STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065233	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Nursing Center	3701 W Radcliff Ave Denver, CO 80236

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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on interviews and record review, the facility failed to ensure one (#17) of two out of 40 sample residents was treated with dignity and respect and cared for in an environment that promoted her quality of life. Specifically, the facility failed to ensure Resident #17 did not suffer from emotional distress by registered nurse (RN) #4. The facility failed to provide Resident #17 an environment free to share her concerns without fear of humiliation, retaliation or intimidation. The facility's failure caused continued emotional distress experienced by the Resident #17. Findings include: I. Resident #17 A. Resident status Resident #17, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease and depression. The 7/29/22 facility assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required supervision with activities of daily living. It indicated the resident did not have any signs or symptoms of depression. The resident did not reject any care during the assessment period. B. Resident interviews Resident #17 was interviewed 10/11/22 at 10:32 a.m. She said about two to three months ago that RN #4 was short with her and embarrassed her in front of other staff members. She said she approached the unit manager, licensed practical nurse (LPN) #1 to make a doctor appointment for the next day regarding a procedure to remove eyelashes on her left eye because the unit manager for her unit was not at work. She said her eyelashes grow inwards and she was experiencing a lot of pain in the left eye. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Actual harm Residents Affected - Few	She said RN #4 approached her in the hallway and chewed me out and said that I didn't need to bother anyone else and I had to wait until my unit manager returned to make the appointment. Resident #17 said she approached the unit manager, licensed practical nurse (LPN) #2, upon her return to the facility, about the incident and told her that I felt like I was at fault and wanted to apologize to RN #4. LPN #2 told Resident #17 that she did not have to apologize. Resident #17 said she continued to feel badly and approached RN #4 the next day to apologize. RN #4 told the resident that she had been chewed out by LPN #2 regarding the incident. Afterwards, Resident #17 said that RN #4 was very cold towards her and would only come in to give her medications and leave. She said RN #4 would not speak with her. During the interview, Resident #17 became emotional and had tears in her eyes when speaking of the encounter with RN #4. Resident #17 said, They were supposed to investigate it and write up a report and they never did that. Resident #17 said RN #4 was no longer employed at the facility because she followed a member of the administrative team to another facility. She and there has been a positive change since she has been gone in the attitudes of the CNAs (certified nurse aides) and residents. C. Record review The mood care plan, initiated on 11/11/18, documented the resident had a diagnosis of depression. It indicated the resident had a history of feeling tearful, hopeless and socially isolating. The interventions included administering antidepressant medications as ordered, completing the PHQ-9 (patient health questionnaire for depression) quarterly and as needed, providing the resident time to discuss concerns, feelings and thoughts as needed. -It did not include any person-centered approaches to manage the resident's depression. The impaired visual function care plan, initiated on 10/10/18 and revised on 1/22/2020, documented the resident's vision was severely impaired to the left eye and had right eye blindness related to macular degeneration, [NAME] disease of the eye and corneal ulceration of left eye (from misalignment of eyelashes as they rub against the eyeball). The interventions included consulting with an eye practitioner as required, explaining activities/sounds in the environment as needed and explaining care and services. II. Additional resident interview Resident #28, who was cognitively intact according to the facility assessment, was interviewed 10/17/22 at 10:30 a.m. Resident #28 said that RN #4 was a good nurse but she was abrupt with many residents and her attitude was someone who was not very happy with her job. She said RN #4 had an air about her where she felt RN #4 thought she was better than the residents and other staff members. III. Staff Interviews LPN #2 was interviewed on 10/13/22 at 5:00 p.m. LPN #2 said she was the unit manager of the unit where Resident #17 resided. She said that RN #4 butted heads with a lot of residents and was no longer employed at the facility. She said she followed the former NHA to another facility. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	LPN #2 said, in early July 2022, she had to take a day off of work. She said when she returned, Resident #17 said she went to LPN #1 to make an appointment for her to remove the eyelashes for her left eye, because she was experiencing pain. She said Resident #17 told her RN #4 accosted (approached aggressively) her in the hall and told Resident #17 that she did not need to bother anyone about her appointment and that she needed to speak with LPN #2 when she returned to work. LPN #2 said Resident #17 felt bad and wanted to smooth things over with RN #4. She said Resident #17 wanted to write an apology note to RN #4. LPN #2 told Resident #17 apologies were not necessary and that she should not feel bad about asking for the appointment. Resident #17 wrote the note and left it for RN #4 on the medication cart. She said she saw RN #4 take the note, unopened, to Resident #17's room. She said Resident #17 told her she found the note she had written RN #4 in her nightstand, unopened. LPN #2 said it was the ultimate (expletive) to someone who was just trying to offer an apology. LPN #2 said Resident #17 continued to feel badly and was emotional about the incident. LPN #2 said she reported this incident, in writing, to the former nursing home administrator (NHA) along with many other complaints from family, staff and residents regarding RN #4. LPN #2 said the former NHA was always smoothing things over and making excuses for RN #4. LPN #2 said the complaint was not addressed and felt the grievance, along with all the other grievances about RN #4, probably ended up in the shredder. LPN #2 said the former NHA and RN #4 were now employed at another facility. The NHA was interviewed on 10/17/22 at 8:15 a.m. He said he was unable to find an investigation regarding the incident between Resident #17 and RN #4. He said he interviewed Resident #17 that day (10/17/22) and she was very tearful and upset when recounting the incident regarding RN #4. He said he was not the NHA at the facility when this event occurred. LPN #2 was interviewed on 10/17/22 at 2:30 p.m. She said the issue regarding Resident #17 not feeling like RN #4 had been giving her the antidepressant medication (which had happened the weekend before the incident, see the former NHA interview below) and the issue with making the appointment were two separate instances. She said she was not aware of the incident with the medications. She said Resident #17 had come to her, the day she returned to work, and told her about the incident with RN #4. She said she immediately informed the former NHA that same day. LPN #6 was interviewed on 10/17/22 at 2:35 p.m. She said any allegations of abuse should be reported immediately to the unit manager, the director of nursing (DON), supervisor on duty and the executive director. She said the types of abuse reported were physical, mental, verbal and neglect. The NHA and former nursing home administrator (FNHA) were interviewed on 10/17/22 at 11:00 a.m. The FNHA said she had completed an investigation regarding Resident #17 reporting RN #4 had not been giving her the antidepressant medication she was prescribed, which was the weekend before the incident with RN #4. She said she had conducted an investigation and resolved the concern with the resident by ensuring the medications were shown to the resident prior to being crushed and mixed with applesauce. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	She said LPN #2 had not reported the incident between Resident #17 and RN #4 to her, however she was able to recount the entire event between Resident #17 and RN #4. She said that event had not been included in the investigation she completed about the medication concern.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on interviews and record review, the facility failed to ensure two (#76 and #17) of three out of 40 sample residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to: -Respond timely to a grievance filed by Resident #76. The resident had a certified nurse aide (CNA) #3 help with the completion of a grievance form. CNA #3 placed the grievance form in her personal bag and placed it in her car instead of turning the grievance form into facility management. CNA #3 left the grievance form in her car until she returned to work six days later, and seven days after the incident, when she gave the grievance form to the social service director (SSD); and, -Respond to a grievance for Resident #17, when she reported her sunglasses missing to staff. Findings include: I. Facility policy and procedure The Grievance Procedures and Concern & Comment Program policy, revised 8/7/21, was sent via email on 10/19/22 at 11:54 a.m. by the director of nursing (DON). It revealed in pertinent part, The Concern & Comment Program is utilized to address the concerns of residents, family members and visitors. The Social Services Director is responsible for the following: Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights, and accommodation of needs. As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated. Immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the Executive Director; and as required by State law. Coordinating orientation and in-service training to ensure that all facility associates know about the facility grievance procedures, the Concern & Comment Program, and their roles in providing responsive customer service to residents and families in grievance resolution. All staff are responsible for the following: Immediately communicating all grievances and concerns expressed by residents, families, and/or visitors to a licensed nurse or department manager. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The associate completing the form will take adequate time to record the concern comprehensively or allow the concerned individual to record their comments on the form. Complete information will facilitate appropriate & prompt follow-up. Resolve the concern, if possible. If resolution is not possible at that time, explain to the individual that another staff member will be assigned to investigate the concern and will contact them as soon as possible. All concerns are reported to the Supervisor on duty who will then contact the Executive Director, Director of Nursing, and/or other personnel as needed. Administrative staff are responsible for the following: Reporting grievances and concerns to the Executive Director and Director of Nursing. Routing the Concern & Comment Form to the Social Services Director and/or Executive Director as well as the appropriate department manager to investigate and resolve the concern. The appointed manager will contact the concerned party within 24 hours to share the status of the investigation and resolution. II. Resident #76 A. Resident status Resident #76, age 84, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included wedge compression fracture of the first, second, and third lumbar vertebrae, osteoporosis, hemiplegia cerebral infarction right side (stroke), muscle weakness, dysphagia (difficulty swallowing), and hypertension (high blood pressure). The 9/14/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene. She required limited assistance with walking in her room, and walking in the corridor. B. Resident interview Resident #76 was interviewed on 10/10/22 at 3:18 p.m. She said the facility did not handle grievances well. She said she turned in a grievance form a few days ago. She said a staff member helped her fill it out and took it from her to hand it in for her. She said she did not know who her form was given to. She said when she did complain no one from staff ever came back to tell her what happened with her complaint or how it would be resolved. She said there really was no point filling out the grievance forms when they did not come back to follow-up with her. She said a CNA from an agency was rude and treated her roommate roughly verbally. She said I said loudly when the situation was happening, watch out roomie, she is bigger than you. She said she complained about the situation to the facility CNA and even filled out a grievance form. She said she never heard anything back from the facility about her grievance. She said she did not know if that specific agency CNA was still allowed to work in the facility or not. She said, I hope they don't allow that agency person back in the building. C. Record review (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility grievance logs for six months were provided by the nursing home administrator on 10/12/22 at 2:00 p.m. The grievance from Resident #76 was not on the log sheet of complaints. The facility grievance card for Resident #76 was provided on 10/13/22 at 10:17 a.m. The front and back of the card was filled in but there were no attachments (which were provided on 10/17/22). The facility grievance for Resident #76 was provided again on 10/17/22 at 8:50 a.m. by the director of nursing (DON). The card had two attachments with it. The attachments were written statements from the social service director (SSD) and another from a registered nurse (RN). The grievance card and attachments revealed: -The reported incident took place on 10/7/22 with no time recorded of the event (Friday). The resident had a staff member help her fill out the grievance form on 10/8/22 at 10:45 a.m. (Saturday). (The staff member said she put the grievance card in her personal bag and left the bag with the grievance form in her car until she returned to work on 10/13/22 Thursday, 6 days later, see interviews below). -Resident #76 described her concern: Rude to roommate. Nurses to care for us. Resident #76 wrote that she provided this information to the staff member CNA #3. Resident #76 wrote CNA #3 was not able to resolve her concern. -The facility investigation and response on 10/13/22 at 8:00 a.m. revealed the SSD spoke to both residents in the room. -Actions taken to resolve/respond to the concern, was education with staff on reporting timely. -The attachments revealed an interview on 10/13/22 at 8:00 a.m of the SSD and the two roommates. The SSD followed-up on the grievance form with the residents. The other attachment was written by a facility RN. The RN dated her timeline of the event on 10/7/22 (Friday). The RN's signature was on the bottom of her written statement but she did not sign a date when she wrote her timeline for the investigation. The RN's timeline did not include that CNA #3 spoke to her about the grievance card. The RN's timeline was a review of conversations with the two residents on 10/7/22. No grievance card was filled out by the RN on 10/7/22. The RN's timeline did not include any conversation with CNA #3 about the grievance. D. Staff interviews The SSD was interviewed on 10/17/22 at 1:08 p.m. She said the incident occurred on 10/7/22 and the grievance card was brought to her on 10/13/22. She said she asked the RN who worked that night to write out a statement on 10/14/22. She said we began immediate education of the staff on how to report grievances. She said very soon the facility would have all staff educated on the subject of grievance reporting. She said the RN who wrote a timeline was not in the building today to be interviewed. She said CNA #3 worked on Saturday 10/8/22 and did not return to work until Thursday 10/13/22. She said she did not know where the grievance card was for the week. She said it was brought to her on 10/13/22. She said CNA #3 told her the reason she waited to hand in the grievance card was because the CNA wanted to speak with the SSD personally about the matter when she handed in the grievance card. