hours., then increase 10 ml per hour every eight hours until the goal rate of 55 ml per hour is reached with 30 ml water flushes every four hours. Add a multivitamin with minerals once per day. On 5/24/22 Resident #11 was sent to the emergency department and returned the same day as his PEG tube was leaking. The hospital was unable to replace the PEG tube as it had not had time to heal since it had been placed. The hospital physician ordered the tube to be wrapped with tape to prevent leaking until it could be replaced in a couple weeks. 2. Nutritional care plans The nutritional care plan, initiated on 5/20/22 and revised on 5/24/22, revealed the resident was at nutritional risk related to NPO status and the resident was to receive 100% of his nutrition needs via his PEG tube. It documented the resident was receiving 255 ml Jevity 1.5 from bolus feeds four times per day until the correct tubing was delivered to the facility. Upon arrival of the tubing the resident would be placed on a continuous enteral feeding via PEG tube of Jevity 1.5 at 55 ml/ hour. The interventions included monitoring the resident's adherence to the NPO diet, monitoring of the resident's electrolytes, monitoring the resident's tolerance of current tube feed orders, providing a multivitamin via the PEG tube as ordered by the physician, and weighing the resident as ordered by the physician. The enteral nutrition care plan, initiated on 5/25/22, revealed the resident had an enteral feeding tube to meet his nutritional needs related to dysphagia (swallowing difficulty). The interventions included providing aspiration precautions, checking the placement of the tube daily prior to providing feedings, monitoring labs as ordered by the physician, and monitoring the resident's skin around the enteral tube. 3. Resident #11's weights Resident #11's weights were documented in the resident's medical record as follows: -On 4/12/22, the resident weighed 197.8 lbs. obtained with a chair scale at the facility. -On 4/21/22, the resident weighed 217 lbs. The resident's weight was obtained at the hospital. -On 5/10/22, the resident weighed 208 lbs. The resident's weight was obtained at the hospital. -On 5/19/22, the hospital RD documented that the resident's weight was 202 lbs. It did not indicate the date in which the weight was obtained. -On 6/1/22, during the survey process, the resident weighed 182.3 lbs obtained with a mechanical lift. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The resident had a 7.8% (15.5 lbs) weight loss, which was considered significant, from 4/12/22 to 6/1/22 in two months. The resident had a 9.8% (19.7 lbs) in 11 days from 5/19/22 to 6/1/22. -The facility failed to obtain an admission weight when the resident was readmitted from the hospital on 5/19/22, his weight was not obtained until 6/1/22 (during the survey), which was 14 days later. The resident was not consistently weighed, nor reweighed for concerns/monitoring when the resident returned from the hospital as indicated by nurse practitioner interview (see below). 4. Nutritional assessments/progress notes The 5/19/22 nutrition progress note documented Resident #11 was readmitted to the facility with a diagnosis of severe sepsis. It indicated the resident would remain NPO and had a PEG tube placed for enteral feedings. The continuous tube feeding hospital physician's order indicated the resident should receive Pivot 1.5 at a rate of 55 ml per hour for 24 hours per day. The hospital RD was agreeable to change the formula from Pivot 1.5 to Jevity 1.5, however the rate should remain at 55 ml per hour for 24 hours with the addition of Proheal three times per day to ensure the resident received adequate protein. It documented the resident was at risk for refeeding syndrome (a potentially fatal syndrome that is caused by a fluid and electrolyte shift that can occur in individuals with limited to no nutrition consumed over several days) as he had not received nutrition for 11 days while he was admitted to the hospital, which required the resident's electrolytes being monitored closely. It indicated the resident's estimated nutritional needs were based on the hospital obtained weight of 202 lbs or 91.8 kg. The residents estimated daily calorie needs were documented as 1836 to 2295 calories (20-25 calories per kg), 92 to 138 grams of protein (1-1.5 grams per kg), and 1836 to 2295 ml fluid per day (1 ml fluid per calorie per day). The recommended tube feed order was Jevity 1.5 at a rate of 55 ml per hour for 24 hours with 30 ml Proheal three times per day and 60-90 ml water flush every four hours. This order provided 2277 calories and 128 grams protein, which meets 100% of the resident's esteemed nutrition needs. It documented the kangaroo pump (used to administer enteral feedings continuously) was not functioning properly upon the residents' readmission to the facility.The facility was unable to obtain a new pump until the following day. A temporary tube feeding order was put into place until the new pump arrived, which read Pivot 1.5 60 ml bolus (a dose of formula given all at once) every four hours with 15 ml water flushes before and after each bolus. Upon arrival of the new pump, the original order of Jevity 1.5 at 55ml per hour for 24 hours with 30ml water flushes every four hours would apply. The 5/24/22 nursing progress note documented the registered nurse (RN) notified the resident's physician that there was not an order in place for the resident to receive continuous enteral nutrition. The on-call physician was notified the facility did not have Jevity 1.5, but did have Jevity 1.2. The on-call physician requested the day provider to address the issue, since there was a change in calories when switching formulas. