STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065243	A. Building B. Wing	11/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Junction Creek Health and Rehabilitation Center	2911 Junction St Durango, CO 81301

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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 0550 Level of Harm - Minimal harm or potential for 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** 45136 Based on interviews and record review, the facility failed to ensure each resident was treated with dignity and respect and cared for in a manner and in an environment that promoted maintenance or enhancement of quality of life for three (#58, #65, #17) of six residents reviewed for dignity out of 34 sample residents. Specifically, the facility failed to ensure Residents #58, #65, and #17 were treated with respect and dignity while receiving care from staff. Findings include: I. Facility policy and procedure A policy for promoting/maintaining resident dignity was provided by the staff development coordinator (SDC) on 11/11/21 at 2:54 p.m. The policy was not dated and read: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. II. Resident #58 A. Resident status Resident #58, age 70, was admitted on [DATE]. According to November 2021 computerized physician orders (CPO), diagnoses included muscle weakness, difficulty walking, type 2 diabetes, depression, anxiety, and chronic pain. The 10/26/21 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #58 did not have any behavioral issues. The resident required setup or cleanup assistance with showers/bathing. B. Resident interview (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 was interviewed on 11/09/21 at 8:58 a.m. He said that there was an incident where the shower certified nurse aide (CNA) did not like how he was washing himself during a shower. He said she took the sponge from him and started scrubbing him down vigorously, being very rough with him in his genital area. He said this was a terrible experience for him and he had not taken a shower since that incident occurred due to not wanting to experience that treatment again. C. Record review A resident complaint form dated 10/17/21 was provided by the nursing home administrator (NHA) on 11/9/21 at 4:56 p.m. It read: Resident voiced concern over an incident with CNA #4 while showering. He felt that CNA #4 rushed, did not give him the time to do things himself, and that overall he felt that CNA #4 treated him in an undignified way. The resident was initially contacted on 10/17/21 by the NHA and her documentation was: Immediate resolution - talked with Resident #58 and let him know that CNA #4 would be given 1:1 education and that the facility would have another CNA provide shower assistance. Director of nursing (DON) to follow up on 10/18/21. The document read that the follow up with the DON occurred on 10/20/21 and documented the following: Followed up with Resident #58 on 10/18/21. The resident does not feel at this time that the incident should be considered abuse and feels that 1:1 education would suffice. Resident #58 encouraged to report any further issues. Resident #58 expresses understanding, no signs or symptoms of psychosocial trauma. The form was not signed by the resident stating that he was satisfied with the resolution. One on one education was provided to CNA #4 on 10/20/21. It read: As with all residents, staff are to treat everyone with respect and dignity at all times. Staff are to slow down and allow residents time to do everything they can for themselves to promote independence. This form was signed by CNA #4 on 10/20/21. CNA #4 had successfully completed the following training: Abuse and neglect in the elder care setting, the nursing assistant: caring for residents with dignity and respect (with video), and the nursing assistant resident rights (with video). The resident had a baseline care plan initiated 10/11/21 and revised 10/29/21 that read in pertinent part: Resident #58 had behaviors related to depression and at times would refuse his showers. It read that the staff should document shower refusal reasons, educate on benefits of proper hygiene, and offer alternative bathing times or days. A bathing/shower task form documented that the resident had not had a shower for the month of October. It documented refusals on 10/12/21, 10/19/21, and 10/26/21. On 10/21/21 it was marked that the resident did not have a shower and the reason was marked as not applicable. There was no documentation of reasons for bathing refusals, education provided, or alternatives offered for Resident #58. D. Staff interviews (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 11/10/21 at 11:35 a.m. She said she had an interview with Resident #58, and asked if he was pleased with the outcome and he said no. He said he wanted CNA #4 to be fired. The DON said when he said that she opened her eyes widely and he retracted his statement and said that he did not think she needed to be fired, but did think that there should be some repercussions for her behavior. The DON told him that the CNA did receive a write-up and 1:1 training. She said Resident #58 said he was ok with the CNA staying in the facility, but did not want her to give him showers anymore. DON said she will tell the bath aide that someone else needed to be showering Resident #58. She said that the resident also had hospice services and nurses came in and bathed him once a week. The DON offered to call and ask the hospice facility if they would come twice weekly, but the resident declined and said once a week was fine. III. Resident #65 A. Resident status Resident #65, age 70, was admitted on [DATE]. According to the November CPO, diagnoses included displaced fracture of the right humerus and right femur, difficulty walking, fibromyalgia, osteoporosis, and acute pain. The 10/31/21 MDS assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 14 out of 15. She required supervision with all activities of daily living (ADL) and was independent with self care and mobility. She had no behavioral issues. B. Resident interview Resident #65 was interviewed on 11/8/21 at 3:26 p.m. She said that she did not feel like she had been treated with dignity and respect from the traveling nurses. Specifically, there was an incident in which a registered nurse (RN) #3 was performing a PCR (polymerase chain reaction) rapid COVID-19 test. Resident #65 said RN #3 was very rough with her and jammed the stick very far up into her nasal cavity. She said she complained of the demeanor of the nurse and RN #3 responded with well apparently I need to learn to do my job since I don't know how and walked out of the room. C. Record review The resident had a baseline care plan initiated 8/7/21 and revised 10/29/21 that read in pertinent part: Resident #65 sometimes exhibited behaviors related to depression and discomfort she was experiencing and frustration of circumstances. During these behaviors the staff should allow the resident time to express her feelings, vent frustrations and concerns, and redirect the resident in an understanding and calm manner. A PHQ-9 (patient health questionnaire) dated on 10/29/21 revealed that Resident #65 had a PHQ-9 score of 15 out of 27, which indicated that the resident had moderately severe depression. A CPO dated 9/7/21 read that the resident should have a daily PCR covid test. A CPO dated 8/7/21 read that the resident was capable of understanding/acting on rights. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #3 had successfully completed the following training: Abuse and neglect in the elder care setting, caring for residents with dignity and respect (with video), and resident rights (with video). D. Staff interviews The DON was interviewed on 11/10/21 at 11:01 a.m. She said that she had not heard of the allegation of mistreatment from RN #3. She said she would follow up with Resident #65. The DON was interviewed again on 11/10/21 at 12:14 p.m. She said that she spoke with Resident #65 and the resident did not feel like it was an abuse situation and just a conflict of personalities between the resident and RN. The DON said she would provide 1:1 education to RN #3 and would try to prevent RN #3 from working with Resident #65 as much as possible. 40467 IV. Resident #17 A. Resident status Resident #17, age 83, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), diagnoses included persistent atrial fibrillation, other specified depressive disorders, mild cognitive impairment, and dementia in other diseases without behavioral disturbances. The 9/6/21 minimum data set (MDS) assessment identified Resident #17's cognition was moderately impaired with a BIMS score of 12 out of 15. She did not exhibit behaviors and had a low severity score of one for the presence of mood problems. According to the MDS, Resident #17 was independent with most of her activities of daily living (ADLs). Resident #17 needed with supervision for bathing. B. Resident interview Resident #17 was interviewed on 11/9/21 at 10:00 a.m. during a group interview. The resident told the group a night nurse was loud, rude and seemed upset with her when Resident #17 asked the nurse questions. Resident #17 said she reported her concern to the receptionist. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17 was interviewed again on 11/10/21 at 8:49 a.m. She said the nurse loudly entered her room in the early morning between 3:00 a.m. and 4:00 a.m. Resident #17 said she wanted to inform the nurse she was not feeling well and wondered if the nurse could suggest anything. She said the nurse remained loud and became rude and hateful in tone. She said the nurse was angry when responding to the resident's questions. The resident said the nurse acted mad when she was trying to tell her she was not feeling good. The resident said she did not want to sound confrontational so she stopped talking. Resident #17 said she could not remember the nurse's name but had worked with her in the past. She said the nurse usually had an apprupt demeanor, but the early morning of 11/8/21, she must have been having a bad night. Resident #17 said her feelings were hurt in the manner she was spoken to. She said the nurse established she was not for me and did not want to deal with me. The resident clarified she felt a lack of support from the nurse. The resident said she did not want to work with the nurse if the nurse continued to behave in the same way; however was concerned the facility would not have someone to replace her. C. Staff interview The director of nurses (DON) was interviewed on 11/11/21 at 9:48 a.m. The DON said she was aware of Resident #17's concerns and identified the nurse as licensed practical nurse (LPN) #3. The DON said she had not spoken to LPN #3 but there was a nurse note regarding the interaction between Resident #17 and LPN #3. The DON said the resident said she had blood in her stool. The LPN discussed potential hemorrhoids and requested to look at the area. The DON said the physician was notified. The receptionist was interviewed on 11/11/21 at 10:23 a.m. She said Resident #17 approached the nurses station on 11/8/21 and told the registered nurse (RN) #5 her night nurse was not nice to her. RN #5 was interviewed on 11/11/21 at 10:30 a.m. The RN said Resident #17 told her the nurse was not nice to her and she was upset that she was woken up by the nurse. RN #17 said another nurse had already reported the resident's concerns to the nursing home administrator (NHA) and the NHA spoke to the resident. The NHA was interviewed on 11/11/21 at 12:43 p.m. with the vice president of operations/nurse consultant (VPO). She said resident concerns/grievances were coordinated by her and she received the residents ' concern cards for follow up. She said she was not aware if a concern card was generated for Resident #17. She said she was aware the resident had expressed a concern with LPN #3 but could recall how she found out. The NHA said she met with Resident #17. The resident told the NHA information that suggested the potential for hemorrhoids. According to the NHA, the resident was upset with the discussion because hemorrhoids were not ladylike. The VPO said she would create a care plan directing staff to communicate to the resident in a ladylike manner. The NHA said the resident did not tell her LPN #3 was rude or loud in tone. The NHA said staff did not report to her that the resident said LPN#3 was not nice to her but should have. The NHA said Resident #17 did not have good feelings about the interaction with LPN #3 but did not tell her she felt the nurse was not nice to her. The VPO said she would meet with Resident #17 to determine if the resident was still expressing the concern. The NHA said if the resident reported she felt the nurse was angry with her, we would have immediately started an investigation. The NHA said she did not document the conversation she had with Resident #17. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The VPO was interviewed on 11/11/21 at 1:25 p.m. after she spoke to Resident #17. The resident relayed her experience with LPN #3 on the overnight shift between 1/7/21 and 1/8/21 to the VPO. She told the VPO she went to the nurses station to speak to the nurse about her cold symptoms. According to the resident, the nurse told her she was eating and would be down to see her in a minute. The resident said the nurse came to her room and seemed angry when she said to the resident what do you need? Resident #17 said was bothered and the resident wondered if she should not ask the nurse questions. The VPO said the resident said the interaction with LPN #3 hurt her feelings. The resident did not state fear or feeling threatened. The VPO said residents should feel comfortable when asking questions, not feel they were inconveniencing staff, and there should be a standard level of respect. She said staff should have reported to the NHA the resident said the nurse was not nice. The VPO said the facility would interview other residents to determine if they felt they have not been treated in a dignified manner. D. Record review The 1/8/2021 LPN #3 nursing note read Resident #17 expressed the concern she has had spotting of blood for over a year and another nurse had given her a diagnosis for the spotting. According to the note, LPN #3 suggested the possibility of hemorrhoids which upset the resident. The resident could not give a name or description of the nurse. The note indicated the resident was also upset and frustrated with LPN #3 could not give another diagnosis and LPN #3 could not identify who the other nurse was. The note read the resident ordered LPN#3 out of the room. The 6/21/21 resident rights/dignity/respect training was provided by the facility on 11/11/21. The training was attended by LPN #3. According to training, the facility was the Residents home and staff needed to ensure they were providing the residents with the utmost care and respect. The 10/28/21 resident rights policy and quiz was provided by the facility on 11/11/12. According to the attendance sheet, LPN #3 received the policy and quiz. E. Facility follow-up The care plan for communication preferences and dignity was initiated on 11/11/21 by the VPO. The care plan read the resident was very ladylike. She could become offended if suggestions were made to the resident that she would deem unlady like ie passing gas, having hemorrhoids. According to the care plan, the resident preferred staff to speak to her in a calm manner and not raise their voice. The care plan interventions directed staff to address the resident calmly and respectfully, allowing her to share uninterrupted thoughts and questions. Deter from unlady conversations when possible and provide a private conversation with a gentle approach when potential unlady conversations were necessary. The VPO provided her 11/11/21 interview record with Resident #17 on 11/11/21. According to the interview record, the resident told the VPO, LPN #3 raised her voice when she asked the resident two to three times what did she need? According to the record, the resident told the VPO she would be comfortable if the nurse provided care to her. The record read the VPO reviewed standards of respect with resident as a staff expectation and offered to provide check ins with the resident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An education packet was created for LPN #3 and provided by the facility on 11/11/21. The packet included education materials on customer service, and respectful communication. According to the respectful communication education staff should pay attention to words and the intentions you have during the communication, treating each person as an individual, suspending critical judgment and be available during the conversation. Staff should understand and communicate understanding and refrain from using the benign or malignant forms of interrupting. The education read Sometimes we feel the need to tell someone a difficult truth. while at times, this can be for good communication; however there are times it can be harmful. Ask yourself these three questions when evaluating whether or not to tell someone the hard truth. Is it kind? Is it true? Is it necessary? The communication education including staff reminders to: -Not raise your voice; -Allow the resident time to respond; -Provide validation, the resident's perception is their reality; -Offer support and reassurance; -Use the residents preferred name; (and) -Pay attention to your body language. Even if the words are nice and your body language is upset or closed off, the wrong message could be sent.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31797 Based on interviews and record review, the facility failed to ensure one (#69) of two residents reviewed for abuse out of 34 sample residents was kept free from abuse. Specifically, the facility failed to protect Resident #69 from verbal abuse by registered nurse (RN) #1. Findings include: I. Facility policy and procedure The Abuse, Neglect and Exploitation policy, revised 10/19/21, was provided by the nursing home administrator (NHA) on 11/9/21. It documented that the policy was created to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. It documented the facility would establish policies and procedures to investigate any such allegations and include training for new and existing staff on activities that constituted abuse, neglect, exploitation and misappropriation of resident property, including reporting procedures and resident abuse prevention. It documented that new employees would be educated on these issues during initial orientation and existing staff would receive annual education through planned in-services and as needed. It documented training would include understanding the behavioral symptoms of residents that may increase the risk of abuse and neglect such as: aggressive and/or catastrophic reactions of residents; wandering or elopement-type behaviors; and outbursts or residents yelling out. The policy documented immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. It documented facility staff should report all alleged violations of abuse to the NHA, state agency, adult protective services and to all other required agencies immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse. II. Resident #69 status Resident #69, younger than 85, was admitted on [DATE]. According to the November 2021 computerized physician orders, diagnoses included spinal stenosis, chronic obstructive pulmonary disorder (COPD), bipolar disorder, alcohol abuse and anxiety disorder. The 11/2/21 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. It documented that the resident was independent with bed mobility, transfers, ambulating in his wheelchair, dressing, eating with set up, toileting and personal hygiene. He required extensive assistance with bathing. The MDS documented no symptoms of a mood disorder, psychosis or behaviors. III. Initial facility investigation (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Suspected Abuse Investigation form was provided by the NHA on 11/9/21. The form was dated 11/4/21 and documented the investigation started on that date. It documented two staff members reported witnessing a nurse being verbally abusive to a resident, using foul language, calling the victim names and taking the resident's jacket away from him, throwing it across the room. The abuse occurred on 11/3/21 at approximately 6:00 p.m. It documented the facility's abuse coordinator, the NHA, was not made aware of this witnessed verbal abuse until an unspecified time on 11/4/21. This investigation form documented certified nurse aides (CNAs) #2 and #3 witnessed RN #1 verbally abuse Resident #69 by using foul language and calling the resident names. The CNAs also said they saw the RN struggling back and forth with the victim, trying to take his jacket due to the victim lighting up a cigarette in his room. The CNAs stated they witnessed the RN taking the resident's jacket and throwing it across the room. This form documented the alleged assailant, RN #1, stated she may have used curse words when dealing with Resident #69 as she was upset with the situation, but denied calling Resident #69 any names. The RN admitted she did take the resident's jacket away from him in order to ensure he did not have any further smoking material. The Interview Record dated 11/4/21, provided by the NHA on 11/9/21, documented CNA #2 checked Resident #69 back into the building on 11/3/21 at 5:20 p.m., following an outing with friends. The CNA stated the resident did not appear to be intoxicated at that time. She said another resident called out from the smoking area that Resident #69 had fallen out of his wheelchair. She said she and another staff member assisted the resident back into his wheelchair while RN #1 stood by on the phone. She said after she returned inside the facility to provide care in her hall, she went back outside to check on Resident #69. She said at this time, RN #1 was outside with the police and she heard the police telling the RN they could not take him in. CNA #2 said, I saw red in (name of RN) eyes and the RN said, " All right, whatever. The CNA said the RN then yelled at her to stay outside with Resident #69, which she did for about 15 minutes. She said the RN came back outside with the phone at the same time CNA #3 returned outside. CNA #3 remained outside while CNA #2 went back inside to pass dinner trays. Someone yelled Resident #69 fell out of his chair again, so CNA #2 ran outside again and observed the RN arguing with Resident #69 back and forth and swearing at him (your drunk a**), while speaking on the phone the entire time. Once the resident allowed staff to help him into his wheelchair again, the RN took the resident back to his room. A short time later, CNA #2 observed RN #1 barging into Resident #69's room and the resident was smoking a lit cigarette. RN #1 snatched it out of his hands then repeatedly. RN #1 was yelling at him, No, you're not going outside because your a** is drunk. RN #1 again came back to Resident #69, stating, No, you're not going outside because I said so. The CNA said the RN was more aggressive towards the resident at this time. The RN was observed grabbing Resident #69's jacket out of his hands and throwing it to the floor in the resident's bathroom. Resident #69 picked the jacket back up off the floor and was overheard telling the RN, This jacket was given to me by my brother [AGE] years ago and you disrespected it. CNA #2 said around 8:00 p.m., she observed the RN and Resident #69 tugging back and forth on the divider curtain in the resident's room. CNA #2 said after thinking about the whole situation, RN #1 was very hostile towards both the resident and witnessing staff. She said she did not even want to say anything back to the RN because of the way she was acting and due to her abusive words. She said the RN was extremely aggressive. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Interview Record dated 11/4/21, provided by the NHA on 11/9/21, documented CNA #3 stated Resident #69 had returned from an outing on 11/3/21 at approximately 5:00 to 5:30 p.m. She also stated the resident did not appear to be intoxicated at that time. After she went to lunch and answered another resident's call light, she was asked to go outside to sit with Resident #69 because he had fallen out of his wheelchair. CNA #2 and RN #1 were sitting with the resident outside when she came to relieve them; they both went back inside while CNA #3 sat with Resident #69. Later in the evening, the resident was in his room, stating that he wanted to go outside to smoke. CNA #3 stated RN #1 told the resident he was not going anywhere because he was drunk. She said Resident #69 and RN #1 began arguing again, so she and CNA #2 stayed to ensure Resident #69 was safe. She stated Resident #69 went to grab his black and white Raider's jacket and RN #1 yanked it so hard, that he (Resident #69) almost got pulled from his wheelchair. She said RN #1 proceeded to [NAME] the jacket and threw it down on the bathroom floor. She said Resident #69 yelled at RN #1 and said the jacket was a gift from his brother. She said RN #1 stated, I don't give a f**k. She said while the other CNA left the room to pick up resident's dinner trays, she stayed in Resident #69's room because of how aggressive (RN #1's name) was being towards (Resident #69's name). She said the resident pulled out a cigarette and again said he was going to smoke. CNA #3 said RN #1 made a phone call, then went into Resident #69's room to check on him. She said RN #1 came back out, then a few minutes later, she went into the room again. She heard RN #1 yelling at Resident #69 and observed RN #1 taking a half-smoking burning cigarette out of the resident's hand. She said this was when the tug of war over the privacy curtain began (see above). She said Resident #69 told RN #1 that she was invading his privacy and RN #1 responded, You don't get any privacy. CNA #3 said she called for another staff member because of how the RN was acting towards the resident. She said off and on, the RN kept arguing with Resident #69. She said the RN told the resident he had to listen to her because she was the supervisor and the resident told the RN she was the stupidvisor. She said the RN then called the resident a drunk a** and told him he was drunk off his a**. Four additional staff were interviewed related to this verbal abuse allegation and documented essentially the same recollection as above. Two residents who witnessed the situation were also interviewed. Resident #69 was interviewed by the NHA on 11/4/21. The resident stated he could not recall all of the events from the previous evening, but he was not happy that staff kept telling him he was drunk. He said the only problem he had was with the nurse (RN #1) that was verbally aggressive towards him throughout the incident. RN #1 was interviewed by the director of nursing (DON) on an unspecified date. The interview documented RN #1 did not remember becoming verbally abusive and was sure she was not physical. The RN reported that she may have cursed, but did not remember due to the chaos of the situation. The Disciplinary Action Record dated 11/5/21 documented CNA #2 failed to report an abuse situation of the administrator on 11/3/21 and reported the incident the following morning instead. It documented that the CNA had been educated numerous times regarding the chain of command for abuse reporting. It documented that education on abuse policies and procedures had also been given to the CNA numerous times, with the most recent education provided to the CNA on 10/21/21 by one on one education. It documented continued performance at that level would result in further disciplinary action up to and including termination. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The One-to-One Education form dated 11/4/21 documented CNA #3 failed to report an abuse situation immediately to a supervisor or administrator. It documented that the staff was educated about the importance of over-reporting versus under-reporting. She was also re-educated on the abuse policy and procedure, types of abuse and duty to report. IV. Staff interviews The NHA was interviewed on 11/10/21 at 8:32 a.m. She said the abuse incident of Resident #69 by RN #1 was not a good situation to begin with. She said Resident #69 returned from an outing and was suspected to be under the influence of alcohol. She said the resident was yelling and cursing at all the staff, while the staff were trying to get him to calm down, be safe and escort him back into his room. She said the two CNAs witnessing the event never mentioned to the staff development coordinator (SDC) about the RN verbally abusing the resident because the police were called and the NHA could see that it was probably not their first thought when they had a resident trying to light up a cigarette when he was next to an oxygen tank in his room. She said the incident was reported as verbal abuse, as they could not substantiate physical abuse. She said, There's no denial it was verbal abuse by the RN. She said Resident #69 was Three quarters to a bottle of Fireball in and a couple of beers and who knows what he had to drink outside of here because the resident stated to his roommate that he had three beers earlier. The NHA said she did not expand the investigation to interview other residents besides the two who witnessed the event to see what other residents might have been subjected to verbal abuse by RN #1 because she knew when she heard the details of the incident, she would be terminating the nurse, who was suspended immediately pending investigation. She said the RN did not return to the building following the incident because she started vacation the day after the abuse occurred. The NHA said she would officially terminate RN #1 this date (11/10/21-during survey), as well as report her to the board of nursing (BON). The NHA was interviewed again on 11/11/21 at 9:00 a.m. She said she knew as soon as she substantiated this allegation of verbal abuse, it would cost me a tag. She said the facility could not substantiate any physical abuse, but resident safety was the facility's primary concern at the time of the verbal abuse. She said abuse training, which included reporting abuse concerns in a timely manner, had been conducted by the SDC within the past month prior to the occurrence. She said training had been done via computer programs and one-to-one training during the COVID-19 pandemic. She confirmed she was the facility's abuse coordinator. She said this abuse investigation was cut and dry that RN #1 would be immediately terminated, so she did not expand the sample of resident interviews. The NHA said the verbal abuse allegation was not reported in a timely manner and the staff involved had been re-educated of the facility's abuse policy. She said the abuse incident on 11/3/21 took approximately seven hours from start to finish, beginning at 4:00 p.m. when Resident #69 returned to the facility from an outing with friends. She said, at that point, staff could smell alcohol on Resident #69's breath. She said after the resident initially fell out of his wheelchair and became belligerent, RN #1 returned to the building to call the on-call nurse, who happened to be the SDC. The SDC called the NHA, who instructed staff to call the police if Resident #69 was intoxicated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said one CNA stayed outside with Resident #69 to monitor him and the resident fell out of his wheelchair again because he was sitting on the edge of the cushion and flailing around. She said Resident #69 refused to return inside at that point. She said a few minutes later, the police arrived and determined Resident #69 was not appropriate to be transported to detox. She said, at some point, RN #1 got the SDC to talk the resident into returning inside the building. She said Resident #69 came inside and the facility began checking on the resident every 15 minutes. She said the resident returned to his room, laid down in bed and started to calm down. She said during one of the 15-minute checks, a CNA observed the resident falling out of bed, causing the resident to get angry again. She said staff observed the resident getting up to get his jacket, which contained cigarettes and a lighter, and the resident proceeded to light up a cigarette in his room, near his oxygen concentrator. She said the first lit cigarette was taken away from the resident, thrown on the floor and stomped out to extinguish. She said the resident got another cigarette, then the tug of war over the jacket between RN #1 and Resident #69 ensued. Witnesses testified they saw RN #1 throw the resident's jacket on the floor. The NHA said police were called again due to the huge safety risk about lit cigarettes in the building. She said the local police department failed to return the facility's second call for help. She said the local hospital refused to accept the resident. She said the resident finally passed out in bed and staff stayed with him one-on-one for the remainder of the night. She said Resident #69 became ill with pneumonia the following day and was sent to the hospital on 11/5/21 for medical reasons. The NHA said she had been made aware of the resident falling out of his wheelchair repeatedly and of the danger of the resident lighting cigarettes in the facility near oxygen, but was not made aware of RN #1's verbal abuse of the resident until 11/4/21 at approximately 12:00 p.m. to 2:00 p.m. She said the SDC started the investigation by interviewing the resident and staff witnesses to the abuse, which is when the facility learned of the RN's verbal abuse toward the resident. She said she then called the corporations' vice president of operations (VPO) to officially start the verbal abuse investigation. The NHA said RN #1 was suspended the following day, 11/5/21. She said RN #1 was interviewed via telephone, as she began her vacation on 11/5/21 and was out of town. She said RN #1 never returned to the facility since 11/3/21 at approximately 10:00 p.m. when her shift ended. She said RN #1 would be officially terminated as of 11/10/21 and the RN was angry about the termination. She said RN #1 should have backed away and let another staff monitor the resident and should have noticed she was not handling the situation with Resident #69 well. The NHA said RN #1 would be reported to the BON on 11/11/21. She said the situation should have been handled much differently by RN #1. V. Facility follow-up In summary, the Suspected Abuse Investigation form, provided by the NHA on 11/9/21, documented that after reviewing the statements, the facility was substantiating verbal abuse of Resident #69 by RN #1. It documented the two CNAs who witnessed the verbal abuse did not report the abuse immediately to anyone. Education on abuse reporting was provided to both CNAs. It documented RN #1 would be terminated for abuse and all staff would be re-educated on reporting abuse immediately.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12905 Based on observations, interviews and record review, the facility failed to provide meaningful, engaging activities to meet the interests of five (#41, #29, #52, #61, #25) of six residents reviewed for activities out of 34 sample residents. Specifically, Residents #41, #29, #52, #61 and #25 were observed spending most of their time in their rooms in bed, unengaged in activities to prevent loneliness and boredom, and improve their quality of life. Findings include: I. Facility policy The Activities policy, dated 8/31/19, was provided by the director of nursing (DON) on 11/11/21 at 10:27 a.m. The policy included the following: Activities refer to any endeavor, other than routine activities of daily living (ADLs) in which a resident participates that is intended to enhance their sense of well-being and promote or enhance physical, cognitive, and emotional health. Activities will be designed with the intent to reflect residents' interests and age, reflect choices of the resident and promote self-esteem, dignity, pleasure, comfort, education, creativity, success and independence. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs II. Resident #41 A. Resident status Resident #41, age 75, was admitted on [DATE]. According to November 2021 computerized physician orders (CPO), diagnoses included Parkinson's disease, frontotemporal dementia and dementia with Lewy bodies. According to the 10/8/21 minimum data set (MDS) assessment, Resident #41 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. No delirium, mood or behavioral symptoms were documented. He needed extensive assistance with activities of daily living (ADLs) including bed mobility, transfers, dressing, ambulation with a wheelchair or walker, and personal hygiene. The 8/15/21 full admission MDS assessment documented music and keeping up with the news were somewhat important to him, and attending religious services was very important to him. B. Observations (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was observed during the survey, conducted 11/8 to 11/11/21, spending most or all of his time in his room in bed. On 11/9/21 from 8:15 a.m. to 6:00 p.m., he was in bed without activities, on his phone trying to get his driver's license and social security cards renewed. On 11/10 and 11/11/21, he was not on the phone but was lying in bed with the television (TV) on, alternately watching it and napping. The resident was never observed to leave his room, have one-to-one visits from staff, have music playing in his room, or newspapers or other reading materials available. There was no DVD player in his room for movies. C. Record review No activity assessment was found in the resident's electronic medical record. Activity participation documentation in the electronic medical record revealed one-to-one activities were documented seven times between 10/27 and 11/6/21 by activities assistant (AA) #2. No other activity participation records were found. The activities care plan, initiated 8/11/21 and revised 10/1/21, identified, I work too hard and too much to have a hobby. All I do now is watch TV and listen to music here and there. Sometimes I may attend church. The goal was to maintain involvement in cognitive stimulation and social activities as desired through review date. Interventions included: -Establish and record prior level of activity involvement and interests by talking with myself, caregivers, and family on admission and as necessary. -I prefer to keep to myself and don't want to be bothered with joining any activities while here. -My preferred activities are: watching TV (all kinds), listening to music (country/western, gospel, piano music) and some religious activities (Pentecostal). -Provide with activities calendar. Notify of any changes to the calendar of activities. -Review activities needs with the family/representative. -Thank (the resident) for attendance at activity function. Interventions added 10/26/21 under behavioral issues included: -I enjoy old movies, so please offer to put one on for me, or discuss my preferred genres. -I enjoy sweet snacks so as applicable please offer me snack options as a means to distract and redirect. -I enjoy talking about sports so please talk with me about the different sports I enjoy watching and used to play. I have talked about baseball specifically. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An undated activity interest assessment provided by the activity director (AD) on 11/11/21 revealed the resident enjoyed old Western music, war movies and old westerns. His favorite drink was milk. He played guitar and enjoyed building things when he was younger. His afternoon routine was movies and TV. Activities he enjoyed: movies. Activity participation records provided by the AD on 11/11/21 for September and October 2021 revealed the resident participated in reading/talking books, TV/radio/movies, talking/conversing/telephone, relaxation, sensory stimulation and intellectual activities. The activities documentation ended on 10/21/21 and nothing was documented for November 2021. One-to-one activity participation during September and October 2021 revealed the resident participated in three activities involving small talk, making sure his TV was working and might want a DVD player on 9/15/21, and needed help finding a business card on an illegible date. D. Staff interview The activities director (AD) was interviewed on 11/11/21 at 12:02 p.m. She said Resident #41 told them he preferred to be left alone in his room, and did not really want to participate in activities. She said they did one-on-ones (1:1s) with him at least twice per week, basically having a conversation and reminiscing, and he did not like to do much but talk with staff. She thought he played baseball in high school. He doesn't mind when we come in with trivia questions because then we have a sweet snack. His activities since he has been here have been basically TV. She said she did not think his activity needs were met. No, honestly I wish I could do more for him, and we encourage him. Talking and reminiscing can only go so far. III. Resident #29 A. Resident status Resident #29, age 78, was admitted on [DATE]. According to the November 2021 CPO, diagnoses included anxiety disorder, obsessive-compulsive personality disorder, depressive disorder, bipolar disorder, and need for assistance with personal care. According to the 10/2/21 MDS assessment, he had severe cognitive impairment with a BIMS score of four out of 15. No delirium, mood or behavioral symptoms were documented. He needed extensive assistance with most ADLs. The 6/21/21 full MDS assessment documented most activity options listed were not very important to him. B. Observations (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was observed during the survey, conducted 11/8 to 11/11/21, spending most or all of his time in his room in bed. He was always glad to greet anyone entering his room, and enjoyed conversing and talking about the pictures on his overbed table of his family members, former occupation as an art glass blower, and hobbies involving the outdoors. No TV or music was playing in his room, and there were otherwise no independent activities or sensory items available in his room. The resident was never observed to leave his room, or to have one-to-one visits from staff. The resident's room was not homelike or decorated with pictures or personal items that reflected his interests and personality. The few photographs he kept out loose on his over-bed table had been severely damaged and were covered with scratches. C. Record review No activity assessment could be found in the resident's electronic medical record. The activity participation 1:1 record documented in the medical record had only one visit on 10/27/21, and one refusal on 11/3/21. The resident's activities care plan, initiated 4/7/21 and revised 10/1/21, identified, I had my own business. I used to blow glass and was really good at it. My favorite thing to make was swans. I also enjoyed teaching young ones about my glass blowing. I come from a long line of military. I was always a hard worker. My favorite past hobby was fishing and hunting. I was also an aircraft pilot. The goal was, I may be interested in 1:1 activities 2x (twice) weekly by the next review date. Interventions included: -Establish and record my prior level of activity involvement and interests by talking with me, caregivers, and family on admission and as necessary. -I need reminders and assistance to activities of choice such as holiday parties or social events. I may not stay the whole time. -I would rather keep to myself in my room. I'm not a very social person. -I tend to stay in my room a lot. I like to tinker around my room and look through all my photo books or lay them out on the table and bed. I sometimes write myself little notes. -Invite me to scheduled activities. -Provide with activities calendar. -Thank me for attendance at activity functions. The resident's 9/6/21 activity preference sheet, provided by the AD on 11/1/21, revealed he was not interested in group activities or outings, but he was interested in 1:1 visits. He liked music in the past and might sing some tunes on good days. He did not watch TV. Regarding arts and crafts, he used to blow glass, he worked at a very famous glass blowing business and his favorite was to do swans. He enjoyed teaching young people about his art. When asked about water activities he said, Oh yes, I fish all the time. He liked to attend volunteer performances in the home sometimes, and he enjoyed animal visits. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Activity participation documents for September and October 2021 documented the resident participated in TV/radio/movies, talking/conversing/telephone, relaxation, sensory stimulation (three times), and intellectual. The resident participated in one meaningful 1:1 activity, a two-hour fall color drive to Coal Bank on 10/13/21. The other five 1:1s involved saying hi and going back to bed (twice), talked about how many players on a baseball team, up and talking and gave him a Chronicle (facility newsletter), dropped off cookies and talked about the weather. No activities were documented during November 2021. D. Staff interview The AD was interviewed on 11/11/21 at 12:15 p.m. She said it was difficult to engage the resident in activities because he preferred to stay in his room. She was not aware that his photos were damaged or what happened to them, and did not know why he had no pictures on his wall, or what types of sensory or artistic pursuits they could involve him in to improve his quality of life. Upon review of his preferences and interests, she acknowledged his activity needs were not met. IV. Resident #52 A. Resident status Resident #52, age 74, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), pertinent diagnoses included abnormalities of gait and mobility, need for assistance with personal care, acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction (paralysis following stroke) affecting left non-dominant side, sepsis, and bladder-neck obstruction. According to the 10/21/21 MDS significant change assessment, Resident #52 was cognitively intact with a BIMS score of 15 out of 15, with no behavioral symptoms and no rejection of care. She required extensive two-person assistance for most ADLs. Ambulation did not occur. Regarding activity preferences, it was very important for her to have music to listen to, be around animals and pets, and keep up with the news. It was somewhat important for her to do things with groups, participate in her favorite activities, go outside for fresh air in good weather, and participate in religious services/practices. B. Resident interview and observations Resident #52 was interviewed on 11/9/21 at 9:23 a.m. She said she was often bored and there were not enough activities. She had vision problems so she was unable to read books, but said she would enjoy books on CD or the Kindle Fire that her daughter had at her home in Denver. She said she would like to go outside and be wheeled around, but they did not have enough staff to take her outside. She said she mostly watched TV and visited with her roommate. She and her roommate did not have a DVD player, CD player or radio in their room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #52 was observed during the survey, conducted 11/8 to 11/11/21, spending all of her time in her room in bed watching TV. The privacy curtain was usually drawn around the resident's bed and between the resident and her roommate, who watched her own TV, and they talked with each other frequently. Resident #52 pleasantly greeted whoever knocked on their door, as her bed was closest to the door, and enjoyed visiting. She enjoyed conversations, had a good sense of humor, and was interested in current events and popular culture. C. Record review No activity notes or activity participation notes were found in the electronic medical record. The activities care plan, initiated 5/17/21 and revised 10/1/21, identified the following interests for past and current hobbies: -I used to sew, do leather stamping, and knit. I did a lot of crafty things. Now I do beadwork, oil paint, needle work. I like to play cutthroat, monopoly, and rummy. I love to be around animals especially cats, I have 8 cats. The goal was, I will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions included: -I would rather keep to myself when it comes to groups but I do like to talk with others. -Invite to scheduled activities. -Preferred activities are: watching TV, animal visits, arts and carts, and reading magazines. -Prefers the following TV channels: NCIS, CNN, Animal Planet. -Provide with activities calendar. Notify of any changes to the calendar of activities. -Review activities needs with the family/representative. The undated resident activity preference sheet, provided by the AD on 11/11/21, revealed the resident's activity preferences included card games and board games, such as Monopoly, [NAME] rummy and solitaire. She played the piano and spoke five languages. She had birthday, cultural and holiday traditions: lots, whatever time it is. She liked older country/western, new wave, and mellow music. She wanted a radio. She enjoyed NCIS, CNN, Animal Planet, and all kinds of movies. She enjoyed basketball and football (Eagles). Her favorite food was tacos. She maybe enjoyed group activities at times, but did not enjoy big groups. She enjoyed needlework, beadwork, oil painting and knitting. She wanted to be invited to group activities to see if it was something she might be interested in. She enjoyed reading magazines but her eyes hurt at times. She enjoyed animal visits and said, Yes, I love cats, I had 8! Her past hobbies included sewing, knitting, crafts, leatherwork, and stamping. Her current interests were reading, TV and movies. Activity participation records for September and October 2021 documented the resident participated in exercise/sports one time, reading/talking books, TV/radio/movies, talking/conversing, telephone, relaxation, sensory stimulation (twice), and intellectual. One-to-one activities occurred five times, and included small talk or conversation. No activities were documented during November 2021. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interview The AD was interviewed on 11/11/21 at 12:28 p.m. She said Resident #52 hasn't had activities. We try to convince her to join in as much as we can but I do feel it could be better, of course. Everyone's (activity programming) could be better right now. V. Resident #61 A. Resident status Resident #61, age 88, was admitted on [DATE] and readmitted on [DATE]. According to the November 2021 CPO, diagnoses included heart, lung and kidney disease; chronic pain; depressive episodes; and unspecified mood disorder. According to the resident's 9/16/21 significant change MDS assessment, she had moderate cognitive impairment with a BIMS score of nine out of 15. She had difficulty sleeping, and was tired with little energy, but otherwise had no mood, delirium or behavioral symptoms. She needed extensive assistance with most ADLs, and used a walker or wheelchair for ambulation. Documented activity preferences showed it was very important to her to have books, newspapers and magazines to read and to keep up with the news. It was somewhat important to her to have music, visits from animals/pets, and participate in her favorite activities. B. Resident interview and observations Resident #61 was interviewed on 11/9/21 at 10:58 a.m. She said there were not enough activities and she was often bored. I like to play bingo but we never get in the loop for some reason. They don't notify me. She was an avid reader and had vision problems, so she needed recent, large print books. She said she liked author [NAME] Steele, she's number one, and she needed a stack of books, because I just devour them. She said her daughter had given her a large print book but she had already read it and she needed new things to read. Just sitting in my room and not doing anything is depressing, and then all you want to do is sleep, and that's no good. Resident #61 said she also enjoyed walking and talking with people, and staff did not get her out of her room to walk often enough. Resident #61 was observed during the survey, conducted 11/8 to 11/11/21, spending all of her time in her room in bed watching TV, talking with her roommate, and looking out the window. She was never observed out of her room, and no reading materials were observed in her room. She enjoyed conversations, and pleasantly greeted everyone who knocked on their door. (continued on next page)