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 10/17/22 at 1:20 p.m. He said the incident happened on 10/7/22. He said the complaint was written on Saturday 10/8/22. He said CNA #3 did not give the complaint form to the SSD until 10/13/22 on Thursday. He said he did not know if the CNA took the written grievance home with her. He said the CNA had been trained to give the grievance card to management immediately but she did not hand the card in to management. He said he did not interview the agency CNA which the complaint was about. He said he did not interview the agency CNA because the facility had placed her on a list to not allow her to work at the facility. He said he did not feel any follow-up was necessary because it was a customer service issue. He said he did not contact the agency to tell them about the CNA in the grievance. He said he would provide the written documentation that the agency CNA on the grievance form was not allowed back to work in the building. (see below, no proof was provided by the facility) CNA #3 was interviewed on 10/17/22 at 1:39 p.m. She said on Saturday 10/8/22 Resident #76 told her an agency CNA was very rude to the resident's roommate. She said she gave a grievance form for Resident #76 to fill out. She said she told an RN in the building about the situation. She said she put the grievance card in her work bag on 10/8/22 and put it in her car for a week. She said she gave the grievance card to the SSD when she worked again on 10/13/22. She said she was wrong not to give the card to the SSD, or the receptionist, or the manager on duty. She said she had never helped a resident with a written grievance before. She said it was the first time she had ever completed one in the years she worked in the facility. She said she learned from the situation to hand the grievance card in immediately. She said from now on she would turn in a grievance to the manager on duty, or even call the SSD or the DON. E. Facility follow-up The facility did not provide the requested information about the reported agency CNA who was not allowed to work in the facility again. The facility did not provide any documentation during survey or afterwards (exit 10/17/22) of the list of agency staff not allowed to work in the facility again. 47350 III. Resident #17 A. Resident status Resident #17, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease and depression. The 7/29/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required supervision with activities of daily living. B. Resident interview (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was interviewed on 10/11/22 at 10:40 a.m. Resident #17 said that a pair of sunglasses were left by her daughter in law with the receptionist about one month ago. The receptionist had placed her name on the glasses and left them on the counter instead of bringing them directly to her. She said the sunglasses were missing and had never been replaced. She said the resident said staff were aware that the sunglasses were missing. C. Record review The 10/17/22 concern and comment form (completed on 10/17/22, during the survey process, completed by the social services assistant) documented the resident was unable to locate an original pair of sunglasses and had initially declined for glasses to be replaced. It did not include the details of the sunglasses, which were labeled with her name, were not returned to her and had been left at the front desk of the facility. The SSA offered to replace the sunglasses (on 10/17/22) and the resident agreed. The resolution documented that Resident #17 would purchase new sunglasses and submit a receipt for reimbursement. The form was signed by the nursing home administrator (NHA) on 10/17/22. II. Staff Interviews Receptionist #1 was interviewed on 10/13/22 at 4:00 p.m. She said Resident #17's granddaughter had brought in a pair of sunglasses about one month prior. She said she had labeled the sunglasses for the resident and placed them on the counter. She said the sunglasses were on the counter when she left for the evening. She said, the next morning, the sunglasses were gone from the counter. She said she asked Resident #17 if she had the sunglasses, and she said they had not been given back to her. She said she reported the missing sunglasses to the social services assistant (SSA). The social services director (SSD) and SSA were interviewed on 10/17/22 at 3:35 p.m. The SSD said grievances and reports of missing items were documented on a concern and comment form. She said the receptionist logged the forms and then provided them to the appropriate department to investigate. The SSA said Receptionist #1 had reported Resident #17's missing sunglasses. She said she did not document the missing sunglasses on a concern and comment form. She said she had talked to Resident #17 after the sunglasses went missing and she did not want them replaced. She said she did not document the conversation with the resident. She said she completed a concern and comment form and met with Resident #17 that day (10/17/22) and determined the resident wanted the sunglasses replaced. She said she submitted the concern and comment form to the NHA.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on interviews, observations and record review, the facility failed to ensure two (#42 and #20) of three residents reviewed for activities of daily living of 40 sample residents were provided the necessary care and services to maintain or improve their level of functioning. Specifically, the facility failed to: -Ensure that Resident #42 received incontinence care timely; and, -Ensure that Resident #42 and #20 received repositioning timely. Findings include: I. Professional reference A. [NAME], T.V. et al. Review of the Current Management of Pressure Ulcers. Advances Wound Care. 2018 [DATE]; 7(2): 57-67. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5792240/ retrieved on 10/21/22. Nursing home patients have a pressure ulcer prevalence of 11% and are most likely to develop pressure ulcer over the sacrum or heels. Nursing home patients were also found to have contractures at a prevalence of 55%. Contractures are caused by decreased elasticity of the tissue surrounding major joints, and the resulting lack of full mobility in the affected extremities significantly the risk of pressure ulcer formation. B. Pechlivanoglou, P. et al. TURNing high risk patients: An economic evaluation of repositioning frequency in long term care. Journal of the American Geriatrics Society. 2018 July; 66(7): 1409-1414. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6097929/ retrieved on 10/22/22. According to current US (United States) practice guidelines, nursing home residents should be repositioned as frequently as required by their condition. Practice guidelines in Canada and the US recommend that patients at high risk of pressure ulcers be repositioned every two hours. II. Facility policy and procedure The Activity of Daily Living policy and procedure, reviewed on 7/17/21, was provided by the nursing home administrator (NHA) on 10/18/22 at 3:34 p.m. It documented, in pertinent part, Purpose: to ensure facilities identify and provide needed care and services that are resident centered, in accordance with residents preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. The resident will receive assistance as needed to complete activities of daily living (ADLs). Any change in the ability to perform ADLs will be documented and reported to the licensed nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For bed/wheelchair mobility the following procedures will be followed: assist residents with bed/wheelchair repositioning as necessary to promote good body alignment and prevent skin breakdown. Explain the importance of changing positions to prevent skin breakdown to the resident. Utilize appropriate safety measures and any necessary equipment to maintain resident safety. After providing assistance, ensure the resident is safe and comfortable and place the call light within reach. III. Resident #42 A. Resident status Resident #42, age 72, was admitted on [DATE]. According to the computerized physician orders (CPO), the resident's diagnoses included hemiplegia and hemiparesis (paralysis) affecting right dominant side, unspecified dementia with behavioral disturbances, contracture of muscle of left ankle and foot, contracture of right shoulder right elbow and right hand, and specified depressive episodes. According to the 8/16/22 minimum data set (MDS) assessment, the resident had short-term and long-term memory impairment with severe impairment in making decisions regarding tasks of daily life. He required extensive assistance of one person with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident was incontinent of bowel and bladder. B. Observations On 10/13/22, during a continuous observation, beginning at 8:30 a.m. and ended at 1:25 p.m. Resident #42 was observed sitting in the day room, in front of the television, in a Broda chair. -At 8:48 a.m. the resident was observed eating breakfast in the day room. -At 9:10 a.m. Resident #42 remained in the day room, in the Broda chair. -At 9:34 a.m. licensed practical nurse (LPN) #2 and LPN #5 took Resident #42 to his room and helped him to bed by standing the resident and doing a pivot transfer. They placed a pillow behind his head and positioned him supine (lying on his back, facing upward). Certified nurse aide (CNA) #4 came into the resident's room, put his oxygen on, lowered the bed and raised the head of the bed to a 45 degree angle. -At 9:45 a.m. CNA#4 brought the resident a blanket and put it on him. -At 10:08 a.m. the Resident #42 remained in the same position. -At 11:05 a.m. LPN #5 checked to ensure dressing was on his pressure ulcer. She did not check the resident's incontinence brief or offer to reposition the resident. -At 11:18 a.m. hospice agency staff went in but left quickly because the resident was asleep. The hospice agency staff did not provide the resident care. -At 12:14 p.m. Resident #42 remained in the same position. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 12:22 p.m. CNA #4 closed the resident's door. She did not enter the resident's room. -At 12:34 p.m. LPN #5 entered the resident's room and gave the resident his medication. She did not offer or provide repositioning to the resident. -At 12:35 p.m. CNA #4 brought the resident his lunch tray, set it on the overbed table and assisted him with eating. -At 12:52 p.m. CNA #4 was finished assisting the resident with his lunch. CNA #4 lowered Resident #42's bed and kept the resident at a 45 degree angle. CNA #4 did not offer to reposition the resident or provide incontinence care. -At 1:17 p.m. Resident #42 remained in the same position. -At 1:25 p.m. CNA #4 entered the resident's room and provided Resident #42 with incontinence care. CNA #4 said the resident was incontinent of urine and the brief was wet. The soiled brief was observed in a trash bag. The brief was heavy, sopping wet, and the moisture could be felt through the bag with a gloved hand. CNA #4 said she had not provided Resident #42 incontinence care since the resident was transferred to the Broda chair for breakfast. After providing incontinence care, the resident was positioned back to the supine position. C. Record review The activities of daily living (ADL) care plan, revised on 10/11/22, documented the resident had a self-care deficit related to a CVA (cerebral vascular accident) with subsequent impaired mobility. It indicated the resident required one person assistance with bed mobility and totally dependent upon staff for personal hygiene and toileting. The interventions included providing the resident with body pillows for positioning while in bed, encouraging the resident to participate in ADLs as he was able, floating the resident's heels while in bed, repositioning the resident in bed as tolerated, placing the resident's call light on the left side of the resident due to visual impairments. D. Staff interview CNA #4 was interviewed on 10/17/22 at 12:25 p.m. She said residents should be offered incontinence care and repositioning every two hours. She said Resident #42 was incontinent and total assistance with repositioning and incontinence care. She said Resident #42 was not able to communicate that he needed incontinence care. Licensed practical nurse (LPN) #5 was interviewed on 10/17/22 at 1:30 p.m. She said Resident #42 was incontinent and needed to be checked and changed every two hours. She said because the resident had a pressure ulcer, he should be repositioned every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 10/17/22 at 7:00 p.m. She said that residents that needed assistance with incontinence care need to be checked and changed every two to three hours. She said that residents who were at high risk for developing pressure ulcers and required total assistance with repositioning should be repositioned or offerred repositioning every two to three hours. 