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 5/24/22 nutritional assessment documented the resident was susceptible to weight loss after being NPO for 11 days and a weight had still not been obtained since the resident's readmission to the facility. The recommended tube feed order was Jevity 1.5 at 55 ml per hour for 24 hours a day with 30 ml Proheal three times per day and 30 ml water flushes every four hours. This provided 2280 calories per day, 84 grams protein per day, and 1320 total volume of formula plus 180 ml of fluid from flushes for a total volume of 1500 ml per day. -However, Jevity 1.5 only contains 76% free water to be included towards total fluid needs per day. The resident was receiving 1003 ml free water from the formula. The 5/24/22 nutritional assessment continued to document the temporary order of 255 ml Jevity 1.5 bolus four times a day with 30 ml water flushes every four hours was put into place as the facility did not have the correct tubing. The estimated nutrition needs were based on the RD assessment from the hospital, which documented the resident needed 1836 to 2295 calories per day, 92 to138 grams protein per day, and 1836 ml fluid per day (one ml per calorie per day). The 5/24/22 nutritional assessment continued to document the continuous enteral feed order of Jevity 1.5 at 55 ml per hour or the 255 ml Jevity 1.5 bolus four times per day in conjunction with 30 ml proheal three times a day met 100% of the resident's estimated calorie/protein needs. -However, the RD note completed on 5/24/22 (see below) documented the bolus feedings only met 94% of the resident caloric needs. The bolus feedings provided 560 calories less than the continuous feedings. In addition, the resident was at risk for refeeding syndrome and was supposed to have his formula administered slowly until he met the goal rate, however he was changed to 255 ml bolus, which he was provided with all 255 ml at one time instead of slow infusion until he met his goal rate. The 5/24/22 nutritional assessment continued to document the RD recommended to increase the water flushes from 30 ml every four hours to 60 ml every four hours and monitor the resident's tolerance to promote adequate hydration status. The interventions included providing enteral nutrition as ordered, increasing water flushes to 60 ml every four hours to promote adequate hydration status, providing 30 ml Proheal three times per day, providing a multivitamin daily as ordered, monitoring weights as ordered, monitoring the resident's tolerance of tube feedings, monitoring the resident's electrolytes for refeeding syndrome, and monitoring the resident's hydration status. The 5/24/22 nutritional assessment continued to document the nutrition plan of care goals included maintaining the resident's current body weight, maintaining the resident's hydration status, and ensuring the resident did not exhibit signs or symptoms of dehydration. The 5/24/22 nutrition progress note documented the kangaroo pump was delivered to the facility, but the facility did not have the correct tubing for the pump. The physician ordered the resident to receive 255 ml of Jevity 1.5 four times per day, 30 ml water flush before and after the feedings and continue the scheduled proheal three times a day. This new order provided 1720 calories, 105 grams protein, 1140 ml fluids. The RD recommended increasing the water flushes to 60 ml every four hours, which met 94% of the residents estimated calorie needs and 100% of his estimated protein needs. The RD indicated she would reevaluate once the continuous feed was initiated. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 5/24/22 nutrition progress note documented the resident was transported to the hospital due to a leak in the resident's PEG tube. The RD indicated she would reassess the resident upon readmission to the facility. The 5/25/22 nutrition progress note documented the PEG tube leak was repaired in the hospital and the resident would continue to receive 255 ml of Jevity 1.5 four times per day as ordered by the physician until the Kangaroo pump tubing was delivered to the facility. -The facility did not provide the Kangroo pump and tubing from when the resident readmitted from the hospital on 5/19/22 with a new PEG tube until at least being identified during the survey on 6/1/22 (see nutrition note below), which was 13 days. The 6/1/22 nutrition progress note (during the survey) documented Resident #11 had triggered for a significant weight loss of 7.8% in 90 days. With the residents recent weight loss, the resident's estimated nutrition needs were recalculated and the RD recommended a new enteral feeding regimen. The nursing staff had reported to the RD that the resident was tolerating the continuous tube feeding well at the rate of 55 ml per hour for 24 hours with 30 ml warm water flushes every four hours. The resident and nursing staff reported no gastrointestinal distress, but indicated the resident had dry mouth, in which fluid flushes were recommended to be increased to support adequate hydration status for the resident. It indicated the resident's estimated nutrition needs based on a weight of 182.3 (83 kg), 2485 to 2900 calories per day (30 to 35 calories per kg of current body weight to promote weight maintenance and weight restoration with recent weight loss), 83 to 124 grams protein per day (1-1.5 grams protein per kg), and 2075 to 2490 ml fluid per day (25 to 30 ml fluid per kg). The new tube feed recommendation of Jevity 1.5 at 65 ml per hour for 24 hours with warm water flushes of 120 ml every three hours in conjunction with 30 ml proheal two times per day provided the resident with 2540 calories per day, 130 grams protein per day, and 2147 ml fluid per day. This recommendation met 100% of the resident's estimated nutrition, protein, and fluid needs. The RD recommended the resident to be weighed weekly. D. Staff interviews The RD was interviewed on 6/1/22 at 10:22 a.m. She said the nursing staff were responsible to obtain admission and readmission weights immediately when the resident arrived at the facility. She said residents were weighed upon admission and then weekly for four weeks. She said if the resident's weight remained stable, the resident was placed on monthly weights. She said if a resident had weight changes, the resident would be weighed weekly until the resident's weight was stable. The RD said the nursing staff were responsible for obtaining heights upon admission and annually. She said this contributed to the nutritional monitoring for residents. The RD said she was responsible for requesting re-weighs when she anticipated an inaccurate weight. She said she notified the restorative nursing aides to obtain a new weight. She said re-weighs should be conducted within 24 hours of the recommendation unless it was requested over the weekend She said she typically used the Mifflin St. Jeor formula to calculate estimated nutrition needs when completing nutritional assessments. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD said Resident #11 was in the hospital for several weeks with severe sepsis. She said he did not get nutrition for 11 days while in the hospital and was at risk for refeeding syndrome. She said since the facility had not obtained a readmission weight when he returned to the facility. She said she used the hospital weight that was obtained the day he was readmitted to the facility, which was 202 lbs (91.8 kg). She said Resident #11 needed 20 to 25 calories per kg body weight, which the original tube feed recommendation met with 2280 calories per day or 24.8 calories per kg. She said the facility was unable to get the correct tubing for the kangaroo pump and the physician ordered the resident to have bolus feedings until the correct tubing was received. She said the new order was 255 ml Jevity 1.5 four times per day through the bolus feeding with 30 ml of Proheal three times per day. She said this provided 1830 calories or 19.9 calories per kg. -However, 19.9 calories per kg of weight was under the recommendation of 20 to 25 calories for kg that was initially recommended by the facility RD. In addition, the resident was at risk for refeeding syndrome and was supposed to have his formula administered slowly until he met the goal rate, however he was changed to 255 ml bolus, which he was provided with all 255 ml at one time for four times a day. She confirmed since the nursing staff was observed providing on 237 ml Jevity 1.5 four times a day with 30 ml proheal three times a day, this provided 1830 calories or 18.76 calories per kg, which was only 94% of the residents estimated nutritional needs. She said since the resident was not meeting his estimated nutrition needs he could have lost weight. The RD said when the physician changed the enteral feeding orders, she should have made a recommendation to increase the feedings as it could have led to weight loss and muscle wasting. The RD said she used the hospital RD's recommendation for fluid needs, which was 15 ml fluid per kg. -However, per the hospital records the hospital RD recommended one ml fluid per one calorie or 1836 ml to 2295 ml fluid per day. He was receiving 900 ml fluid per day, which was a deficit of 936 ml of fluid per day. She confirmed she recommended increasing the resident's water flushes to 60 ml every four hours on 5/24/22 and it had still not been implemented. She said she would email the nursing management to update the orders in the electronic medical record when she had recommendations for enteral feedings. She confirmed, based on Resident #11 receiving 237 ml Jevity 1.5 four times a day and 30 ml water flushes every six hours, the resident was receiving 900 ml of fluid per day, which was significantly lower than the residents estimated fluid needs. She said reporting thirst or white build-up in the cracks of the lips and mouth were signs of dehydration. She said since the resident was not meeting his estimated fluid needs the resident could become dehydrated. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	She said with the weight obtained on 6/1/22, of 182.3 lbs, Resident #11 was considered to have sustained a significant weight loss. She said the decrease of calories could have contributed to the resident's significant weight loss. The nurse practitioner (NP) was interviewed on 6/1/22 at 1:00 p.m. She said the facility should have obtained a readmission weight for Resident #11 upon his return to the facility. She said the resident's weight was used to monitor if the resident was meeting their estimated nutritional needs. She said she had ordered the facility to obtain a weight, but it had not been completed. She said the weight that was obtained on 6/1/22 by the facility of 182.3 lbs revealed a significant weight loss. She said she relied on the RD to accurately calculate and ensure the estimated nutritional needs were met for all residents on enteral feeding. The director of nursing (DON) was interviewed on 6/1/22 at 1:28 p.m. She said admission and readmission weights should be completed as soon as the resident arrived at the facility. She said the RD should have requested a new weight when she completed a readmission assessment for Resident #11. She said a calorie deficit greater than 500 calories per day was concerning and could lead to weight loss. III. Resident #2 A. Resident status Resident #2, age 77, was admitted on [DATE] and discharged on [DATE] (during the survey) to the hospital. According to the May 2022 CPO, the diagnoses included dementia, type two diabetes mellitus (DM2), pressure ulcer stage 3, depression, gastro-esophageal reflux disease, protein-calorie malnutrition, anemia, and dysphagia. The 3/24/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. He required extensive assistance of two people for bed mobility, transfers, dressing and toileting. He required extensive assistance of one person for personal hygiene and set-up assistance for eating. It documented the resident had not had a significant weight loss during the assessment period and had a diagnosis of malnutrition. B. Observations During a continuous observation on 5/25/22 beginning at 11:01 a.m. and ended at 3:50 p.m. the following was observed: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	At 11:22 a.m. two unidentified certified nurse aides (CNA) entered Resident #2's room after donning personal protective equipment (PPE) as Resident #2 was on isolation precautions related to a recent positive COVID-19 test. At 11:32 a.m. the two unidentified CNAs exited Resident #2's room with a soiled brief. They closed the door to the resident's room upon exiting. At 1:01 p.m. CNA #3 entered Resident #2's room dressed in PPE with the resident's