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Junction Creek Health and Rehabilitation Center	2911 Junction St Durango, CO 81301

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/11/21 at 10:30 a.m., the activity room was observed, with a large activity table covered with pictures to color and a few crayons. An activity cabinet was against the opposite wall, but it was locked with a large chain and padlock. A set of bookshelves was against the far wall with a selection of books, only two of which were large print. The activity director (AD) said the books were for resident use, and they were just asked to return them when they were finished. With the activity director's permission, the surveyor borrowed the two large print books and shared them with Resident #61. She was interested in and accepted one of the novels, and said she had read the author before. She was not interested in the [NAME] novel, and said she did not like murder mysteries. Her roommate gladly accepted that book, saying she also needed large print books. C. Record review The resident's electronic medical record revealed no activities notes or activities participation records. The resident's 7/19/21 activity assessment listed the following interests: watching TV, playing card games, reading, garden work, and being outside. The activities care plan, initiated 7/20/21 and revised 10/1/21, identified, My activity preferences, hobbies and interests: I like to keep up with the current news and events. I love to learn new things. I read all the time. I love to be out in my garden. I have two Pomeranians at home, I love dogs. The goal was, I will maintain involvement in cognitive stimulation, social activities as desired through review date. Interventions included: -Establish and record prior level of activity involvement and interests by talking with myself, caregivers, and family on admission and as necessary. -I prefer the following TV channels: news, educational, history, Nat Geo. -Invite to scheduled activities. -My preferred activities are: playing rummy, watching TV, garden work, reading, talking with others, animal visits. -Provide with activities calendar. Notify of any changes to the calendar of activities. -Thank (the resident) for attendance at activity functions. Review of activity assessments and participation records provided by the AD on the afternoon of 11/11/21 revealed the following: The activity preference sheet, dated 10/21/21, identified Resident #61 enjoyed [NAME] rummy which she used to play with her husband; music such as [NAME] Miller; TV news, educational and game shows; socials sometimes; gardening ([NAME]!); loves dogs. -Really, I'm happy reading, watching TV, and going out with my daughter and to visit her. -I love to read, needs to be large print. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The activity participation records for September and October 2021 revealed reading/talking books nine times; exercise/sports one time; sensory stimulation one time; and TV/radio/movies, talking/conversing/telephone, relaxation and intellectual frequently documented. Nothing was documented after 10/21/21. The record of 1:1 activities for September and October 2021 documented conversations and small talk on 9/2, 9/9, 9/10, 9/15, 9/16, and 9/29/21. She was out with her daughter all day on 9/22/21. On 10/6/21, conversation about everything - longs to hold conversation was documented. No 1:1s were documented after 10/6/21. D. Staff interview The AD was interviewed on 11/11/21 at 12:35 p.m. She said, regarding Resident #61, She is one we sit with and do hand massages with whatever she wants us to use, talking, socializing, she likes the Daily Chronicles (facility newsletter) in big print. She did join in on bingo in the beginning, we tried hallway bingo in the beginning (of the pandemic), but it was hard for us to do it that way. The AD said that for residents who enjoyed reading, the facility had joined Talking Books for the Blind and Disabled, and the local library used to deliver books but they suspended that service during the pandemic. She said she would talk with Resident #61 and other residents about their reading preferences, and would get them signed up to receive regular books per their preferences from Talking Books. She said she hoped that once the facility was cleared for their current outbreak involving staff members, they would be able to provide more activity choices for residents. She said they had an activity consultant, who would be visiting and assisting them with their activities program soon. She said she felt they had enough activity staff, as she had three activity assistants. The AD acknowledged Resident #61's activity needs were not met. 40467 VI. Resident #25 A. Resident status Resident #25, age 88, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), diagnoses included dementia without behavioral disturbances, personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits. The 9/23/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. He required extensive assistance from two or more persons for bed mobility, transfers, toileting, dressing and personal hygiene. He required extensive physical assistance from one person for locomotion on and off the unit. B. Observations and resident interview (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #25 was interviewed on 11/9/21 at 8:45 a.m. Resident #25 said he was bored to death. He said he missed having people to talk to and has not had activities offered to him inside or outside of his room for awhile. He said he also missed talking to his friends at meals. Resident #25 said he could only watch television and it was not currently working. Review of the television remote determined it was missing a battery. -At 3:53 p.m. Resident #25 was observed in his room watching television. On 11/10/21 at 8:45 a.m. Resident #25 was observed in his room. The television was turned on. The resident said there was nothing on he wanted to watch. -At 10:07 a.m. Resident #25 was observed sitting in his room. His eyes were closed but he was awake. In a somber voice, he said there was nothing going on, nothing to do and was bored to death. He said no one had offered him an activity other than to watch television. The morning observations did not identify activity intervention or visits. -At 3:28 p.m. Resident #25 was observed sleeping. On 11/11/21 at 11:44 a.m., Resident #25 was observed watching television. C. Record review The activity care plan, revised 3/31/21, read Resident #25 was a very social person and loved to talk. According to the care plan, the resident and his family expressed how social he was and identified activities of interest including football, listening to old classic country music, watching movies, tv games shows and time outside on warm days. The care plan indicated Resident #25 used to race horses and likes to watch horse races. The care plan read his preferred activities were bingo, happy hour, social events, and current news. According to the activity care plan, the resident would participate in activities of choice three to five times per week. The activity assessment, dated 7/19/21, identified Resident #25 had an interest in participating in his favorite activities. According to the assessment, the resident preferred to engage in activities in the morning. The resident activity preference sheet, undated, read Resident #25 stated he liked to be around people, social events, playing bingo, sports, fishing, listening to music and having animal visits. The preference sheet identified the resident did not like arts and crafts. The September 2021 participation record for Resident #25 identified the resident was offered activities on 19 days between 9/1/21 and 9/30/21. The September 2021 one to one activity record identified Resident #25 received conversation between 9/1/21 and 9/30/21. The October 2021 paper participation record for Resident #25 identified the resident was offered and engaged in activities on 10/1/21, 10/5/21, 10/6/21, 10/7/21, 10/12/21, 10/13/21, 10/14/21 and 10/21/21. The record did not indicate the resident refused or was unavailable to participate in other activity attempts. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The October 2021 electronic participation record identified the resident was offered and engaged in activities on 10/19/21, 10/20/21, and 10/22/21. According to October 2021 electronic participation record, Resident #25 only refused one offered activity (10/26/21) during October 2021. The October 2021 paper one to one activity record identified Resident #25 received one to one activities on 10/6/21 with set up of a football schedule and on 10/12/21 with small jokes. The October 2021 electronic one to one activity record identified Resident #25 received one to one activities on 10/20/21 and 10/21/21. The activities offered and participated were conversation while he watched television. On 10/20/21, Resident #25 read a newspaper, book, or magazine. The review of the electronic and paper participation record did not indicate the resident refused or was unavailable to participate in other activity attempts during one to one visits. The November 2021 one to one visit record revealed Resident #25 had limited activities of choice offered. The one to one record for the resident identified on 11/5/21 the resident had a sensory activity. The record did not indicate what type of sensory activity was offered. On 11/5/21, the resident had a family/friend visit. On 11/2/21, 11/3/21, 11/4/21, 11/5/21, 11/6/21 and 11/10/21, revealed Resident #25 was offered a conversation while he watched television. No other activities or activity interventions were offered to the resident between 11/1/21 and 11/10/21. Review of the November 2021 activity records did not identify the resident refused or was unavailable for offered activities. Resident #25's activity participation records (group/individual) were reviewed with the activity director (AD) on 11/10/21 at 3:31 p.m. The review identified the resident had a continued decline in activity involvement. The records indicated the resident rarely refused activities but they were not regularly available to the resident. The review revealed Resident #25 did not have a November 2021 activity participation record for Resident #25 but according to the AD, all residents including Resident #25 should have had opportunities for activity participation and an activity participation record documenting the offers and engagement. D. Staff interviews The activity assistant (AA) #2 was interviewed on 11/10/21 at 10:51 a.m. The AA said the facility was currently under COVID-19 restrictions and could not have group activities. She said all current activities consisted of door to door one on one visits. She said the individual activities primarily consisted of coloring or some trivia. AA #2 said they would drop off coloring supplies to residents if they were interested. She said sometimes she would sit down with the residents to help them color or talk about a television program they were watching. AA #2 said the best way to get residents engaged in individual activities was to offer candy and sit down with them. She said there was not enough time to sit down with all the facility residents everyday. The AD was interviewed on 11/10/21 at 10:54 a.m. The AD said the activity staff's role in the facility was to engage residents so they would be happy and have a more meaningful life. The AD confirmed group activities were not currently available for the residents because of current COVID-19 restrictions related to outbreak status. She said residents were still offered activities during one to one visits. The AD said all residents were currently offered one to one visits. She said her staff tried to visit at least all the residents in one hall a day. She said she and her staff would also try to do random visits with residents. (continued on next page)