47350 IV. Resident #20 A. Resident status Resident #20, age 83, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included contracture of the left and right knee, contracture of left hand, wrist, elbow and shoulder. The 7/27/22 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 one person with bed mobility, dressing, toileting and personal hygiene and extensive assistance of two people for transfers. B. Observations During a continuous observation on 10/12/22, beginning at 9:25 a.m. and ended at 2:30 p.m., Resident #20 was observed eating breakfast using her right hand. Resident was positioned on her back with bilateral legs tipped to the right side. -At 10:10 a.m. an unidentified certified nursing assistant (CNA) was observed taking blood pressure on the resident's left arm. Resident #20 remained on her back in the same position. -At 11:50 a.m. an unidentified staff member was observed delivering the lunch meal tray to the resident. -At 2:30 p.m. an unidentified CNA entered the resident's room. She did not offer to reposition the resident. During a continuous observation on 10/13/22, beginning at 9:00 a.m. and ended at 2:00 p.m., Resident #20 was observed eating breakfast in her room. She was lying on the bed, positioned on her back. -At 1:30 p.m., registered nurse (RN) #2 entered Resident #20's room to complete a skin assessment. During the skin assessment, unidentified crumbs were observed on linens underneath the resident, pillows were observed placed between the resident's knees and feet. The resident's legs were positioned to the right. Pillows were not placed behind the resident's back. Prior to the skin assessment at 1:30 p.m., facility staff had not entered Resident #20's room and offered the resident repositioning in over four hours. C. Record review (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan included the resident was at risk for skin impairment related to decreased mobility, bilateral foot drop, incontinence, cognitive impairment, severe contracture to bilateral knees, skin fragile and prone to bruising (initiated 6/18/18, revised 5/6/19). The interventions included rearranging bed to encourage repositioning (initiated 2/19/19), encouraging the resident to get up in the Broda chair as much as she would allow (initiated 2/26/2020), placing body pillow between the resident's legs, feet, buttocks, and bilateral knees (initiated 8/14/19), an air mattress with bolsters (initiated 8/15/18) and assisting the resident with frequent position changes as tolerated (initiated 8/15/18). The alteration in ADL self-care performance care plan documented the resident required assistance with ADLs related to dementia, limited range of motion, musculoskeletal impairment and bilateral contractures (initiated 7/5/18). It indicated the resident was totally dependent of one to two staff members with bed mobility and repositioning. D. Staff interviews Licensed practical nurse (LPN) #6 was interviewed on 10/17/22 at 2:35 p.m. She said Resident #20 was unable to reposition without nursing staff assistance. CNA #5 was interviewed on 10/17/22 at 2:40 p.m. She said Resident #20 was fully dependent and required two people for rolling or changing position. He said that the resident should be repositioned every one to two hours.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on observations, record review, and staff interviews, the facility failed to provide an ongoing program to support residents in their chosen activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two (#84 and #71) of four out of 40 sample residents. Specifically, the facility failed to offer and provide personalized activity programs for Resident #84 and Resident #71. Findings include: I. Facility policy and procedure The Therapeutic Activities Program policy and procedure, revised 4/1/22, was provided by the nursing home administrator (NHA) on 10/18/22 at 3:34 p.m. It documented, in the pertinent part, The facility activities program will be directed by a qualified activities director. The director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activity program. This includes completion and/or directing/delegating the completion of the activities component of the comprehensive assessment; and contributing. Directing the activity program includes scheduling of activities, both individuals and groups implementing and/or directing/delegating the implementation of the programs, monitoring the response and or reviewing/evaluating the response to the programs to determine if the activities meet the assessed needs of the resident, and making revisions as necessary. The facility should implement an ongoing resident centered activities program that incorporates the residents interest, hobbies and cultural preferences which is integral to maintaining and/or improving resident's physical, mental and psychosocial well-being and independence. To create opportunities for each resident to have a meaningful life by supporting his/her domains of wellness (Security, autonomy, growth, connectedness, identity, joy and meaning). Procedure program scheduling: it is important for residents to have a choice about which activities they participate in, whether they are part of a formal activities program or self-directed. Additionally, a resident's needs and choices for how he or she spends time, both inside and outside the facility, should also be supported and accommodated, to the extent possible, including making transportation arrangements. Program types: Individual or independent programming ensures that all residents who are unable or unwilling to participate in group programs have consistent, goal oriented and individualized recreation opportunities. All residents have a need for engagement and meaningful activities. Residents who prefer not to participate in group programs and/or independently involved in recreation pursuits will be identified through an assessment process. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Individual interventions will be developed based on each resident's assessed needs. The individual program will be provided according to a consistent schedule identifying specific days of the week and the timeframe in which the program will occur. Each resident's individual program will include interventions that meet the resident's assessed social, emotional, physical, spiritual and cognitive functioning needs. These approaches will reflect the resident's lifestyle and interests and will be incorporated into the interdisciplinary care plan. Group programming ensures each resident the opportunity for active participation in group programming designed to accommodate his or her social and or cognitive abilities to promote quality of life. The resident population will be assessed according to each resident's present cognitive capability, physical functioning, and endurance as it relates to his or her social functioning to determine the level of programming in which each resident would best function. Independent recreation participation will be documented in the progress notes to reflect planned approaches and progress towards goals. The current participation record will be maintained daily, organized and accessible to recreation service staff. All participation records are maintained as part of the medical record for three months and then submitted to medical records. II. Resident # 71 A. Resident status Resident #71, age [AGE] years old, was admitted on [DATE]. According to October 2022 computerized physician's orders (CPO), diagnoses included cognitive communication deficit, chronic respiratory failure, depression and dementia. The 9/16/22 minimum data set (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 one person with bed mobility, toileting and personal hygiene and supervision with transfers. The 8/16/22 MDS assessment documented reading and keeping up with the news was very important to the resident and going outside to enjoy the weather and doing his preferred activities was somewhat important. B. Observations On 10/12/22, during a continuous observation beginning at 9:15 a.m. and ended at 3:16 p.m., Resident #71 was observed sitting in his wheelchair, in his room with no meaningful activities. -At 9:27 a.m. the resident was in his chair with his food on the table, but he was not eating. -At 9:34 a.m. certified nurse aide (CNA) #4 entered the resident's room and asked him if he needed his glasses. CNA #4 gave the resident his glasses and then left the room. -At 10:00 a.m. activity staff were observed asking other residents if they wanted to attend the exercise group activity. They did not enter Resident #71's room to invite him. -At 10:20 a.m. Resident #71 was observed sleeping in his wheelchair. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 10:45 a.m. Resident #71 remained sitting in the wheelchair in his room. The activity staff were observed walking through the hallway and were asking some residents if they wanted to participate in the crafting group activity. The activity staff did not go into Resident #71's room to ask him if he wanted to participate in the group activity. -At 12:04 p.m. the resident's family member entered the resident's room to visit with him and left the facility at 1:04 p.m. -At 2:22 p.m. Resident #71 was observed sitting in his room, in his wheelchair. -At 3:16 p.m. the activity staff were observed walking throughout the hallway asking some residents if they wanted to attend a group activity of making candy bags. The activity staff did not go into Resident #71's room or ask the resident if he would like to participate in the group activity. On 10/13/22, during a continuous observation beginning at 9:03 a.m. and ended at 12:20 p.m., an activity staff member was observed entering Resident #71's room to drop off the Daily Chronicle. -At 9:14 a.m. the resident was in his room, sitting in the wheelchair. The television was not turned on and the resident did not have any meaningful activity while in his room. An unidentified CNA entered the resident's room. She did not speak to the resident and then exited the room. -At 9:36 a.m. an unidentified CNA entered Resident #71's room and changed the bedding. Upon exiting the room, the CNA shut the door. Activity staff were observed walking throughout the hallway asking some residents if they wanted to attend the group activity which was exercising. Activity staff did not go into Resident #71's room or ask the resident if he would like to participate in the group activity. -At 11:14 a.m. the resident propelled himself in his wheelchair out of his room and into the hallway. -At 11:27 a.m. the resident's family member entered the nursing unit and wheeled the resident back to his room to visit. C. Record review The activity care plan, dated on 8/23/22, documented that Resident #71 enjoyed the paper daily, music, time with his family, socializing and watching television, but needed assistance with channel selection. The interventions included encouraging communication with his family, encouraging the resident to spend time outside of his room interacting with peers and staff members, spending time with visitors in the common areas to increase time out of his room and endurance, and encouraging participation in activities by assisting him to and from activities. It indicated the resident required reminders for group activity times and locations. The 8/29/22 activity progress note documented that the resident had a subscription to the newspaper and received it daily. It indicated he was observed watching television, sleeping, socializing with employees and people watching. The resident had little to no interest in attending group activities at this time, however last quarter the resident participated in happy hour, sweet shop, calendar review, holiday events, and order in lunch group activities/events. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 9/14/22 activities evaluation documented that the following activities were somewhat important to the resident: animals and pets, community outings, music, and social parties. It indicated the following activities were very important to the resident: current news, family and friends, movies, reading, sports and television. The August 2022 participation records documented Resident #71 participated in the following activities: current events on 20 occasions, received the newspaper on 23 occasions, reading on 17 occasions, watched television on 15 occasions, went for a wheelchair walk on three occasions and looked outside through the window on 11 occasions. The September 2022 participation record documented the resident participated in five sessions of current events, had five family visits, received mail delivery nine times and newspaper delivered 22 times and socialized on six occasions. The October 2022 participation record documented Resident #71 received mail delivery on three occasions, newspaper delivery on 16 occasions, socialized on three occasions, watched sports on one occasion and watched television on 15 occasions. D. Staff interviews Certified nurses aide (CNA) #4 was interviewed on 10/71/22 at 12:25 p.m. She said that Resident #71 enjoyed watching television. She said he did not leave his room often. The activities director (AD) was interviewed on 10/71/22 at 2:40 p.m. She said Resident #71 liked activities that involved food and would bring him food to his room for the men's lunch. She said that he did not participate in other group activities and the activities staff tried to invite him to activities that revolved around food. She said the resident was not on a one-to-one activity program. She said she did not know why the resident was not invited to the group activities on 10/12/22 and 10/13/22. She said the resident should have been invited and given the opportunity to decline. 