lunch tray. He exited the room at 1:02 p.m. and closed the resident's door. A 3:45 p.m. facility staff had still not entered the resident's room since delivering his lunch tray. The lunch tray remained covered and untouched. -The resident was not provided any encouragement or eating assistance. He did not receive double portions as indicated on his meal tickets and care plan. C. Record review The nutritional care plan, initiated on 9/22/2020 and revised on 3/23/22, documented the resident was at nutritional risk related to diagnosis of clostridium difficile (C. Diff), hypertension, dementia, depression, diabetes mellitus type two (DM2), gout, and absence of a digestive tract. It indicated the resident had increased energy needs related to an unstageable pressure wound to the left foot. The interventions included encouraging fluids, providing proheal protein supplement, honoring food preferences, providing double portions, weighing the resident, monitoring changes in nutritional statues (changes in intake, ability to feed self, unplanned weight loss/gain, abnormal labs) and reporting to the dietitian, offering alternative food choices if less than 50% of a meal was consumed, and monitoring the resident's intake at all meals. Resident #2's weights from November 2021 to May 2022 were documented as follows: -On 11/2/21, the resident weighed 181 lbs. -On 12/5/21, the resident weighed 183.7 lbs. -On 1/8/22, the resident weighed 185.6 lbs. -On 2/8/22, the resident weighed 184.1 lbs. -On 3/9/22, the resident weighed 181.4 lbs. -On 4/4/22, the resident weighed 177.2 lbs. -On 5/11/22, the resident weighed 167.9 lbs. -The resident had a 5.2% weight loss (20.7 lbs), which was considered significant from 4/4/22 to 5/11/22, and a 8.8% weight loss (21.4 lbs), which was considered significant from 2/8/22 to 5/11/22. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 3/23/22 nutritional assessment documented the resident was on a consistent carbohydrate diet with large portions. He received 30 ml Proheal three times a day to promote wound healing related to a diagnosis of malnutrition. It documented the resident's current weight of 181.4 lbs had been stable within his usual weight range of 180 lbs. for six months. It indicated the resident averaged a meal intake of 86% over that past week, which was consistent from previous assessments. The resident reported he was happy with the food and had no additional preferences. The interventions included providing a diet as ordered by the physician, providing double portions, and providing 30 ml Proheal three times per day to promote skin healing. The care plan goals included maintaining the resident's current weight and skin integrity improvement. The 5/13/22 nutrition note documented the resident had sustained a weight loss and the RD requested a re-weigh. The 5/17/22 nutrition note documented the resident had triggered for a significant weight loss of 5.2% in 30 days and 8.8% in 90 days. A re-weigh was requested by the RD. The resident reported he had noticed gradual weight loss despite good meal intakes. The RD obtained new dietary preferences from the resident and updated them in the meal system. The resident agreed to add a frozen nutrition treat twice per day with lunch and dinner. In addition, the RD recommended weekly weights and noted the resident may benefit from liberalizing a consistent carbohydrate diet to a regular diet to increase the resident's caloric intake. -According to the resident's medical record, the facility had not obtained a re-weigh as requested by the RD. Thirteen days after the reweigh was requested by the RD, the resident was sent to the hospital on 5/25/22 for a change of condition as he became unresponsive. The 5/24/22 nutrition progress note documented the resident requested to have the frozen nutrition treated with lunch and dinner discontinued and to trial a different supplement. The resident agreed to trial fortified pudding with lunch and dinner. The resident's weekly weight had still not been obtained. D. Staff interviews The RD was interviewed on 6/1/22 at 10:22 a.m. She said she requested Resident #2 be reweighed on 5/17/22 and had not received the re-weigh as of 5/25/22 when the resident was sent to the hospital. She said the facility staff should obtain the re-weigh sooner than 13 days after it was requested. She said when Resident #2 triggered for significant weight loss, she visited with the resident and he was only agreable to having supplements added at lunch and dinner. The RD said since the resident was on double portions, he should have been served a double entree, a starch, and a vegetable at meals. The RD said the CNAs were responsible for documenting the amount each resident consumed in the electronic medical record (EMR). She said there were several meals that did not have the amount consumed documented. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The RD said Resident #2 had a significant weight loss, which could have potentially been prevented if an intervention was put into place earlier. The DON was interviewed on 6/1/22 at 1:28 p.m. She said the staff should have obtained Resident #2's re-weigh within 24 hours of the RD making the request.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on record review, observations and interviews, the facility failed to ensure one (#1) of three residents were free of significant medication errors out of 24 sample residents. Specifically, the facility failed to ensure Resident #1 was not administered another resident's medications which caused a decline in his medical condition which required hospitalization . The facility further failed to ensure interventions identified as part of the performance improvement plan were put into place to prevent any additional significant medication errors. Resident #1 received 300 milligrams (mg) Metoprolol (a medication for blood pressure), 10 milliequivalents (meq) potassium (mineral supplement) and 12.5 mg Clozaril (a medication used for schizophrenia) that were not prescribed to him on 2/5/22. He experienced a significant change of condition, became unresponsive and was sent to the emergency room . Upon discovering the significant medication error, the facility implemented a quality assurance performance improvement (QAPI) plan to prevent further medication errors within the facility. However, during the survey process, it was determined the facility failed to ensure the interventions identified in the QAPI were implemented to prevent further significant medication errors. Findings include: I. Professional reference According to Fundamentals of Nursing, by [NAME], [NAME], Stockert, Hall & [NAME], 9th Edition (copyright 2017), page 624-627. A medication error can cause or lead to inappropriate medication use or patient harm. Medication errors include inaccurate prescribing, administering the wrong medication, giving the medication using the wrong route or time interval, administering extra doses, and/or failing to administer a medication. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	6. The right documentation Medication errors often occur because a patient gets a drug intended for another patient. Therefore an important step in safe medication administration is being sure that you give the right medication to the right patient. It is difficult to remember every patient's name and face. Before administering a medication, use at least two patient identifiers. II. Resident #1 A. Resident status Resident #1, age 83, was admitted on [DATE]. According to the January 2022 computerized physician orders (CPO), the diagnoses included muscle weakness, hyponatremia (lower than normal level of sodium in the blood stream), cerebral edema (swelling of the brain), gastro-esophageal reflux disease (GERD), injury of the head, and presence of a cardiac defibrillator. The 1/24/22 nursing progress note documented the resident had mild cognitive impairment and he required staff assistance with all activities of daily living (ADLs). B. Record review The 2/5/22 nursing progress note documented at 8:25 a.m. registered nurse (RN) #1 entered the resident's room to notify him of a medication error. Upon entering the room RN #1 noticed the resident was drooling and his feet were hanging over the side of the bed. RN #1 attempted to wake the resident, but the resident was not responding to questions. RN #1 repositioned the resident in the bed. -At 8:55 a.m. RN #1 called poison control. A list of the medications the resident received were provided to poison control from the RN. Poison control recommended the resident be sent to the hospital. The 2/5/22 situation, background, appearance, review, and notification (SBAR) form documented the resident had a change of condition related to a medication error. He had an altered level of consciousness by being drowsy and difficult to arouse. The resident's functional status remained stable, however the resident had respiratory changes. The physician was notified of the change of condition. The 2/5/22 hospital transfer form documented the resident's blood pressure was 96/54, a heart rate of 77, respiration rate of 17, temperature of 98.9, and oxygen saturation of 92%. It indicated the resident's representative was notified of the resident's transfer to the hospital. The investigation report following the significant medication error on 2/5/22 was provided by the director of nursing (DON) on 5/6/22 at 11:00 a.m. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The 2/5/22 event summary report documented Resident #1 received three medications that were not prescribed to him including: 300 mg Metoprolol (a medication for blood pressure), 10 milliequivalents (meq) potassium (mineral supplement) and 12.5 mg Clozaril (a medication used for schizophrenia). The root cause of the significant medication error was related to the licensed nurse not using a patient identifier when administering the resident's medication. The resident decompensated quickly after the medication error and required emergent medical care. The licensed nurse was provided education regarding the five rights of medication administration. It documented ongoing education for licensed nurses regarding medication administration was provided. The 2/7/22 QAPI meeting summary documented an audit was completed for photos of residents in their charts and nametags on all residents' rooms to prevent further significant medication errors. -However, during the survey process, observations showed four residents did not have name tags outside of their rooms as an identifiers, as was indicated on the facilities QAPI plan. On the 500 hallway, four rooms had the residents documented in the wrong room in their electronic medical record. The resident who was physically in the A side of the room was listed in the medical charting system as residing on the B side of the room. The name tags on the outside of the rooms were also incorrect in identifying which resident resided in each bed. The facility failed to ensure the interventions set forth in the QAPI plan were in place and audited for accuracy to prevent any further significant medication errors. III. Staff interviews The DON was interviewed on 6/1/22 at 1:28 p.m. She said licensed practical nurse (LPN) #5 had a significant medication error on 2/5/22 while administering medications. She said LPN #5 started working at the facility on that day and was being trained by RN #1. The DON said LPN #5 caught her mistake and reported it to RN #1. RN #1 then assessed Resident #1, who had already begun to decompensate. The DON said RN #1 contacted the provider who ordered for nursing to monitor the resident for any further changes. She said RN #1 also contacted poison control who recommended sending the resident to the hospital for further medical care. She said a competency assessment had been conducted for LPN #5 on 2/5/22 following the medication error. She said on the spot training was provided alongside a medication administration audit for all licensed nurses in the facility. She said this was considered the audits the facility put into place through the QAPI program following the significant medication error. She said following the medication error on 2/5/22, the admissions coordinator conducted an audit to ensure all residents had a name tag outside of their room and a picture in their chart as a resident identifier. She said the licensed nurses should use identifiers to ensure medications were being administered to the correct resident. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	She said the admissions coordinator was responsible for continuing to ensure all residents had name tags for their room and pictures in their medical chart, but she recently left the facility. She said no other staff member had taken over that area to ensure the name tags, pictures and medical records were accurate. The DON said she had conducted an audit during the survey process and noted residents on the 500 hallway to be in the wrong rooms. She said several residents were physically residing in the A side of the room, but the electronic medical records and the nametags outside of the resident's room indicated they were in the B side of the room. She said she found several residents throughout the facility that did not have name tags on their door. She said this could lead to further medication errors. She said she updated the resident rooms in the electronic medical records and the nametags.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 46022 Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the resident's nutritional needs. Specifically, the facility failed to: -Follow correct portion sizes to ensure adequate nutrition were provided to the residents; and, -Follow recipe modifications for pureed and mechanically altered diets. Findings include: I. Professional reference According to The Nutrition Care Manual website, Transitioning Texture-Modified Diet Terminology and Definitions to IDDSI (International Dysphagia Standardization Initiative) Framework, https://www.nutritioncaremanual.org/auth.cfm (Retrieved 6/9/22), Dysphagia Level 3: Advanced or mechanical soft diet: no hard sticky, or crunchy foods, foods should be moist, mixed-consistency foods are allowed if tolerated and should be assessed by clinician (Speech language pathologist), food particles are served in bite-sized pieces (less than 1 inch), meats are cut up, chopped or ground (moist), crusty dry breads not allowed, most other moist breads are bread products allowed, salad, raw vegetables, and most fresh fruit are not allowed, adequate dentition and chewing ability expected. Dysphagia Level 1: Pureed: All foods are pureed, blended, or strained for a smooth consistency with no lumps, some softened desserts and bread items allowed if gelled throughout, soups, casseroles should be pureed and strained, and foods that require chewing or bolus formation are not allowed. I. Failure to follow correct portion sizes to ensure adequate nutrition was provided to residents. A. Observation and record review During the dinner meal on 5/26/22 beginning at 11:19 a.m. and ended at 1:21 p.m., cook #1 used the following scoop sizes: A #16 scoop (four tablespoons) for the scalloped potatoes for the consistent carbohydrate diet; A four ounce (oz) ladle was used for the tomato soup; and, Tongs were used for the barbeque chicken, which the recipe specified one skin on boneless chicken thigh was to be served. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The #16 scoop (four tablespoons), measuring 2.07 ounces (oz), was 1.68 oz less than the 1/2 cup (4 oz) specified on the menu extension sheet for the scalloped potatoes for the consistent carbohydrate diet. -The recipe called for 3/4 cup of tomato soup. One four ounce ladle was used, which was two ounces less than the amount that was to be served. At 12:45 p.m. cook #1 said the chicken thighs were falling apart. She said she was unsure how much to give the residents. Cook #1 had two of the six units left to serve and said she was running out of chicken. She said she would serve smaller portions of chicken, so she would not run out of chicken. -The servings of chicken were two to three inches (silver dollar size) big per serving that were served to approximately 15 to 20 residents, when the other residents received whole boneless chicken thighs. At 1:04 p.m. the kitchen ran out of barbeque chicken to serve the residents. She retrieved frozen chicken breasts and began cooking it on the flat top grill. When the chicken reached the correct temperature, she placed the chicken in barbeque sauce and served it to the remaining residents on the 600 unit (six residents). Cook #1 said she followed the production sheet guidelines on how many portions of chicken to make, but the production sheet was often wrong. II. Failure to follow recipe modifications for pureed and mechanical altered diets A. Observations and record review During the lunch meal on 5/26/22 beginning at 11:19 a.m. and ended at 1:21 p.m., the following was observed: Cook #1 placed several chicken thighs into the food processor. She turned on the machine and let it run until the chicken was finely chopped, less than 1/2 inch per piece of chicken. She placed the chicken into a metal pan and placed it in the steam table to stay warm until meal service. Cook #1 placed several chicken thighs into the blender. She took the chicken juice and barbeque sauce that was left on the sheet tray from cooking and poured it into the blender. She turned on the blender and blended until it resembled a tomato soup consistency. She placed the pureed chicken into a metal pan and placed it in the steam table to stay warm until meal service. At the start of meal service, cook #1 said the pureed chicken separated and appeared thin. She sprinkled powdered thickener into the chicken until she said it appeared thick enough. -When the pureed chicken was put onto the plate it remained runny with a liquid surrounding the base that appeared to be fat. It was not the appropriate consistency for puree diet due to potential choking. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:04 p.m. cook #1 ran out of regular barbeque chicken and dysphagia advanced (ground) chicken. She began cooking frozen chicken on the flat top to serve to the residents. She said two pieces of chicken were stuck together and were not cooking as fast as the other pieces. She began to chop the cooking chicken into pieces with a spatula. She said the chopped chicken could be used for the dysphagia advanced diet. -The chicken cook #1 chopped by hand and served to residents on a dysphagia advanced diet was uneven and had several pieces that were greater than one inch (as indicated in the professional reference above). The barbeque chicken recipe was provided by the dietary account manager (DAM) on 6/1/22 at 11:45 a.m. It revealed, in pertinent part, chop/ground meat: prepare per recipe. Remove needed portions. Transfer to the food processor, chop to pea size for chop meat and rice size for ground meat. Puree: Prepare per recipe. Remove needed portions, reserve sauce. Transfer to a food processor, blend until smooth. If too thick, add a small amount of reserved suce,a low sodium broth or hot water. If it is too thin, add a small amount of non-nutritive food thickener. Process until soft whipped cream consistency. B. Staff interviews The registered dietitian (RD) and the dining account manager (DAM) were interviewed on 6/1/22 at 11:29 a.m. The RD said cook #1 served the wrong amount of scalloped potatoes to the residents on a consistent carbohydrate diet. The DAM said the portion sizes on the menu should be followed for all residents. The DAM said the residents should have received an entire chicken thigh for lunch. She said more chicken should have been prepared so that all residents received adequate portions as indicated by the menus to meet their estimated nutritional needs. She said the additional barbeque chicken that was cooked should have been placed into the food processor and not chopped by hand to ensure the correct consistency for the mechanically altered diet. She said since the chicken was chopped by hand it was in bigger pieces than it was specified on the menu. The RD said it could be dangerous to serve residents the wrong mechanically altered diet as it could be a potential choking risk. The director of nursing (DON) was interviewed on 6/1/22 at 2:28 p.m. She said it was important for the cooks to follow the correct portion sizes to ensure residents received the correct amount of nutrition. She said the cooks were responsible for following the recipes to ensure the menu items were mechanically altered correctly to ensure the safety of the residents. She said providing residents with chicken pieces that were large would put the residents at a risk of choking.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46370 Based on observations, interviews and record review, the facility failed to ensure food and drink was palatable, attractive, and at a safe and appetizing temperature. Specifically, the facility failed to ensure resident food was palatable in taste, texture, appearance, and temperature. Findings include: I. Resident interviews All residents were identified by assessment and facility as interviewable. Resident #3 was interviewed on 5/25/22 at 12:29 p.m. He said he received fish for lunch that day. He said the fish was very slimy, so he was unable to eat it. He said it was easy to lose weight, because the food tasted so bad he frequently did not eat. Resident #19 and Resident #20 were interviewed on 5/26/22 at 3:54 p.m. Resident #20 said their meals were often delivered cold. Resident #20 said he often had to force himself to eat the meals, even though they are terrible, because he was a diabetic. Resident #19 said he did not eat lunch that day because the barbeque chicken was too tough for him to chew. Resident #19 said the meat was frequently too tough for him to consume. Resident #21 was interviewed on 6/1/22 at 9:16 a.m. Resident #21 said the food was not to her liking; she preferred the ensure and milk. She said she never liked the food at the facility and did not eat much of it. The food had no taste and it was bland. Resident #22 was interviewed on 6/1/22 at 9:22 a.m. Resident #22 said the food was inconsistent, some days it was good and others days not good. She said she got the food she ordered but it was food that she could not chew. She was edentulous and said they never asked her if she needed her food soft. When the food was served to her room it was sometimes cold, most of the time warm but never hot. Resident #17 was interviewed on 6/1/22 at 9:29 a.m. Resident #17 said the food was fair. Some food was better than others. The food was always served cold and she ate cold meals most of the time. Resident #23 was interviewed on 6/1/22 at 9:48 a.m. Resident #23 said the portion sizes were small and they did not serve milk at all meals. He said he would like more water and snacks in the evening, such as peanut butter and jelly sandwiches, cookies or cake. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlas Post Acute	2611 Jones Ave Pueblo, CO 81004

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was interviewed on 6/1/22 at 11:21 a.m. Resident #4 said he always gets his meals delivered to his room late, he gets dinner between 6:30 p.m. and 7:00 p.m. He said his food was always cold, it had no taste and he did not enjoy it. He said he could ask for something different but said they would bring him something cold. II. Food committee minutes 4/19/22 comments included: -fish, stewed tomatoes, cinnamon apples were foods that were generally not liked. -the residents had to ask for beverages between meals. -breakfast needed improvement and condiment caddies needed to be restocked. -comments: fried eggs looked like roadkill. 5/31/22 comments included: -mixed vegetables were generally not liked. -sometimes the food did not match the tickets. -they would like to see less fish. -the residents had to ask for beverages between meals. III. Test tray A test tray for a regular diet was evaluated immediately after the last resident had been served their room tray for lunch on 5/26/22 at 1:32 p.m. The test tray consisted of barbeque chicken, mixed vegetables, and scalloped potatoes: -The barbeque chicken was extremely dry and without sauce the chicken would have been difficult to swallow. -The mixed vegetables were over cooked, had no texture and did not require chewing. -The scalloped potatoes were bland with no taste. -The test tray did not have a garnish. IV Staff interviews The registered dietitian (RD) and dining account manager (DAM) were interviewed on 6/1/22 at 11:29 a.m. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DAM said vegetables were cooked based upon the recipe guidelines. She said vegetables should require chewing and have texture to them. The DAM said the cooks often bring her a sample of the food prior to serving it to the residents. She said all meals should be served with a garnish to improve the appearance of the plate. The RD said she frequently visited with Resident #2. She said he often said the food did not taste good and he received it cold. 46022