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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** 12905 Based on observations, record review and interviews, the facility failed to prevent pressure ulcers from developing for two (#52 and #51) of five residents reviewed for pressure ulcers out of 34 sample residents. Resident #52 was admitted to the facility with intact skin, and no pressure ulcers, and developed multiple areas of skin breakdown to her buttocks, perineal area, heels and ankles. The facility failed to consistently and accurately assess and monitor the resident's skin and provide adequate pressure-relieving interventions. As a result, Resident #52 developed multiple pressure areas, some of which had healed. Her skin breakdown as of 11/11/21 included two unstageable pressure ulcers to her heel, irritated and reddened areas to her thigh from the strap that held her catheter tubing in place, irritation to her nose and ears from her oxygen nasal cannula and tubing. Resident #52 said she experienced discomfort, soreness and burning as a result of pressure areas acquired at the facility. Resident #51 was admitted with intact skin and developed skin breakdown described as blisters and open areas to his coccyx. The facility failed to ensure Resident #51 received the standard level of care necessary to prevent development of pressure ulcers. Findings include: I. Professional references 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: Quick Reference Guide, [NAME] Haesler (Ed.), Cambridge Media: [NAME] Park, Western Australia; 2014, from http://www.npuap.org (11/16/21): Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury. Stage 4 Pressure Injury: Full-thickness skin and tissue loss. Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss, this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). The National Pressure Ulcer Advisory Panel (NPUAP), Prevention and Treatment of Pressure Ulcers reads that steps to prevent the emergence of pressure ulcers in individuals identified as being at high risk include scheduled repositioning to avoid individuals being in a position that places pressure on a vulnerable area for a long period of time. The following steps should be taken to prevent the worsening of existing pressure ulcers and promote healing: -Positioning that places pressure on the pressure ulcer should be avoided. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The pressure ulcer should be assessed upon development and reassessed at least weekly. The results of assessments should be documented. -The ulcer should be observed with each dressing change for signs of infection, improvement, deterioration, or other complications. -Signs of deterioration in the wound should be addressed immediately. -The assessment should include: location, category/stage, size, tissue type, color, peri-wound (skin around the wound) condition, wound edges, exudate, undermining/tunneling, order. According to Key Points for Pressure Ulcer Staging and Documentation, 11/23/13, MedLeague.com (11/16/21), in pertinent part: Pressure ulcer staging and correct documentation are critical in acute care settings as well as long-term care settings. Pressure ulcers are caused by unrelieved pressure. Any bony prominence is at the highest risk. After a pressure ulcer has been assessed it is essential that the correct stage of pressure ulcer is assigned and documented. Here are a few essential do's and don ' ts of pressure ulcer staging. Pressure ulcers are assessed as Stage 1, 2, 3, 4, Unstageable and Deep Tissue Injury. Documentation must accurately reflect each stage. The higher the stage the more underlying tissue damage there is. Once a pressure ulcer is 'staged' it can progress to a higher stage but can NEVER be 'BACK-STAGED, REVERSE STAGED or DOWN STAGED.' Example: A Stage 3 pressure ulcer can worsen and become a Stage 4 but it NEVER becomes a Stage 2 as it heals. II. Facility policy The Pressure Injury Prevention and Management policy, dated 1/1/2020, provided by the corporate vice president of operations (VPO) on 11/11/21, in pertinent part: The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Assessments of pressure injuries will be performed by a licensed nurse and documented in wound rounds or in skin/wound portal in the medical record. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS (minimum data set assessment). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Training in the completion of the pressure injury risk assessment, full body skin assessment, and pressure injury assessment will be provided as needed. III. Resident #52 A. Resident status Resident #52, age 74, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), pertinent diagnoses included abnormalities of gait and mobility, need for assistance with personal care, acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction (paralysis following stroke) affecting left non-dominant side, sepsis, and bladder-neck obstruction. According to the 10/21/21 minimum data set (MDS) significant change assessment, Resident #52 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15, with no behavioral symptoms and no rejection of care. She required extensive two-person assistance for activities of daily living (ADLs) including bed mobility, transfers, toilet use, dressing and bathing. Ambulation did not occur. She had an indwelling catheter and was always incontinent of bowel. She had occasional mild pain and weight loss without a physician-prescribed weight loss regimen. She had two stage 2 pressure ulcers, none present upon admission, and moisture associated skin damage. She was not on a turning/repositioning schedule. She had pressure-relieving devices to her bed and chair, pressure ulcer care, nutritional/hydration interventions, and applications of dressings/ointments/medications other than to her feet. According to the 5/19/21 admission MDS assessment, Resident #52 was at risk but had no pressure ulcers upon admission. B. Resident interview/observations Resident #52 was interviewed on 11/9/21 at 9:10 a.m. She was lying on her back in bed, her heels were not floated and one of her padded booties was on the floor. She said her booties did not stay on, and that nursing staff had to come in periodically and make sure her left leg was on the bed. She said her legs and feet jerked uncontrollably at times, and her booties fell off. She said the staff tried to float her heels, reposition her, and remind her to wear booties, but they had to check frequently because of her involuntary movements to her legs and feet. She said she had wounds on both feet because her feet jerked and twitched. She said physical therapy had her doing exercises while she was in bed and she did that so her feet did not get stiff and jerk and twitch. She said she did not take medications to address the jerking and twitching, just pain medications like Tylenol, but she used to have a Fentanyl patch. She said she had an open wound on her bottom but it was healed now. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #52 said, and observation revealed, she did not have an alternating air mattress, and said, That would be nice. She said she just had a regular hospital bed mattress now. She said the wounds on her feet hurt, especially when her legs moved back and forth and it rubbed her skin. That's why they need to have my boot on and the moisturizer to keep my feet from drying out. She was wearing her right bootie (heel protector) but not her left. She said she had skin breakdown/irritation to her nose and ears from her oxygen nasal cannula and tubing. She said they would not give her any ointment to relieve the discomfort to her nose or padding to protect the sensitive skin around her ears. Her nostrils just above her lip were red and irritated. She said she had just pulled a scab off her thigh that was caused by the Velcro strap that held her catheter tubing in place (cross-reference F690 catheter care). She said she also had skin issues related to moisture, and that nursing staff used moisture barrier and powder to treat those areas. Observations during the survey conducted 11/8 to 11/11/21 revealed the resident was always in her bed lying on her back. She was able to shift her weight and slightly reposition herself using a trapeze bar above her bed and repositioning rails on the upper bilateral sides of her bed. On 11/8/21 from 2:00 to 6:00 p.m. and 11/9/21 from 8:15 a.m. to 5:00 p.m., the resident's heels were not consistently floated with pillows, her soft padded booties were not on her feet, and her heels and/or the sides of her feet frequently rested directly on the mattress. Observations on 11/10/21 and 11/11/21 from 8:15 a.m. to 6:00 p.m. revealed the resident's heels were more consistently floated and her booties were on during frequent observations. During wound care observations on 11/10/21 at 10:33 a.m., licensed practical nurse (LPN) #2 washed her hands and donned gloves. The resident had two scabbed areas to her left heel, which LPN #2 cleaned with wound cleanser and painted with betadine. She used a new swab for each wound and replaced the resident's heel protectors afterwards. The resident's left heel had a wound on the medial posterior the size of a dime that was difficult to visualize due to the resident's discomfort when her leg was moved or lifted, but the area was partially covered with a dark red scab. The resident's second heel wound, on the lateral side of her heel, was approximately the size of a pencil eraser and was completely covered with a dark red scab. Her buttocks were intact, and her skin was clear from any excoriation. The site where her strap held her catheter tubing in place appeared excoriated with dryness and a superficial wound with a pink wound bed about the size of a nickel. The strap had been moved to a different part of the resident's leg. C. Record review The resident's pressure ulcer care plan, revised on 10/29/21, identified the potential for and actual pressure ulcer development related to immobility. I have 2 pressure ulcers to the medial and outer aspect of my left heel. The goal was, I will have intact skin, free of redness, blisters or discoloration by/through review date. Interventions included: -Assist and encourage me to reposition and or turn at frequent intervals to provide pressure relief. -Complete a full body check weekly and document -Encourage and assist me to change positions for prevention of pressure ulcers. -Encourage small frequent position changes. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Encourage and assist me to reposition in chair frequently for comfort and pressure reduction. -Interdisciplinary team (IDT) referrals as indicated to registered dietitian (RD), physical therapy (PT), occupational therapy (OT) or other. -Observe nutritional status. Serve diet as ordered, observe intake and record. -Observe/document/report as needed (PRN) any changes in skin status: appearance, color. -Provide incontinence care after each incontinence episode, or per established toileting plan. -Use pillows to reposition me off of my pressure areas. -Encourage adequate hydration and nutrition to assist in the healing process of my wounds. -Please ensure that I am wearing my heel protectors at all times while in bed. -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. -Educate me/family/caregivers of causative factors and measures to prevent skin injury. -Encourage and assist me to reposition frequently. Use pillows to position me off my pressure areas. -Follow facility protocols for treatment of injury. -Identify/document potential causative factors and eliminate/resolve where possible. -Keep skin clean and dry. Use lotion on dry skin and apply moisture barrier cream as needed. -Monitor dressing to ensure it is intact and adhering. -Observe site for redness, swelling, increasing drainage, pain. -Observe/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs/symptoms of infection, maceration etc. to physician. -Use a draw sheet or lifting device to move me. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Current pertinent physician orders included: -Use catheter securing device to reduce excessive tension on the tubing and facilitate urine flow. Rotate site of securement daily and as needed every day shift, dated 6/12/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-Observe skin integrity every shift at pressure points from the oxygen delivery device while in use every shift, dated 6/26/21. -Cleanse both wounds to left medial and outer heel with wound cleanser. Paint with betadine ensuring not to get on healthy skin. Please reapply heel protectors at all times. Observe for abnormalities to wound bed, surrounding skin, or pain associated with wound. Document + (plus sign) for no abnormalities noted, - (minus sign) for abnormalities, must document abnormalities in nursing notes, every day and evening shift, dated 10/30/21. (On the treatment administration record from 11/1 to 11/11/21, abnormalities were documented on the evening shift on 11/1, 11/2 and 11/3/21. Day shift documented no abnormalities, and did not document on 11/4/21.) The nursing admission assessment on 5/12/21 documented the resident's skin was intact and she had no pressure ulcer risk. Physician progress notes on 5/18/21 documented the resident's skin was warm and dry. The summary of plans included skin care. The 5/19/21 Braden scale for predicting pressure sore risk, documented a score of 16, at risk, due to occasionally moist skin, chairfast, slightly limited mobility, probably inadequate nutrition and potential for friction and shear. (The scoring scale was at risk 15-18, moderate risk 13-14, high risk 10-12 and very high risk nine or below.) The 5/20/21 skin assessment documented intact skin. The resident was hospitalized from 5/20/21 through 6/8/21. There were no nurses' notes regarding the resident's skin condition upon her return from the hospital on 6/9/21. The 6/10/21 skin assessment documented an existing pressure ulcer described as two open wounds to sacrum, red and friable; fragile, excoriated perineum, and rash with open sores to her groin and labia. -There were no further nursing notes or evidence of physician notification. The 6/11/21 Braden scale assessed her at risk with a score of 15. The 6/16/21 weekly pressure ulcer record documented a sacrum pressure ulcer, date of onset 6/9/21, documented as a stage 1 and a stage 2 in the same assessment, 3x3 cm, described as a stage 2 to sacrum presents as intact dark purple superficial area with surrounding excoriation. Dark area peeling off on one edge presenting healthy blanchable skin surrounding the purple area. The ulcer was documented as admitted with as the resident had been in the hospital. The IDT team recommended to continue with treatment. Wound team to reassess weekly until healed. The 6/17/21 skin assessment documented excoriation with superficial open areas to buttocks, dark eschar skin to left buttocks. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-There was no documentation of a wound assessment of the dark eschar which indicated an unstageable pressure ulcer. The 6/23/21 weekly pressure ulcer record documented a 2x2 cm stage 2 to the sacrum described as very superficial pressure area presenting as dark tissue with surrounding blanchable excoriation, no s/sx (signs/symptoms) of infection noted. The wound bed was described as black. The IDT recommended to continue treatment, wound team to assess weekly, and hospital wound care following as well. -There were no notes in the resident's medical record regarding hospital wound care. The 6/27/21 skin assessment documented no changes to the sacral wound. The 6/30/21 weekly pressure ulcer record documented the sacral wound as a stage 2 measuring 4.0 x 2.6 cm, black/purple tissue to wound bed with surrounding excoriation to skin. Skin sloughing off from surrounding (area), does (complain of) minor discomfort when area is cleansed. The wound had deteriorated, increased in size as well as surrounding skin with excoriation. -There were no changes to treatment, and no documentation of hospital wound care. The 6/17/21 physician progress notes documented the resident's skin was warm and dry and plans included skin care. -The resident's skin breakdown was not documented. The 7/4/21 skin assessment documented new and existing skin issues, (left) upper thigh healing skin tear (2x2 cm), (left) outer ankle blister (2 x 2 cm with 4mm depth), 3 excoriation areas on (left) buttocks, reddened peri area, (left) sacrum necrotic area, (left/right) buttocks reddened. -There was no evidence in the medical record that the physician was notified. On 7/7/21 the weekly pressure ulcer record documented: (1) The existing sacral pressure ulcer measured 4.8 x 3.0 cm, assessed as stage 2, wound improving in size, black eschar has sloughed off revealing healthy pink tissue to wound bed with surrounding excoriation to skin. A new order was received to cleanse the wound and back, apply Aquaphor to healthy tissue and leave wound open to air as it appears foam adhesive may be worsening surrounding excoriation. (2) The new left buttock pressure ulcer measured 2.1 x 1.2 cm, stage 2, new wound to left buttock to the side of previous sacral wound. Area presents with 75% slough with surrounding excoriation/sloughing of skin. The wound bed description was yellow. New orders were received to cleanse wound, apply mixture of A&D ointment and antifungal cream, leaving open to air. The onset date was 7/4/21. (3) The new unstageable pressure ulcer to the left heel measured 2.2 cm length x 2.0 cm width, was described as a new intact blister to left heel with translucent intact skin with darker hard tissue to blister edges, first observed on 7/4/21. New orders were received to paint with betadine twice daily. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-There were no corresponding nurses' notes and the physician was not notified until 7/7/21, three days after the new pressure ulcers were identified as acquired. The 7/11/21 skin assessment documented existing pressure ulcers described as left upper thigh healing skin tear, left outer ankle blister and three excoriation areas on left buttocks. -The sacral pressure ulcer was not documented. The 7/14/21 weekly pressure ulcer record documented: (1) Sacrum pressure ulcer, 4.0 x 3.5 cm, stage 2, wound continues with 25% slough to wound bed with surrounding excoriation of lower back. (2) Left buttock, 1.0 x 2.3 cm, stage 2, wound continued with slough to 25% of wound with surrounding excoriation. (3) Left heel, 2x2 cm, unstageable, hard intact non fluid filled blister to left outer aspect of heel. Treatment to all wounds continued as ordered. Physician progress notes on 7/14/21 documented nothing about skin status or pressure ulcers. Summary of plans included skin care. The 7/18/21 skin assessment documented new and existing issues as follows: 3 open wounds on left buttocks with granulation tissue continues, left ankle blister; and existing-left thigh skin tear with scab, abdominal fold with excoriation. Further description of skin issues: gluteal fold reddened, peri area reddened, buttocks reddened on left side. -The sacrum pressure ulcer was not documented. The 7/20/21 Braden scale assessed the resident at high risk with a score of 12, due to very moist skin, bedfast, very limited mobility, probably inadequate intake, and friction and shear problem. The 7/21/21 weekly pressure ulcer record documented: (1) Sacrum 4.1 x 3.5 cm, stage 2, same description as previous assessment. (2) Left buttock 1.2 x 2.5 cm, stage 2, same description. (3) Left heel 2x2 cm, unstageable, hard intact non fluid filled blister to left outer aspect of heel. -The sacrum and left buttock wounds were slightly larger, but the left buttock was the only wound documented as deteriorated. No new orders or treatments were documented. The 7/25/21 skin assessment documented three open wounds on left buttocks with granulation tissue remain, left ankle open area where pustule was, redness under gluteal fold and perineal area. -The sacral wound was not documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 7/28/21 weekly pressure ulcer record documented: (1) Sacrum 4.0 x 1.7 cm, stage 2, wound bed with healthy granulation, improved. (2) Left buttock 1x2 cm, stage 1, wound bed beefy red. (3) Left heel 1.8 x 1.6 cm, unstageable, improved in size and appearance, intact, hard, translucent blister continues. -Although the left buttock wound was documented initially as a stage 2, it was downgraded to stage 1 in addition to improved. The 8/1/21 skin assessment documented three open wounds on left buttocks with granulation tissue, and left ankle open area where pustule was. The 8/4/21 weekly pressure ulcer record documented: (1) Sacrum 3.0 x 2.3 cm, 0.9cm depth stage 2, area with beefy red granulation tissue throughout, improved. (2) Left buttock, 1.0 x 1.3 stage 2, with 25% slough, diffuse edges, improved. (3) Left heel 1.0 x 1.3 cm, stage 1, improved, previously black eschar now open superficial area with red healthy tissue. -Although the heel wound previously had black eschar which indicated an unstageable wound, it was downgraded to stage 1. The 8/8/21 skin assessment documented slowly resolving pressure ulcers on buttocks and red groin area. -The sacral and heel wounds were not documented. The 8/11/21 weekly pressure ulcer record documented: (1) Sacrum 3.0 x 2.3 stage 2, pink to beefy red with granulation tissue throughout, no change. (2) Left buttock 1.0 x 1.3 cm stage 2 with 25% slough, diffuse edges, no change. (3) Left heel 1.0 x 1.3 stage 2, open, superficial, red healthy tissue noted, no change. -The left heel wound, previously documented as stage 1, was documented again as stage 2. The 8/15/21 skin assessment simply documented buttocks healing well. -However, the resident had three documented pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 8/17/21 skin assessment documented a new pressure ulcer described as 2x2 open area to left lateral heel. -The other pressure ulcers were not documented. On 8/17/21 at 9:18 a.m. nursing notes documented pressure from lying on side and not wearing booties. Resident has 2x2 centimeter (cm) open area to her left lateral heel. The resident's representative and primary care clinician were notified. -No further skin issues or details were documented, although the resident continued with three documented wounds. The 8/18/21 weekly pressure ulcer record documented: (1) Sacrum 3.0 x 2.3 cm stage 2, no change. (2) Left buttock 1.0 x 1.3 cm stage 2, no change. (3) Left heel 1.0 x 1.3 stage 2, no change. -There was no documentation of the new left lateral heel wound, documented on the 8/17/21 skin assessment (above). The 8/23/21 skin assessment documented a stage 2 pressure ulcer to the left buttock and an unstageable scabbed abrasion to the front left thigh. The 8/25/21 weekly pressure ulcer record documented: (1) Sacrum 3.0 x 2.3 cm stage 1, no change. (2) Left buttock 1.0 x 1.3 cm stage 1, no change. (3) Left heel 1.0 x 1.3 cm stage 1, wound with only very superficial translucent skin, no change. -Although all the wounds were documented without change, they were downgraded to stage 1. Only one wound was documented to the resident's heel, although the 8/17/21 skin assessment documented a new heel wound. The 8/30/21 skin assessment documented only red buttocks, and no other wounds. On 9/1/21 at 10:53 p.m. a late entry nursing note documented wound care rounds revealed the resident's left buttock wound was healed and two other wounds (location undocumented) continued, which the wound care team would continue following. The 9/1/21 weekly pressure ulcer record documented: (1) Sacrum 2.2 x 1.0 cm stage 1, improved. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(2) Left heel 0.8 x 0.8 cm, no stage documented, improved. The 9/6/21 skin assessment documented red buttocks and no other wounds or skin issues. The 9/8/21 weekly pressure ulcer record documented: (1) Sacrum 2.3 x 1.0 cm stage 1, small decrease in size, improved. (2) Left heel 0.5 x 0.5 cm, no stage documented, improved. On 9/12/21 at 6:48 a.m. nursing notes documented a small wound remained on one buttock and no other wounds were documented. The 9/13/21 skin assessment documented red buttocks and no other skin issues. Physician progress notes on 9/14/21 documented nothing about skin status or pressure ulcers. Summary of plans included skin care. The 9/15/21 weekly pressure ulcer record documented: (1) Sacrum 2.3 x 1.0 cm, no stage documented, no change. (2) Left heel 0.5 x 0.5 cm, no stage documented, no change. The 9/20/21 skin assessment documented red buttocks. The 9/22/21 weekly pressure ulcer record documented: (1) Sacrum 2.1 x 1.0 cm, no stage documented, improved. (2) Left heel 0.5 x 0.5 cm, no stage documented, no change. The 9/27/21 skin assessment documented red buttocks. The 9/29/21 weekly pressure ulcer record documented: (1) Sacrum 2.1 x 1.0 cm, no stage documented, no change. (2) Left heel 0.5 x 0.5, no stage documented, no change. The 10/6/21 weekly pressure ulcer record documented: (1) Sacrum 2.1 x 1.0 cm, no stage, no change. (2) Left heel 0.5 x 0.5 cm, no stage, no change. The 10/11/21 skin assessment documented buttocks are still red and excoriated, treatment in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/11/21 at 6:00 a.m. a late entry nursing note documented buttocks were still red and excoriated, treatment in place, and no other wounds were documented. The 10/13/21 weekly pressure ulcer record documented: (1) Sacrum 2.1 x 1.0 cm, no stage, no change. (2) Left heel 0.5 x 0.3 cm, no stage, improved. On 10/18/21 at 6:00 p.m. nursing notes documented for previously identified areas, treatment for bilateral buttocks still in place, with no other wounds documented. -The skin assessment on the same date documented the same, with no documentation of the sacrum or left heel. The resident's 10/19/21 Braden scale for predicting pressure ulcer risk revealed she scored 16, at risk, due to slightly limited sensory perception, skin occasionally moist, chairfast, slightly limited mobility, and friction/shear problem. On 10/20/21 a nursing note late entry documented the resident's sacrum was healed, skin clean, dry, intact, problem closed. No other wounds were documented. The 10/20/21 weekly pressure ulcer record documented: (1) Nothing regarding the sacrum. (2) Left heel 0.4 x 0.4 cm stage 2, no change, pressure ulcer to left heel continues. Area free from s/sx of infection. Wound bed red with thin scab covering. On 10/25/21 a nursing note documented the resident's skin was intact. -The 10/25/21 skin assessment documented the same. The 10/27/21 weekly pressure ulcer record documented: (1) Left heel 0.5 x 0.5 cm stage 2, pressure ulcer to left heel continues, no change, stable wound. (2) Left heel 0.4 x 0.4 cm stage 2, new wound to left medial heel, no s/sx of infection, wound bed red and blanchable. The physician was notified on 10/27/21 and treatment was to continue. -Although