43135 III. Resident #84 A. Resident Status Resident #84, age 92, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included chronic respiratory failure, chronic obstructive pulmonary disease (COPD), muscle weakness, chest pain, and depression. According to the 9/22/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance with bed mobility, transfers, toilet use, and personal hygiene. She required total dependence on staff with walking in the corridor, and locomotion on and off the unit. It was important for her to go outside and get fresh air when the weather was good. B. Observations (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During daily observations of the resident she was observed in her room lying on her bed. Her bed was the first bed to the right upon entry into the room. Her bed faced the hallway door with her back to a privacy curtain. During observations the angles of her bed varied from flat on her back to a 30 degree angle. Her roommate's bed was next to the window. Each day it was very dark in her room with the privacy curtain drawn which blocked a view of the window. Even if the resident turned herself around 180 degrees she would only see a curtain. On 10/10/22 at 9:30 a.m. the resident was on her bed in a dark room, a privacy curtain drawn to separate the roommates which blocked the window, and the resident was looking at her computer tablet. On 10/11/22 at 10:15 a.m. the resident was on her bed in a dark room, a privacy curtain drawn to separate the roommates, which blocked the window, and the resident was looking at her computer tablet. On 10/12/22 at 10:20 a.m. the resident was on her bed in a dark room, a privacy curtain drawn to separate the roommates, which blocked the window, and the resident was looking at her computer tablet. At 2:00 p.m. the privacy curtain was pulled back to the wall, the window was visible and there was sunlight throughout the room. The resident had her back to the window, her bed was up at a 30 degree angle, and she had her computer tablet. She did not face the window. On 10/13/22 at 10:20 a.m. and 4:00 p.m. the resident was on her bed in a dark room, a privacy curtain drawn to separate the roommates which blocked the window, and the resident was looking at her computer tablet. On 10/17/22 at 8:20 a.m., 11:30 a.m. and 2:22 p.m. the resident was on her bed in a dark room, a privacy curtain drawn to separate the roommates which blocked the window, and the resident was looking at her computer tablet. C. Resident interview Resident #84 was interviewed on 10/10/22 at 9:30 a.m. She said she requested the facility move her to a room which had a bed by the window. She said that being in bed all day next to the wall in a dark room was depressing. She said she had depression and it was relieved at times by going outside, and also being able to look out a window. She said she asked someone to take her outside in a wheelchair this week because it was perfect fall weather. She said she had not been out of her bed for about two weeks and that was depressing to her. Resident #84 was interviewed again on 10/12/22 at 10:20 a.m. She said she could not see behind the privacy curtain that separated her area from her roommates. She said she needed staff help to get out of her bed. She said she could not see out the window but she said a staff member told her she was on a list for a room with a bed by the window. She said she did not know when that would happen but hoped it would be soon. She said she asked again to go outside in a wheelchair and was told someone would take her outside today or tomorrow. Resident #84 was interviewed again on 10/13/22 at 4:00 p.m. She said no staff took her outside yesterday or today. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Record review Care Plan The comprehensive care plan, 9/16/22, identified the resident had seasonal depression and enjoyed sunshine. On 10/5/22 it was identified to offer to take the resident outside. The resident required one staff member to provide moderate to maximum assistance to move between surfaces and utilize a wheelchair. Assessment The 9/22/22 MDS admission assessment revealed it was important for the resident to have reading materials, visit with pets, and to go outside to get fresh air when the weather was good. The 9/25/22 activities assessment revealed the resident enjoyed the outdoors. The resident's preferred way to be outdoors was to look out the window from her bed. The 10/4/22 psychosocial note written by the social service director (SSD) revealed, the social worker discussed with the resident her voicing she had seasonal depression, and asking staff to offer to take her outside/out of her room. Activity Participation The activity participation records were provided by the SSD on 10/17/22 at 2:27 p.m. It was revealed, -September 2022 the resident was only offered activities twice since her admission on 9/15/22. She was offered the two activities both on the same day 9/28/22. She declined the offer to a garden group, and to order lunch in. She was not offered any other activities in the month, including the category of patio time. -October 2022 the resident was offered activities three times (during the survey). On 10/11/22 she declined the offer categorized as travelog. On 10/12/22 she declined two activity offers, crafts, and trivia. She was not offered any other activities in the 17 days of the month, including the category of patio time. E. Staff interviews The SSD was interviewed on 10/17/22 at 1:56 p.m. She said she had offered to take the resident outside and so had the staff. She said she did not know which staff offered to take her outside. She said she had written down in her progress notes that she offered to take the resident outside. She said primarily it was the activity department's job to take the resident outside. She said she would provide her progress notes of the outside invites. -No progress notes of outside invites were provided by the SSD. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nursing home administrator (NHA) was interviewed on 10/17/22 at 2:05 p.m. He said the resident was on a list to get moved to a room with a bed by the window. He said the facility was redoing floors in a few rooms. He said when that project was finished the resident would then be offered to move to a room with a bed by the window. The activity director was interviewed on 10/17/22 at 2:40 p.m. She said Resident #84 liked to go outdoors and liked to look out the window. She said on the activity participation record there was a section called patio time which meant to take a resident outdoors. She said she did not have any documentation or proof that the resident was offered activities or declined any other activities other than what was on the activity log since she was admitted . The AD said she only had documentation that the resident declined invites twice in September 2022 and three times in October 2022. She said the resident was not provided one-to-one visits from the activity department. She said in the future she could ask the resident what specific days she would like to go outside and take her on those days. She said the resident liked looking through her window to view the outside as one of her activities of choice. She said she had not been in the resident's room in about a month. She said she was unaware her roommate was next to the window and that Resident #84's privacy curtain was often pulled. She was also unaware the resident's back was to the window. She said she needed to be helped by staff into her wheelchair in order to go outside. She said she could not say if her department offered to take her outside and said she had no other documentation. She said she would fix the situation right away.

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	065233	A. Building B. Wing	10/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hallmark Nursing Center	3701 W Radcliff Ave Denver, CO 80236

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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** 46851 Based on observations, record review and interview, the facility failed to provide the necessary treatment and services to prevent the development of pressure injuries for one (#42) of two residents reviewed for pressure injury out of 40 sample residents. Resident #42 was identified by the facility as a high risk for developing pressure injuries upon his admission to the facility. On 9/13/22, the resident developed a pressure injury to the right trochanter (hip). The facility failed to ensure an initial assessment of the pressure injury was completed upon the residents admission, The physician was not notified timely and a treatment order was not put into place until 9/26/22; 13 days after the pressure injury was identified. A treatment note dated 9/27/22, by the wound physician, documented the resident had a stage 3 facility acquired pressure injury to her right hip. The facility failed to take sufficient steps to promote wound healing and prevent further skin breakdown. Additionally, the facility failed to ensure that repositioning and incontinence care were provided to the resident in a timely manner. Findings include: I. Professional reference According to the National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2018, retrieved from https://www.ehob.com/media/2018/04/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guidline.pdf on 10/27/22, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate 'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Bruising indicates suspected deep tissue injury. Category/Stage 3: Full Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as 'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Pressure Ulcer Prevention policy and procedure, last reviewed April 2022, was provided by the nursing home administrator (NHA) on 10/18/22 at 3:41 p.m. It revealed, in pertinent part, To provide associates and licensed nurses procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPUAP (national pressure injury advisory panel) and WOCN (wound, osteomyelitis, continence nurses society). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Based on the comprehensive assessment of a resident the facility must ensure that a resident receives care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing. A skin assessment/inspection occurs on admission/readmission. Skin observations also occur throughout point of care provided by CNA's (certified nurse aide) during ADL (activities of daily care) care (bathing, dressing, incontinent care, etc.). Any changes or open areas are reported to the nurse. A risk assessment tool, Braden scale or Norton Scale, determines the residents risk for pressure injury development. The scores documented on the tool and placed in the resident's medical records using the appropriate form. Certain risk factors have been identified that increase a resident's susceptibility to develop or impair healing of pressure injuries. Examples include but are not limited to: impaired/decreased mobility and decreased functional ability, comorbid conditions, cognitive impairment, exposure of skin to urinary and fecal incontinence, and the history of healed injury. A skin assessment/inspection should be performed weekly by a licensed nurse. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Upon admission and throughout stay at a minimum a pressure redistribution surface is in use with turning and repositioning as needed with ADL care/assistance incontinent care if needed to include skin barriers application as needed, preventative wheelchair cushion is indicated, etc. Skin inspections with particular attention to bony prominences, skin cleansing with appropriate cleanser at time of swelling and routine intervals, treat dry skin with moisturizers, minimize skin exposure to incontinence using devices (i.e. briefs) and skin barriers, minimize injury due to shear and friction through proper positioning, transfers and turning schedules, improve residents mobility in activity when potential exists(restorative). Measures to protect the resident against adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care: reposition at least every two to four hours (per NPIAP standards) as consistent with overall patient goal in medical condition; utilize positioning devices to keep bony prominences from direct contact; ensure proper body alignment when side-lying; heel protection/suspension if indicated; maintain HOB (head of bed) at the lowest degree of elevation consistent with medication conditions;, a pressure redistribution mattress service is placed under the resident; when positioned in a wheelchair, the resident is to be placed on a pressure reduction device and repositioned; when positioned in a wheelchair, consideration is given to postural alignment, distribution weight, balance, and stability. The Documentation and Assessment of Wounds policy and procedure, reviewed April 2022, was provided by the NHA on 10/18/22 at 3:41 p.m. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	It revealed, in pertinent part, To guide the associates and licensed nurse in the assessment of the wounds to include pressure ulcer/injuries, venous, arterial, diabetic, dehisced surgical wounds, and other (not otherwise specified). Based on the comprehensive assessment of a resident, the facility must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. A wound assessment/documentation is required to occur at a minimum weekly. Nurses performing the treatment would perform an prn (as needed) assessment/documentation if noted change has occurred i.e. wound has healed/resolved, appears infected, or appears to have declined. It may not be practical for the weekly assessment to occur on the 7th day deadline due to dressing not required to be changed on due date, wound round or MD (medical doctor) schedule changes, follow-up appointments, or resident's refusal. For those purposes would obtain wound assessment/documentation prior to if able or within the calendar week to maintain assessment and documentation compliance. Documentation is located in the EHR (electronic health record) progress notes, wound observation tool and/or skin integrity data collection tools. Additional documentation from MD office visits or wound clinic notes may be located in the hard copy medical record. III. Failure to provide the necessary treatment and service to prevent the development of pressure injuries for Resident #42 A. Resident #42's status Resident #42, age 72, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (paralysis) affecting right dominant side, unspecified dementia with behavioral disturbances, contracture of muscle of left ankle and foot, contracture of right shoulder right elbow and right hand and specified depressive episodes. According to the 8/16/22 minimum data set (MDS) assessment, the resident had short-term and long-term memory impairment with severe impairment in making decisions regarding tasks of daily life. The resident required extensive assistance of one person with bed mobility, transfers, dressing, toileting and personal hygiene. The MDS documented the resident was incontinent of bowel and bladder and did not have any unhealed pressure ulcers. The resident was on hospice care. B. Observations On 10/12/22, during a continuous observation, beginning at 2:06 p.m. and ended at 3:18 p.m., Resident #42 was observed laying in the supine position (laying on his back) with his feet directly onto the mattress. -At 2:55 p.m. Resident #42 remained in the same position. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-At 3:18 p.m. Resident #42 was laying in bed, awake. He attempted to sit up in bed but was unable to reposition himself. On 10/13/22, during a continuous observation, beginning at 8:30 a.m. and ended at 1:25 p.m. Resident #42 was observed sitting in the day room, in front of the television, in a Broda chair. -At 8:48 a.m. the resident was observed eating breakfast in the day room, in the Broda chair. -At 9:10 a.m. Resident #42 remained in the day room, in the Broda chair. -At 9:34 a.m. licensed practical nurse (LPN) #2 and LPN #5 took Resident #42 to his room and helped him to bed by standing the resident and doing a pivot transfer. They placed a pillow behind his head and positioned him supine. The resident's feet were placed directly on the mattress. Certified nurse aide (CNA) #4 came into the resident's room, put his oxygen on, lowered the bed and positioned the resident at 45% angle. -At 9:45 a.m. CNA#4 brought the resident a blanket and put it on him. The resident's feet remained directly on the bed. -At 10:08 a.m. the Resident #42 remained in the same position. -At 11:05 a.m. LPN #5 checked to ensure dressing was on his pressure ulcer. She did not check the resident's incontinence brief or offer to reposition the resident. -At 11:18 a.m. hospice agency staff went in but left because the resident was asleep. The hospice agency staff did not provide the resident care. -At 12:14 p.m. Resident #42 remained in the same position. -At 12:22 p.m. CNA #4 closed the resident's door. She did not enter the resident's room. -At 12:34 p.m. LPN #5 entered the resident's room and gave the resident his medication. She did not offer or provide repositioning to the resident. -At 12:35 p.m. CNA #4 brought the resident his lunch tray, set it on the overbed table and assisted him with eating. -At 12:52 p.m. CNA#4 was finished assisting the resident with his lunch. CNA #4 lowered Resident #42's bed and kept the resident at a 45 degree angle. CNA #4 did not offer to reposition the resident or provide incontinence care. -At 1:17 p.m. Resident #42 remained in the same position. -At 1:25 p.m. CNA #4 entered the resident's room and provided Resident #42 with incontinence care. CNA#4 said the resident was incontinant with urine and the brief was wet. The soiled brief was observed in a trash bag. The brief was heavy, sopping wet, and the moisture could be felt with a gloved hand. CNA #4 said she had not provided Resident #42 incontinence care since the resident was transferred to the Broda chair for breakfast. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	After providing incontinence care, CNA#4 did not float the resident's heels. The resident was still laying in the supine position. Cross-reference F677: the facility failed to provide incontinence care and repositioning timely for Resident #42. C. Record review The cognition care plan, revised 10/5/22, documented the resident had impaired cognitive skills related to dementia, had trouble word findings and had short-term and long-term memory loss. The activities of daily living (ADL) care plan, revised on 10/11/22, documented the resident had a self-care deficit related to a CVA (cerebral vascular accident) with subsequent impaired mobility. It indicated the resident required one person assistance with bed mobility and totally dependent upon staff for personal hygiene and toileting. The interventions included providing the resident with body pillows for positioning while in bed, encouraging the resident to participate in ADLs as he was able, floating the resident's heels while in bed, repositioning the resident in bed as tolerated, placing the resident's call light on the left side of the resident due to visual impairments. The skin integrity care plan, revised on 10/10/22, revealed Resident #42 was at risk for an alteration in his skin integrity due to impaired mobility, incontinence and a right hand contracture. The interventions included placing an arm rest pad on the left side for skin integrity, applying lotion to the resident's bilateral upper and lower extremities daily, cleaning and drying the resident's skin after each incontinent episode with barrier ointment being applied, completing the Braden scale assessment quarterly or as indicated, checking for proper positioning when the resident was up in the Broda chair, following wound care orders, a pressure reducing mattress to the bed and cushion for the wheelchair and weekly skin checks. The skin impairment care plan, revised on 10/11/22, documented the resident had a stage three pressure injury to the right trochanter (any of two bony protuberances by which muscles are attached to the upper part of the thigh bone). The interventions included assessing the location, size, and treatment of the skin injury, cleaning and drying the resident's skin after each incontinent episode, identifying and documenting potential causative factors and resolving where possible, using a draw sheet or lifting device to move the resident and documenting weekly treatments to include the measurements of each area of skin breakdown with any notable changes or observations. The 10/6/22 Braden assessment documented the resident was at a high risk for pressure ulcers with a score of 11 out of 23. A lower score indicates more risk. III. Failure to assess, notify the physician and put a treatment in place timely upon the identification of a pressure injury A. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 9/13/22 weekly skin integrity data collection documented the resident's skin was intact, however the 9/13/22 nursing progress note documented the resident had an open area to the right hip, was improving in size and condition, and it did not have any signs and symptoms of infection. It indicated the nurse applied skin prep to the open area. The September 2022 medication administration record (MAR) and the treatment administration record (TAR) did not reveal documentation of a treatment of the pressure injury to the resident's right trochanter until 9/26/22, 13 days after the pressure injury was identified, according to the 9/13/22 nursing progress notes. The wound physician note dated 9/27/22 documented that resident had a stage three pressure ulcer located on the right hip, that was acquired at the facility. The 9/27/22 weekly skin integrity data collection documented the resident sustained friction/shearing to the right hip. The 9/27/22 wound observation tool assessment documented Resident #42 acquired a stage three pressure injury to the right trochanter on 9/21/22. It revealed the wound was unchanged with 20 % (percent) slough (part of the inflammatory process consisting of fibrin, white blood cells, bacteria and debris, along with dead tissue and other proteinaceous material) The wound observation document revealed the wound was 2 cm (centimeters) length x 1.7 cm width x 0.2 cm depth. The treatment order was to apply Medihoney with a foam dressing every day. A review of the resident's medical record revealed the wound was not thoroughly assessed until 9/27/22, when the wound was identified on 9/13/22. A wound physician note dated 10/4/22 documented that resident had a stage three pressure ulcer located on the right hip. The wound physician used an anesthetic instrument 2% lidocaine intervention used as an anesthetic to numb sensation of pain. Also in place was an alternating pressure mattress. A wound physician note dated 10/11/22 documented that resident had a stage three pressure ulcer located on the right hip, the progress was better, complexity was high. Preventive measures care in place, offloading heels and plan in care. -The physician did not give any other details for preventative measures. B. Observations -On 10/13/22 at 11:00 a.m. LPN #2 was observed providing a treatment to Resident #42's stage three pressure injury to the right trochanter. -LPN #2 removed the treatment dressing and a small amount of light yellow purulent (pus) drainage was observed on the dressing. The wound edges appeared pink and the wound bed was difficult to visualize due to residual slough and drainage in the wound. -The measurements were: 0.5 cm length x 0.3 cm width x 0.1 cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	IV. Staff interviews LPN #4 was interviewed on 10/17/22 at 1:30 p.m. LPN #4 said Resident #42 had a pressure ulcer to the right hip that was being monitored daily. LPN #2 said Resident #42 was a high risk for developing pressure injuries and should be repositioned every two hours. When a new wound was identified, the registered nurse (RN) should be notified to perform an assessment and physician to obtain treatment orders. The director of nursing (DON) was interviewed on 10/17/22 at 7:00 p.m. The DON said that skin observations should be conducted every day during ADL care. She said any indication of skin breakdown should be reported to the nurse and an assessment should be completed. She said the physician should notify the physician to obtain a treatment order as soon as a wound was identified. She said she and the unit manager observed all wounds in the facility with the wound physician every Tuesday. She said the wound physician would assess the wound, provide treatments and document any changes to the treatment orders. The DON said any skin breakdown observed should be reported to the physician and a treatment should be put in place immediately. The DON said Resident #42 required assistance from staff for bed mobility and repositioning. She said repositioning should be provided or offered to Resident #42 approximately every two to three hours. She acknowledged the MAR and TAR did not reveal a treatment had been put into place until 9/26/22, 13 days after the nurse documented the wound to the right hip.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43135 Based on observation, resident and staff interviews, and record review, the facility failed to ensure two (#18 and #42) of six residents reviewed with limited mobility reviewed for range of motion (ROM) received appropriate services, equipment, and assistance to maintain maximal mobility and services to prevent further decrease in ROM, out of 40 sample residents reviewed. Specifically, the facility failed to provide: -Resident #18 contracture management services to maintain or prevent decline to his range of motion for contractures in his left elbow, left wrist, and left hand. He was not being offered or provided items for his left hand for his contracture. (carrots or rolled towel). He had not been evaluated for contracture devices since 2020. -Resident #42 had contracture management services for contractures to his right upper extremity. Findings include: I. Facility policy and procedure The Range of Motion and Exercise policy, revised 10/11/21, was sent via email on 10/19/22 at 11:54 a.m. by the director of nursing (DON). It revealed in pertinent part, The facility will provide Range-of-Motion Exercises in accordance with professional standards of practice as outlined by [NAME] through the procedure. Passive range-of-motion (ROM) exercises refer to movement of a joint through partial or complete range of activity with the assistance of a health care provider. Full ROM involves flexion, extension, abduction, adduction, and rotation of the affected joint. Indications for ROM exercises include patients with temporary or permanent loss of mobility, sensation, or consciousness. These exercises have been shown to improve or maintain joint mobility, strength, and endurance and prepare the patient for ambulation. When included as a key component of care, ROM exercises can enhance patient outcomes, improve gas exchange, reduce rates of ventilator-associated pneumonia, shorten the duration of mechanical ventilation, reduce the risk of contractures and enhance long-term functional ability. II. Resident #18 A. Resident status (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #18, age 75, was admitted on [DATE] and readmitted on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included cerebral infarction affecting the left non-dominant side (stroke), vascular dementia with behavioral disturbance, acute respiratory failure with hypoxia (not enough oxygen in the blood), stage three chronic kidney disease, gastro-esophageal reflux disease (GERD), legal blindness, depression, anxiety disorder, contracture of the left elbow, left wrist, left hand, and contracture of the right and left knee. The 7/27/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required extensive assistance with bed mobility, transfers, locomotion on and off the unit, dressing, eating, toilet use and personal hygiene. He required total dependence on staff for bathing. The resident did not reject care from staff. A seven day look back revealed the resident did not receive physical therapy, occupational therapy, and was not on a program with restorative nursing. -According to the director of nursing (DON) he had not received a restorative nursing evaluation since 2020, see interview below. B. Observations and interview On 10/10/22 at 3:52 p.m. Resident #18 was observed lying in bed, he used his right hand to hold his left wrist and hand next to his chest. He was not wearing any hand or elbow contracture devices. Resident #18 said he had terrible contractures in his left hand and left wrist. He said sometimes he put a rolled up tissue in his left hand to help make my contracture not hurt. He said his contractures did not get any better over time. He said the staff did not give or offer him anything to put in his hand or for his wrist. He said he had never heard of any device that was soft to put in his hand. He said sometimes he rolled up a corner of a blanket to hold in his palm to avoid his hand feeling bad. He said he would not refuse any items for his contractures if the staff provided something for him. On 10/11/22 at 10:00 a.m. Resident #18 was lying on his bed sleeping. His right hand held his left wrist close to his chest. His left hand was holding the corner material of his beige blanket. On 10/12/22 at 9:19 a.m. Resident #18 was lying on his bed. His left hand was bent over and his fingertips almost touched his left wrist. He did not have any contracture devices on his left hand. Resident #18 said sometimes his wrist and hand hurt, and sometimes it did not. He said he could push his soft beige blanket into his left palm to relieve any pressure he felt at times. At 3:36 p.m. the resident was in his wheelchair in his room. His right hand cradled his left wrist and hand to his chest. He did not have any contracture devices in his left hand. On 10/13/22 at 8:30 a.m. the resident was in his wheelchair in the dining room. He had his arms crossed across his chest with his right hand holding his left wrist while a staff member assisted him with eating. He did not have any devices for contractures in his left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/17/22 at 11:00 a.m. Resident #18 was lying on his bed. His right wrist was holding his left wrist and left hand close to his chest. He did not have any contracture devices in his left hand. C. Record review The 10/2/18 comprehensive care plan, revised on 10/5/22, revealed the resident had limited physical mobility with contractures. He had contractures to his bilateral knees, left hand, left elbow and left wrist that were all present upon his admission. The goal was he would remain free of complications related to immobility through the next review date. The intervention was to cleanse his inner left hand contracture with soap and water, and dry completely daily. His multiple contractures to his wrist was one of the reasons he was a fall risk. -There were no current nursing or therapy notes which regarded that the resident was evaluated to maintain or prevent further worsening of his contractures. C. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 10/17/22 at 8:30 a.m. She said Resident #18 always used his right hand to hold his bent over left hand and held it close to his body. She said he did not wear a brace, or a sling, or anything in his hand. The director of rehab (DOR) was interviewed on 10/17/22 at 5:15 p.m. She said the last contracture evaluation Resident #18 had been in 2020. She said she remembered Resident #18 refused to wear any splinting. She said he had been on restorative before but when a resident refused help from restorative three times, they would be dropped from the program. She said we could offer him contracture management and restorative services for range of motion (ROM) exercises. She said every resident was reviewed for contractures every three months which included a staff member looking visually at their contracture. She said she had a spreadsheet that listed the residents in the facility who had contractures. She said it was important to have preventative measures in place so that contractures did not worsen. She said the facility needed to do better on his daily plan of care. She said she did not know if Resident #18 ' s contracture had worsened since his last evaluation which was a few years ago. She said she would look in the medical records to see if since 2020 any preventative measures for contractures and interventions were put in place for Resident #18. She said if she found pertinent information she would send it via email. -No follow-up email was sent regarding Resident #18 ' s contractures or interventions. The director of nursing (DON) was interviewed on 10/17/22 at 5:26 p.m. She said she was responsible for restorative nursing. She said she assigned a nurse to the program and the facility had only one restorative certified nurse aide (RCNA). She said the RCNA a few times a week was taken off of her restorative work to be a certified nurse aide (CNA) on the floor to help out when there was a staffing need. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said Resident #18 was encouraged to attend the activity departments exercise program. She said she did not know how often he attended an exercise program. She said he was evaluated for transfers in 2021. She said there were no preventative measures for his contractures indicated in his care plan. She said she knew a few years ago he did a restorative program but then refused. She said she did not know how long ago it was since he had been offered again to have a restorative program. She said the facility could offer him devices to help his contractures. She said she did not have any documentation that he was offered any measures for his left wrist and hand in the last six months. Licensed practical nurse (LPN) #1 was interviewed on 10/17/22 at 5:30 p.m. She said she was responsible for restorative nursing with the DON. She said the facility had one RCNA for the entire building who sometimes was required to work on the floor and did not perform restorative duties. She said she was aware Resident #18 had left wrist and left hand contractures and that he did not have any devices for his hands. She said she would help get him evaluated for devices right away. D. Facility follow-up On 10/19/22 at 5:29 p.m. director of rehab (DOR) emailed a occupational therapy evaluation and plan of treatment on 10/18/22 (after survey) for Resident #18. 46851 III. Resident #42 A. Resident status Resident #42, age 72, was admitted on [DATE]. According to the October 2022 CPO, the resident's diagnoses included hemiplegia and hemiparesis (paralysis) affecting right dominant side, unspecified dementia with behavioral disturbances, contracture of muscle of left ankle and foot, contracture of right shoulder, right elbow and right hand. According to the 8/16/22 MDS assessment, the resident had short-term and long-term memory impairment with severe impairment in making decisions about tasks of daily life. He required extensive assistance of one person with bed mobility, transfers, dressing, toileting and personal hygiene. The resident received restorative therapy. B. Observations On 10/12/22 at 2:06 p.m. Resident #42 was observed in his room. The resident ' s fingers were touching his palms and his wrist on his right hand and his arms were on his chest. He was lying supine (on his back). The resident did not have a splint of preventative measures in place for his contractures. -At 3:18 p.m. Resident #42 was laying in the same position. He did not have any preventative measures in place for his contractures. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/13/22 at 8:30 a.m. Resident #42 was observed sitting in the day room in his Broda chair, in front of the television. The resident did not have any preventative measures in place for his contractures. -At 9:45 a.m. certified nurse aide (CNA) #4 brought a blanket and put it on the residents feet. She did not offer the resident any preventative measures for his contracture. -At 1:17 p.m. the resident was observed in his room, lying supine in the bed. The resident did not have any preventative measures in place for his contractures. C. Record review The limited range of motion care plan, initiated 8/23/22, revealed that the resident had contractures to the right wrist, right elbow, right shoulder, right hand and left ankle. The interventions included observing and reporting any signs of immobility, contractures forming or worsening, thrombus formation or skin-breakdown; providing supportive care and assistance with mobility as needed; and providing active and passive range of motion. It indicated the resident required total assistance for passive stretching of the bilateral ankles. The October 2022 CPO documented a restorative nursing range of motion program for the resident. -However, it did not include any instructions regarding which areas, how many days per week or minutes during each session. According to the October 2022 restorative nursing range of motion program documentation the resident participated in total assistance of the bilateral left ankle on six out of 14 occasions. -It did not indicate if any other range of motion was provided for the resident ' s other contractions. D. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 10/17/22 at 1:30 p.m. She said the nurses or CNAs provided active range of motion (ROM) with Resident #42. She said the ROM was not documented in the resident ' s medical record. She said the facility staff communicated verbally that the ROM was completed for the resident. The director of rehabilitation (DOR) was interviewed on 10/17/22 at 5:15 p.m She said the facility offered daily restorative therapy for residents with contractions. She said that only the restorative nurse performed range of motion on the resident under the restorative program plan. She said Resident #42 had a brace but threw it last time he was at therapy and it was still in the therapy room. She said they have tried a rolled up towel in the past and he refused. -However, the DOR was unable to provide documentation of the resident's refusal of the splints and preventative measures such as the rolled towel during and after the survey process.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observations, interviews, and record review, the facility failed to ensure one (#36) of four residents reviewed for nutrition out of 40 sample residents received the care and services necessary to meet their nutritional needs to maintain their highest level of physical well being. Resident #36 was admitted on [DATE] with diagnoses including depression, congestive heart failure, and hypertension. Dietary interventions included snacks in the evening, two proteins during meals, 2% milk served with meals, and fortified foods when possible. Since admission on 2/10/22 it was documented that Resident #36 was losing weight with variable meal intakes. A nutritional supplement was added on 3/23/22 and discontinued on 4/28/22 due to the resident's preference. The resident continued to lose weight and on 6/16/22 other interventions were put in place including additional proteins at meals, 2% milk served with meals, and fortified foods when possible. The 8/15/22 quarterly nutrition assessment documented that the resident had a significant weight loss of 15. 8% over the past 180 days (since admission) and this was an unplanned weight change. No additional interventions were put into place. On 8/20/22 orders were placed for the resident to not be weighed for comfort. Meal intakes continued to be variable, interviews and observations during the survey indicated the resident said she did not like the food served and was not provided with milk (cross-reference F803 for menus). The care plan did not include nutritional interventions and just addressed weight fluctuations despite the resident's significant weight loss. Findings include: I. Facility policy The Hydration and Nutrition policy, revised 7/14/21, was provided by the director of nursing (DON) on 10/18/22 at 3:33 p.m. It read, in pertinent part, Adequate nutrition and hydration are essential for overall function. Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status. A minimum of three meals are provided each day. If a meal or particular food is refused, the resident is offered a substitute of a similar nutritive value. Snacks are given between meals and at bedtime according to the resident desire and/or need. An ongoing assessment of the ability to consume and assimilate food and fluid is conducted by nursing personnel and all concerns are reported to the nurse. II. Resident status Resident #36, age 86, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included depression, congestive heart failure, and hypertension. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The 8/15/22 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. It indicated the resident required set up assistance for eating. It indicated the resident did not have difficulty swallowing. It indicated the resident had weight loss and was not on a physician prescribed weight loss regimen. The section related to dental status was incomplete. III. Resident interview Resident #36 was interviewed on 10/11/22 at 10:20 a.m. She said the food at the facility was not good. She said she had complained about the food to the staff but she was unsure who and they did not do anything. She said she did not try to get a different meal if she did not like what was served. She said she was independent with eating and preferred to eat in her room. She said she had lost about 25 pounds since admission and was not on any supplemental nutrition. She said she usually ate about 50% of her meals. Resident #36 was interviewed again on 10/12/22 at 1:00 p.m. She said she ordered a cobb salad for lunch and it was good. The resident had eaten 50% of her salad and no milk was on her tray. The resident had two drinks. Resident #36 was interviewed again on 10/13/22 at 9:05 a.m. She said breakfast was good that morning and she had eaten about 50%. She said no milk was served with breakfast but she did not like milk. The resident had eaten 50% of her breakfast and no milk was on her tray. IV. Record review Weights since admission revealed the following: -On 2/10/22 the resident weighed 173.4 pounds; -On 2/12/22 the resident weighed 173.6 pounds; -On 2/13/22 the resident weighed 173.3 pounds; -On 2/18/22 the resident weighed 170.0 pounds; -On 2/24/22 the resident weighed 168.7 pounds; -On 3/4/22 the resident weighed 165.1 pounds; -On 3/15/22 the resident weighed 162.4 pounds; -On 3/26/22 the resident weighed 159.8 pounds; -On 4/3/22 the resident weighed 160.1 pounds; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-On 5/1/22 the resident weighed 157.1 pounds; -On 6/6/22 the resident weighed 156.8 pounds; -On 6/12/22 the resident weighed 155.1 pounds; -On 6/26/22 the resident weighed 155.1 pounds; -On 7/1/22 the resident weighed 155.6 pounds; -On 7/25/22 the resident weighed 151.7 pounds; -On 8/1/22 the resident weighed 149.8 pounds, a 23.6 pound weight loss over six months, which was 13.6%. The nutrition care plan, revised 6/1/22, indicated Resident #36 was at risk for weight fluctuations related to current health status. Interventions included assistance with meals as needed, education with resident and family on storage and preparation of outside food, education with resident and family on potential weight fluctuations, and encouraging and providing diet order. -No interventions or food preferences were included in the care plan until 10/13/22 (during survey). The updated nutrition care plan, initiated 10/13/22 (during the survey), indicated Resident #36 was at risk for poor nutrition related to being a selective eater, history of weight loss, and declining nutritional interventions. Interventions included encouraging fluids between meals, offering choices and honoring preferences, offering snacks in between meals, and providing tray set up. The October 2022 CPO revealed the following: -Evening snack at bedtime for nutrition support and document percentage consumed, ordered 7/27/22; and, -Resident on palliative care, do not weigh for quality of life, ordered 8/20/22. The initial nutritional assessment was completed on 2/14/22. It indicated Resident #36 was on a regular diet with regular texture and thin liquids. It indicated the resident was not on nutritional supplements. It indicated the resident's intake for breakfast and lunch was 76-100% and dinner was 51-75%. It indicated the resident had her own teeth, had no difficulty swallowing, and required set up assistance with meals. It indicated the resident's current intake was meeting their estimated protein and caloric needs. It indicated no nutritional diagnosis and interventions related to nutrition included encouragement and fluids in between meals. The 3/9/22 a nutrition progress note indicated Resident #36 had a 3% weight loss over three weeks and 2Cal Med Pass two times a day was ordered as a supplement. The 4/28/22 a nutrition progress note indicated Resident #36 did not like the 2Cal Med Pass and the order was discontinued. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-However, there were no other nutritional supplements offered to the resident or her dietary preferences obtained when she had 3% weight loss. The 5/5/22 a nutrition progress note indicated Resident #36 had a 5% weight loss over ten weeks. It indicated weight continued to trend downward with variable intakes of 25-75%. It indicated no nutritional interventions. The quarterly nutritional assessment was completed on 5/19/22. It indicated Resident #36 continued on a regular diet with regular texture and thin liquids. It indicated no significant weight loss and intakes ranged from 25-100%. It indicated the resident's protein and caloric needs were not being met. It indicated no nutritional interventions were in place due to the resident's dislike for oral nutrition supplements. The 6/16/22 nutrition progress note indicated Resident #36 had weight fluctuations and was down 5% over 12 weeks. It indicated two protein items and 8 ounces 2% milk were added to the tray card. The 6/24/22 a nutrition progress note indicated Resident #36 verbalized she did not want to eat because nothing sounded or looked good to her. It indicated Resident #36 did not like oral nutrition supplements and was not willing to try. It indicated the resident was agreeable to have two protein items and 8 ounces of milk at meals. The 7/28/22 a nutrition progress note indicated Resident #36 had 10% weight loss over 21 weeks. It indicated the addition of an evening snack as a supplement. The quarterly nutritional assessment was completed on 8/15/22. It indicated Resident #36 continued on a regular diet with regular texture and thin liquids. It indicated the resident's weight at admission was 173.4 pounds and current weight was 149.8 pounds. It indicated the resident had a significant weight loss of 15.8% decrease over the past 180 days and this was not a planned weight change. The assessment indicated two protein items, 2% milk, and fortified foods, if possible, would be served at all meals. It indicated an evening snack was initiated as a supplement. The summary of the assessment indicated no change in nutrition intervention and indicated the resident did not like oral nutrition supplements. The 8/15/22 nutrition progress note indicated Resident #36 refused to be weighed. It indicated the resident was on palliative care. It indicated the family was to bring in outside fast food and snacks to increase oral intake. The 9/15/22 physician progress note indicated Resident #36 was seen due to concerns for weight loss. It noted the resident had lost 24 pounds since admission and a hospice consultation was discussed with the resident and family. The 9/22/22 physician progress note indicated the resident was not eligible for hospice. It indicated the resident reported decreased appetite. The meal intake records from 9/18/22 to 10/17/22 indicated the resident's intake was variable and typically between 25-75%. -A request was made for meal percentage intakes since admission but these were not provided. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The snack intakes from the medication administration record were reviewed from 7/27/22-10/17/22 and indicated minimal snack intake. July and August 2022 had 0% intake of snacks documented. The September 2022 intake had ten days of 100% intake and two days of 20-25% documented. The October 2022 intake had one day of 100% documented. An order for 2Cal Med Pass twice a day was initiated on 3/23/22 and discontinued on 4/28/22. The medication administration record indicated minimal intake of this supplement with the majority of intake documented as 0%. V. Interviews The registered dietitian consultant (RDC) and licensed practical nurse (LPN) #1 were interviewed on 10/13/22 at 3:27 p.m. The RDC said Resident #36 had weight loss prior to the do not weigh order. She said the do not weigh order was in place for comfort and the family preferred it. She said the resident did not take any nutritional supplements. She said the resident was able to choose her preferred meals and frequently ordered a salad or her family would often bring in food. She said the resident consumed more when family was present. She said the dietary staff could fortify foods such as sauce or gravy and it would be given depending on what the resident ordered and what was on the meal service line. She said the weight loss was expected. She said the resident did not have weight loss interventions because the resident declined the interventions. She said interventions should be included in the care plan such as food preferences, snacks, assessment of chewing and swallowing as needed, and accepting food and fluids as described. She said the resident's care plan should have more interventions than it currently had due to the resident's health status. She said it was expected the resident's weight would decline due to the lack of interventions and the resident not being willing to accept interventions. -However, the interventions were not routinely offered, her dietary preferences were not obtained nor were her complaints addressed regarding the food. LPN #1 said snacks were available to the resident but she did not typically eat them. LPN #1 said the resident did not eat more if staff was present. She said the resident did not complain of the food taste or texture and she could order whatever she wanted. She said her intake was usually 50%. Registered nurse (RN) #1 was interviewed on 10/17/22 at 1:34 p.m. She said Resident #36 ate about 50% of her food during meals. She said the resident did not ask for a different entree if she did not like what was served since she ordered her meals. She said she had not heard the resident complain about the taste or texture of the food. Certified nurse aide (CNA) #2 was interviewed on 10/17/22 at 3:11 p.m. She said the CNAs took the residents' orders before meals to determine if they wanted the main entree or something from the alternative menu. She said snacks were available to the residents but they were only given if the resident requested it. She said the snacks available were string cheese, yogurt, or a peanut butter and jelly sandwich. She was unsure if Resident #36 ever requested a snack. The DON was interviewed on 10/17/22 at 6:56 p.m. She said she was part of resident at risk meetings as well as interdisciplinary team meetings. She said these meetings were weekly. She said the facility's registered dietitian was out on medical leave and the RDC was filling in as needed but was not attending the weekly meetings. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46851 Based on observations, record review and interviews, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice for two (#71 and #39) out of two residents reviewed for respiratory care out of 40 sample residents. Specifically, the facility failed to: -Ensure Resident #71 had a physician's order in place for oxygen therapy; and, -Ensure oxygen was administered according to physician orders for Resident #39. Findings include: I. Resident #71 A. Resident status Resident #71, age [AGE] years old, was admitted on [DATE]. According to October 2022 computerized physician's orders (CPO), diagnoses included chronic obstructive pulmonary disease, chronic respiratory failure, and chronic atrial fibrillation. The 9/16/22 minimum data set (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 one person with bed mobility, toileting and personal hygiene and supervision with transfers. It indicated the resident was not receiving oxygen therapy. B. Observations On 10/12/22, at 9:15 a.m. and at 3:16 p.m., Resident #71 was observed using oxygen at 4 liters. On 10/13/22, at 9:00 a.m. and at 12:20 p.m., Resident #71 was observed using oxygen at 4 liters. C. Record review The respiratory care plan, initiated on 8/15/22, documented the resident required oxygen therapy at 4 LPM (liters per minute). -A review of Resident #72's electronic medical record on 10/12/22 did not reveal a physician's order for the resident to receive oxygen therapy. II. Resident #39 A. Resident status (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #39, age [AGE] years old, was admitted on [DATE]. According to October 2022 CPO, diagnoses included acute respiratory failure. The 8/12/22 MDS assessment revealed he had moderate cognitive impaired with a brief interview of mental status score of eight out of 15. He required two person assistance for bed mobility, transfers, and dressing and one person assistance with toileting and personal hygiene. It indicated the resident was receiving oxygen therapy. B. Observations On 10/12/22, at 10:07 a.m. and 1:00 p.m., 10/13/22 at 8:35 a.m. and 10/17/22 at 9:48 a.m., Resident #39 was observed with oxygen on and set at 3 LPM. C. Record review According to the October 2022 CPO, Resident #39 had an order for continuous oxygen at 1 LPM, ordered on 10/10/22. The respiratory care plan, initiated on 8/15/22, documented that Resident #39 was receiving oxygen therapy continuously at 1 LPM. III. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 10/17/22 at 1:30 p.m. She said Resident #39 had a physician's order that documented he should receive continuous oxygen at 1 LPM. She confirmed Resident #39 was currently receiving 3 LPM, instead of the ordered 1 LPM. LPN #3 was interviewed on 10/17/22 at 2 p.m. She said Resident #71 did not have a physician's order to receive oxygen therapy. She confirmed the resident was currently receiving 4 LPM of continuous oxygen. She said oxygen therapy required a physician's order. The director of nursing was interviewed on 10/17/22 at 7:00 p.m. She said oxygen therapy required a physician's order. She said the physician's order should be followed and the resident should not be placed on different LPM unless the physician had been contacted and given the order for the change. She confirmed Resident #71 did not have a physician's order for oxygen therapy until during the survey process (10/17/22).

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and interviews, the facility failed to ensure one (#13) of five out of 40 sample residents were free from unnecessary drugs as possible. Specifically, the facility failed to ensure a pharmacy recommendation was followed up on for Resident #13. Findings include: I. Facility policy and procedure The Unnecessary Medication policy and procedure, reviewed on 5/10/22, was provided by the nursing home administrator (NHA) on 10/19/22 at 11:27 a.m. It revealed, in pertinent part, Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug used without adequate monitoring or in the presence of adverse consequences which indicate the dose should be decreased or discontinued. II. Resident #13 A. Resident status Resident #13, age 67, admitted on [DATE]. According to the October 2022 computer physician orders (CPO), the diagnoses included left below the knee amputation, memory deficit following cerebral infarction, type II diabetes mellitus, heart failure, chronic kidney disease, major depressive disorder, anxiety, chronic, pulmonary emboli, pulmonary hypertension and morbid obesity. The 7/26/22 minimum data set (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 and transfers and extensive assistance of one person with dressing, toileting and personal hygiene. B. Record review The 9/30/22 pharmacy consultation report documented due to resident's moderate to high risk of fall due to muscle weakness and dementia, the pharmacist made the following recommendations: -Cetirizine (antihistamine) medication be discontinued; and -Atorvastatin (cholesterol medication) dosage decreased. It did not indicate the physician had reviewed or responded to the pharmacist's recommendations. The October 2022 CPO, reviewed on 10/17/22, documented the following physician orders: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cetirizine 10 mg every 24 hours as needed-ordered on 1/25/22. -Atorvastatin 20 mg by mouth at bedtime-ordered on 1/25/22. The Cetirizine medication had not been discontinued and the Atorvastatin had not been reduced. III. Staff interviews The director of nursing (DON) was interviewed on 10/17/22 at 6:50 p.m. She said the pharmacist audited residents' medications monthly. She said the pharmacist recommendations were given to the unit manager and the unit manager was responsible to follow up with the physician. She said the unit manager was responsible to follow up with the physician to ensure he had reviewed the recommendation, documented his approval and disapproval of the recommendation and ensured the medications were changed when appropriate. She confirmed the pharmacy recommendation for Resident #13 had not been followed up on with the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47350 Based on observation and interview, the facility failed to ensure all drugs and biologicals used in the facility were properly stored and labeled in one out of three medication carts. Specifically, the facility failed to ensure medications were labeled with open dates. Findings include: I. Professional reference A. According to the Centers for Disease Control Injection Safety for Multi-Dose Vials, last updated on June 20, 2019 retrieved from https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html retrieved on 10/20/22 included the following recommendations, If a multi-dose vial has been accessed (e.g. needle punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different date for that unopened vial. B. According to Symbicort manufacturer guidelines, last updated on May 2021 retrieved from https://www.mysymbicort.com/copd/taking-symbicort.html retrieved on 10/21/22 included the following recommendations, Discard inhaler when the arrow points to the red zone and reads (0) or three months after taken out of the pouch, whichever comes first. C. According to Spiriva manufacturer guidelines, last updated on 11/21 retrieved from https://content.boehringer-ingelheim.com/DAM/68a8a6b5-4e9a-4508-85d3-af1e01205009/spiriva%20respimat-us-pi.pdf on 10/27/22 included the following recommendations, Discard Spiriva Respimat inhaler 3 months after inserting the Spiriva Respimat inhaler even if it contains some unused medicine or when the inhaler is locked (after 60 puffs), whichever comes first. II. Observations On 10/17/22 at 2:30 p.m., with licensed practical nurse (LPN) #4, the west side unit medication cart #1 was observed with the following: -Two eye drop containers were not labeled with open dates or the resident names; -One Spiriva inhaler and one Symbicort inhaler was not labeled with an open date or the resident's name; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-One tube of antibiotic ointment was not labeled with an open date; -One vial of Humalog insulin was not labeled with an open date; -One Lantus insulin pen was not labeled with an open date; and, -One Glargine insulin pen was not labeled with an open date. III. Staff interviews LPN #4 was interviewed on 10/17/22 at 2:30 p.m. LPN #4 said she did not know if the eye drops, antibiotic ointment or inhalers required open dates. She also said the insulin pens were required to be labeled with an open date. She said she was unsure if the vial of insulin needed to be labeled with an open date. The director of nursing (DON) was interviewed on 10/17/22 at 6:25 p.m. She said insulin pens and vials should be labeled with an open date because depending on the type of insulin, they had a shelf life once opened. She said inhalers and eye drops should be labeled with the resident's name and the open date.