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 46022 Based on observations, interviews, and record review, the facility failed to ensure meals were served according to resident allergies and preferences for five (#24, #19, #18, #17 and #9) out of 24 sample residents. Specifically, the facility failed to: -Ensure Resident #24 was served protein during the lunch meal; -Ensure Resident #17 and #18 were not served foods that were identified on their meal ticket to be classified as an allergy; and, -Ensure Resident #19 and Resident #9 were served food according to their preferences. Findings include: I. Observations During a continuous observation on 5/26/22 beginning at 11:19 a.m. and ended at 1:21 p.m. the following was observed: Resident #24 was served scalloped potatoes and mixed vegetables. He was not served barbeque chicken or ham, which were the protein items listed on the menu. Cook #1 said there was not a protein selected on the resident's meal ticket. She said since there was not a protein selected, she would not serve one to the resident. Resident #17 and Resident #18 were served scalloped potatoes, which contained milk and cheese according to the recipe. Cook #1 acknowledged both residents were lactose intolerant, which was identified on their meal ticket. She said the residents ordered the meal, so they were responsible for knowing what ingredients were in each menu item. II. Resident interviews All residents were identified by facility and assessment as interviewable. Resident #19 and Resident #20 were interviewed on 5/26/22 at 3:54 p.m. Resident #19 said he received the barbeque chicken for lunch. He said he did not like chicken. He said the alternative menu item was ham, which was always too tough and dry for him to chew. He said there were often no other choices on the menu that he liked, so he would skip meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #20 said the residents automatically received the meal of the day. He said if he wanted the alternative meal or an item off the always available menu, he had to notify the kitchen an hour and a half before the scheduled meal time. Resident #20 said sometimes he was unable to do this due to therapy or other appointments, so he had to eat the meal of the day. He said he often did not like the meal of the day and many times would not receive the food that he ordered. Resident #9 was interviewed on 6/1/22 at 12:18 p.m. She said the residents at the facility were not able to make choices on the menu. She said the menu was set and they were not allowed to make suggestions. She said she frequently requested to have fresh fruit, as the canned fruit contained too much sugar for her liking. She said the kitchen bought apples, but that was the only fresh fruit option. She said she used to attend the food committee meeting, but found it useless because any suggestions that were provided by the residents were never implemented. III. Record review The grievance/concern form dated 3/29/22 documented Resident #9 said there was no fresh fruit for diabetics. The resolution to the grievance documented offering apples at every meal. The grievance/concern form dated 3/29/22 documented Resident #10 requested a second baked potato, but was refused by the kitchen staff. The resolution to the grievance documented offering another form of potato to the resident when baked potatoes were not available. The resident allergy report was provided by the registered dietitian (RD) on 6/1/22 at 1:30 p.m. It documented Resident #17 and Resident #18 were lactose intolerant. IV. Staff interviews The RD and the dining account manager (DAM) were interviewed on 6/1/22 at 11:29 a.m. The RD said she documented each resident's dislikes into the meal tracker system. She said the meal tracker populated the resident's meal tickets, which were followed by the cooks. She said if a resident did not like the main entree, the meal tracker system would automatically default the resident's meal to the alternative option. She said the main entree for lunch on 5/26/22 was barbeque chicken and the alternative was ham. She said since Resident #24 did not like barbeque sauce or ham, the meal tracker system did not populate a protein item for the resident. She said an alternative protein option should have been provided to Resident #24 to meet his preferences and protein needs. She said allergies and intolerances were listed on the meal tickets. She said Resident #17 and Resident #18 were both lactose intolerant. She said they should not have received the scalloped potatoes for lunch on 5/26/22. She said a lactose free alternative should have been provided. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said the cooks were responsible for ensuring residents with allergies and intolerances were not served items that contained their allergies/intolerances. The DAM said she held a food committee once a month. She said during the meeting she reviewed the upcoming menu with the residents who attended the meeting. The RD said the facility used a three week cycle menu. She said the facility had recently started using the summer menu. She said the DAM and herself reviewed the new menu with the residents in the food committee. She said the DAM and herself were unable to make changes to the menu. She said if changes were made to the menu they had to be taken to the corporate level. She said these requests were only approved on a case by case situation. She said residents did not have a choice to change the menu items they were being served.