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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. 43135 Based on observations, record review, and interviews the facility failed to ensure menus were followed to meet the residents' nutritional needs on two of two units. Specifically, the facility failed to follow the menu. Menu items were omitted without substitutions being made of the same nutritional value. Findings include: I. Facility policy and procedure The Menu, Substitution, and Alternative policy and procedure, 4/15/22, was sent via email on 10/18/22 at 3:34 p.m. by the director of nursing (DON). It revealed in pertinent part, Menus are planned in advance and are followed as written in order to meet the nutritional needs of the residents in accordance with established national guidelines. Residents with known dislikes of food and beverage items, who express a refusal of the food served or request a different meal choice are offered a substitute of similar nutritive value. Menus are reviewed for nutritional adequacy, approved and signed by the Registered Dietitian prior to beginning a new cycle. The Director of Food and Nutrition Services signs and dates the menus as used. Menus are served as written, unless changed due to an unpopular item on the menu, an item that could not be procured or a special meal. The Director of Food and Nutrition Services/Registered Dietitian documents the substitution on the extended menu and the Menu Substitution Record. Only the Director of Food and Nutrition Services, designee or the Registered Dietitian substitute menu items. Menus meet the nutritional needs of residents in accordance with established national guidelines. The Director of Food and Nutrition Services or Registered Dietitian ensures a planned menu alternate that is nutritionally equivalent is available on the menu. Each resident's preferences are followed to the extent nutritionally and medically desirable in order to promote food acceptance. II. Record review The facility's menus and nutritive values for week one and two were provided by the dietary manager (DM) on 10/10/22 at 12:46 p.m. The weekly menu cycle was Sunday through Saturday. Each breakfast menu included a beverage of choice and milk. Each dinner menu included a beverage of choice and milk. -Week one had milk listed on the menu calendar for every breakfast and dinner. -Week two had milk listed on the menu calendar for every breakfast and dinner. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Milk was documented to be eight ounces for a regular diet, four ounces of whole milk for liberal renal diet, and skim milk for cardiac diets. III. Observations and interviews On 10/12/22 at 5:10 p.m.-5:30 p.m. in the dining room residents were not offered milk which was on the dinner menu. The dietary cook (DC) was interviewed on 10/12/22 at 5:12 p.m. The DC said if residents wanted milk they could have it but the resident must ask for it. She said the kitchen did not offer milk substitutes like cheese sticks or cottage cheese with the meals. The following residents were interviewed on 10/12/22 between 5:15-5:30 p.m. during the dinner meal in the dining room about being offered milk. Resident #7 said They do not offer me milk and I do not ask for it. I have two sodas. Resident #21 said I did not ask for milk. The staff did not offer me a substitute like cheese sticks or yogurt. Resident #193 said I am not offered milk with meals and I do not ask for it. Resident #57 said I only get water. I am not offered milk with meals. I would take a glass of milk if they offered whole milk but they only serve 2% milk. On 10/13/22 between 8:20 a.m.-8:25 a.m. the following residents were interviewed who receive room trays with meals in their rooms. Resident #13 said It says milk on the menu but I drink two sodas at night. The staff have never offered me a cheese stick of cottage cheese as a substitute. I don ' t think they do that here. Resident #76 said We do not get milk or substitutes offered with our meals. Observations on 10/13/22 at 8:05 a.m. during the breakfast meal in the dining room revealed the residents were not served or offered milk. IV. Staff interviews The dietary manager (DM) was interviewed on 10/17/22 at 9:25 a.m. She said everything that was on the menu should be served with each meal. She said if residents did not like milk when it was on the menu they could have cottage cheese or a cheese stick instead. She said she was unaware alternatives to milk were not being offered with the meals. She said she did not know if milk was on the menu for protein or dairy needs. She said she was unaware some residents were drinking only soda and not being offered milk. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The registered dietitian consultant (RDC) was interviewed on 10/17/22 at 2:23 p.m. She said the facility did not need to offer a dairy substitute because the staff knew their residents. She said she would not offer other vegetables if a resident refused. She said she did not agree that if milk was on the menu other dairy items should be offered. She said the milk was on the menu for dairy needs. She provided the facility a la carte menu which revealed yogurt, cottage cheese, pudding and ice cream were available. The facility had the items in the kitchen but they were not offered for substitutes with meals which had milk on the menu. V. Facility follow-up On 10/18/22 at 1:01 p.m. the RD emailed additional information concerning milk being offered. She wrote the company spent $3,493.00 on milk products. She wrote concerning the dietary staff that they know the residents very well, including those who will or will not accept milk or a dairy equivalent. She wrote the regulation did not construe to limit the resident's right to make personal dietary choices. The facility failed to offer milk or offer any milk substitutes when milk was on the menu two times per day. How much the facility spent on dairy products was not the observation or an indication of offers. The information provided that the dietary staff knew each resident making them qualified to not offer milk or a milk substitute was not the observation. Also limiting the resident's right to make personal dietary choices was not the observation but rather being offered and then the resident could make personal dietary choice was the observation.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations and interviews, the facility failed to ensure beverages were provided and within reach for the resident for two (#58 and #41) of two residents reviewed for hydration out of 40 sample residents. Specifically, the facility failed to: -Ensure Resident #58 had access to a sufficient amount of water throughout the day; and, -Ensure Resident #41's water pitcher was within reach. Findings include: I. Facility policy The Hydration and Nutrition policy and procedure, revised on 7/14/21, was provided by the nursing home administrator (NHA) on 10/19/22 at 11:27 a.m. It revealed in pertinent part,The resident is offered sufficient fluid intake to maintain proper hydration and health. Fluid is available to residents at all times. A hydration cart may be utilized. II. Resident #58 A. Resident status Resident #58, age 73, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO) the diagnoses included hypokalemia (low blood potassium), paraplegia (paralysis) and dysphagia (swallowing difficulty). The 9/7/22 minimum data set (MDS) revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of one person for dressing and personal hygiene.She required extensive assistance of two people for bed mobility, transfers and toileting. B. Resident interview and observations Resident #58 was interviewed on 10/11/22 at 10:12 a.m. She said that the small cup she was given by the facility staff did not hold enough water for her. She said she would like a larger glass. She said she had a hard time holding the water pitcher, so the facility had given her a small cup instead. She said she drinks the small cup quickly. She said the staff filled her cup only when she called them. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She did not have any water or other beverages within her reach. During a continuous observation on 10/12/22, beginning at 9:25 a.m. and ended at 2:30 p.m., Resident #58 was observed lying in her bed. The resident did not have any water on the bedside table or in her room. -At 12:10 p.m. the door was open and a lunch tray was set up in front of the resident. There was a coffee cup observed on the meal tray. -At 2:30 p.m. an unidentified certified nursing aide (CNA) entered Resident #58's room and offered the resident ice and water. She filled a small, 4 oz (ounce) clear cup less than halfway with water. On 10/13/22 at 9:12 a.m. Resident #58 was observed with a small, 4 oz clear cup filled a quarter of the way with water. III. Resident #41 A. Resident status Resident #41, age 93, was admitted on [DATE]. According to the October 2022 CPO, the diagnoses included atrial fibrillation and end stage renal failure. The 8/15/22 minimum data set (MDS) revealed that the resident had severe cognitive impairment with brief interview for mental score of six out of 15. She required extensive assistance with one assist for bed mobility, transfers, dressing, toileting and personal hygiene. B. Observations On 10/10/22 at 10:12 a.m., Resident #41 was observed lying in bed. The resident's water pitcher was sitting on top of the heating/cooling unit across the room and not within reach of the resident. On 10/12/22 at 2:30 p.m. Resident #41 was observed lying in bed. The bedside table was observed across the room from the resident's bed with two coffee cups and a water pitcher. It was not within reach of the resident. On 10/13/22 at 9:50 a.m. Resident #41 was observed lying in bed, asleep.The resident's bedside table, with the water pitcher, was against the wall on the opposite side of the room. -At 10:45 a.m. an unidentified CNA entered the resident's room and refilled the water pitcher. After she filled the water pitcher, she did not move the water pitcher within reach of the resident. It remained on the opposite side of the room. IV. Staff interviews CNA #5 was interviewed on 10/17/22 at 2:40 p.m. She said an ice chest was used to fill residents' water pitchers. She said the CNAs tried to pass water one to two times per shift. She said the water pitcher should be placed within reach of the resident. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #5 said that Resident #58 can have a water pitcher but she usually wanted the clear cup or a cup with a handle. She said the resident preferred to have her beverages in a sippy cup. Licensed practical nurse (LPN) #6 was interviewed on 10/17/22 at 2:35 p.m. She said Resident #58 preferred the smaller clear cups used when passing medications for water. She said the water pitchers were too heavy for the resident to handle. She said the resident was able to ask the facility staff to refill her water cup. LPN #6 said that Resident #41 was able to verbalize some needs, but the nursing staff needed to anticipate the resident's needs. LPN #6 said the resident was alert enough to say no thank you. She said Resident #41 was not able to get up on her own. She said Resident #41 would only be able to get to the water pitcher across the room if she was in her wheelchair. The director of nursing (DON) was interviewed on 10/17/22 at 6:50 p.m. She said ice water was offered at the request of the resident and at least once per shift for all three shifts. She said it was a personal preference whether a resident has a pitcher or cup. She said the medication cups held approximately 4 oz. She said the water pitchers or cups of water should be placed in reach of the resident. She said Resident #58 could push the call light if she wanted any further water. She confirmed Resident #41 was not able to get out of bed without staff assistance. She said the water pitcher should be within reach of the resident.