an additional heel wound had been previously identified in a skin assessment, this was the first time it appeared on the weekly pressure ulcer record. The 11/1/21 skin assessment documented previously identified areas, see below, described as bilateral buttocks with treatment in place. On 11/1/21 at 9:23 p.m., nursing notes documented cleanse both wounds to left medial and outer heel with w[TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31797 Based on record review and interviews, the facility failed to ensure the facility provided adequate supervision and monitoring for two (#38,#72) residents of six residents reviewed for falls and accidents out of 34 sample residents. Resident #38 who had severe cognitive deficits and resided on the facility's memory care unit (MCU), resulting in four falls in four months. One of the falls, which occurred on 8/4/21, resulted in harm to the resident. Due to a deep laceration to her right outer hand, Resident #38 required transport to the local emergency room for stitches. The facility also failed to provide supervision, monitoring and education to staff to prevent Resident #38 from eloping from the MCU's secured patio via a gate on 10/4/21, which led to the resident sustaining another fall in the community while away from the facility. The facility failed to thoroughly investigate and document every fall Resident #38 sustained in IDT meetings, including adding new and effective fall interventions to the resident's care plan following every fall. Additionally the facility failed to provide adequate supervision and safe environment to prevent Resident #72, with multiple incidents of exit seeking and dangerous elopement attempts, from eloping from the facility on 9/9/21. The facility failed to develop an effective performance improvement plan (PIP) for resident falls until the recertification survey began on 11/8/21. I. Facility policy The Elopement and Wandering Resident policy, dated 2021, was provided by the nursing home administrator (NHA) on 11/11/21 at 3:45 p.m. The policy read in pertinent part: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. The facility shall establish and utilize a systems approach to monitor and manage residents at risk for elopement or unsafe wandering, including identification and risk assessment and evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary According to the policy the interdisciplinary team (IDT) would evaluate the factors contributing to the resident ' s risk in order to develop a person-centered care plan. Interventions would be included in the care plan and communicated with staff to increase staff awareness of the resident ' s risk. The policy guided staff to provide adequate supervision to help prevent accidents or elopements and evaluate the effectiveness of the interventions, modifying as needed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The policy defined elopement when a resident leaves the premise or a safe area without authorization and/or any necessary supervision to do so. The policy defined wandering occurrence as random or repetitive locomotion that may be goal-directed or non goal-directed or aimless. The policy gave the search for an exit as an example of wandering. The Accidents and Supervision policy, revised November 2017, was provided by the NHA on 11/11/21 at 8:05 a.m. The policy read in pertinent part: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: -Identifying hazards and risks; -Evaluating and analyzing hazards and risks; -Implementing interventions to reduce hazards and risks; and, -Monitoring for effectiveness and modifying interventions when necessary. According to the policy the facility should establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. All staff should be involved in the observation and identification of potential hazards in the environment while considering the unique characteristics and abilities of each resident. The policy read the facility should make reasonable efforts to identify hazard and risk factors for each resident and provide various sources of information about the hazards and risks in the residents ' environment. The policy indicated the sources of information could include but not limited to quality assessment and insurance activities (QAPI), environmental rounds, the minimal data set assessment (MDS), a resident ' s medical history, a physical examination, and the facility assessment. II. Resident #38 A. Resident status Resident #38, age 85, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), diagnoses included dementia with behaviors, abnormality of gait and mobility and muscle weakness. Resident #38 resided in the facility's secured memory care unit (MCU). The minimum data set (MDS) assessment dated [DATE] documented the resident had severe cognitive deficits with a brief interview for mental status (BIMS) score of four out of 15. It documented the resident required supervision with set up for bed mobility, transfers, ambulating with her walker and eating. She requires extensive assistance from one for dressing, toileting, personal hygiene and bathing. The MDS documented the resident had physical and verbal behavioral symptoms towards others on a daily basis, as well as behavioral symptoms not directed towards others on a daily basis. It documented the resident rejected care and also wandered on a daily basis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	B. Resident observations Resident #38 was initially observed on 11/8/21 at 1:30 p.m. She was seated at a table on the MCU, putting together a large-sized puzzle. She was pleasant, smiling and displayed a calm manner. -At 6:00 p.m., she was eating her dinner at a table in the MCU dining room with another resident and they were socializing together. The resident was observed on 11/9/21 at 9:30 a.m. She was seated at a table in the MCU dining room by herself and she was independently looking at a People magazine. -At 12:01 p.m., the resident was, once again, having a meal with her friend and was eating her meal independently. -At 3:45 p.m., the resident was in her room taking a nap. Resident #38 was observed on 11/10/21 at 8:15 a.m. She was seated alone and finishing her breakfast. Her walker was not observed within reach of the resident or anywhere nearby. -At approximately 10:15 a.m., the resident was engaged in an activity with assistant activity (AA) #1 of making eagle pictures by tracing their hands. Resident #38 was observed on 11/11/21 at 10:33 a.m. She was with AA #1 participating in a Veteran's Day trivia activity. She said she could remember back to WWII and that her family was so happy when the war ended. Her walker was observed to be in another common area of the MCU at this time. -At 12:53 p.m., the resident was observed going through her dresser drawers looking for clothes because she wanted to go and see her mother for a few days. Staff redirected her back to the group of residents in the common area and she readily complied with staff. -At 3:00 p.m., Resident #38 was observed to be engaged with three other resident coloring pictures. She was coloring [NAME]. Her walker was left in another room with a glass of water on it. It was not within reach of the resident at this time. C. Record review The care plan dated 10/17/21 related to falls documented Resident #38 was at risk for falls related to gait/balance problems. Unaware of safety needs, wandering. The goal was to have decreased risk of falls with the staff helping the resident as needed. The general intervention was to anticipate and meet the resident's needs. More specific interventions related to falls included needing a safe environment with even floors free from spills and/or clutter, documenting the resident's falls had been happening the majority of the time in the evening, so the resident would need stand-by assistance when walking at that time, offering the resident a seat if she was pacing and to be outside with her when she was outside in the patio area in case she needed redirection or assistance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The progress note related to this elopement, dated 10/4/21 at 9:41 p.m. documented Resident #38 eloped from the facility at approximately 5:00 p.m. It documented the back gate in the MCU secured patio area had been left open by a staff member using that entrance. It documented Resident #38 had been actively exit seeking all afternoon. The resident was discovered making her way down the sidewalk outside by a passerby on the street, who then apparently let someone in the facility know where she was. The housekeeping supervisor was the first person to discover the resident alone on the sidewalk. Resident #38 had fallen on the sidewalk (See fall investigation #1 below). When the documenting nurse was alerted and reached the scene, there were several staff members already present who had helped Resident #38 stand up and retrieved a wheelchair to escort her back into the building. Resident #38 appeared a bit shaken, but was consolable. She mentioned that her right knee hurt. There were no visible signs of abrasions at this time. Emergency medical services arrived at approximately 5:45 p.m. and transported the resident to the local hospital for evaluation. She returned from the hospital at 9:45 p.m. and was returned to her room on the MCU, where she was assisted to bed. This progress note documented one hour checks, as well as neurological exams due to the unwitnessed fall the resident sustained while she had eloped from the facility's MCU. E. Fall investigations 1. Fall #1 The SBAR form dated 7/29/21 documented Resident #38 sustained an unwitnessed fall on 7/29/21 at 1:45 p. m. as the resident was found outside, lying on the grass, yelling for help. It documented the resident sustained several new abrasions and the fall was related to the resident's agitation and the uneven ground she was walking on. The progress note dated 7/30/21 documented the IDT met with Resident #38 after her fall. It documented the resident had no memory of falling, but the resident sustained abrasions to her arms. It documented a CNA observed the resident had gone outside and saw the resident trying to pick up and throw her walker. It documented the CNA tried to go out to assist the resident and redirect her, but she had already fallen. The IDT post fall review dated 9/2/21, which was completed over a month since the resident's fall occurred, documented Resident #38 sustained abrasions to her forehead, left wrist and her left 3rd and 4th knuckles. IDT recommended that physical therapy reassess the resident's type of walker being utilized for appropriateness. It documented staff would be educated to be out with this resident when she was outside to supervise her more efficiently and provide assistance to the resident in a timely manner. The facility failed to adequately supervise and monitor Resident #38 while she was ambulating outside, per the MDS assessment dated [DATE]. (See above). 2. Fall #2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The SBAR form dated 8/4/21 documented Resident #38 sustained a witnessed fall on 8/4/21 at 8:54 p.m. with the resident falling on her knees, front and face. She rolled onto her back by the time staff got to her. She sustained a small cut on the bridge of her nose and a bruise to her forehead. She also suffered a deep cut to her right outer hand by the little finger, which needed stitches. She sustained a skin tear to her right lower arm, measuring 3 cm X 3 cm. She was sent to the local hospital's emergency room for stitches for the deep cut. The progress note dated 8/5/21 documented the IDT met with Resident #38 after her fall. It documented the resident had no memory of the fall, but did sustain a few injuries. The resident complained of mild pain. Staff state Resident #38 was agitated at the time of fall as evidenced by making statements of wanting to go home, while she was pulling on the back gate outside the MCU. They said the resident fell forward. The resident's care plan was updated and staff was advised to use prn (as needed) Ativan (an anti-anxiety medication) if the resident became too agitated. The IDT post fall review dated 8/16/21 documented the fall occurred at 5:35 p.m., which was an approximate three hour difference than documented in the SBAR above. It documented the resident required first aid, including stitches. It documented Resident #38 was pulling on a patio gate handle, trying to get it open. She turned to the left and fell on her knees and face. There was a small round pipe by the wall, which probably cut her hand. The resident sustained no loss of consciousness. She was trying to go home. IDT recommended staff notify the MD of possible need for med(ication) review. Anxiety meds were increased as deemed appropriate. PT to evaluate the type of walker for appropriateness. Staff to assist the resident while outside in the courtyard. Neuro(logical checks) done in case she did hit her head. The facility failed to adequately supervise or re-direct Resident #38 while she was actively trying to elope from the facility in order to prevent her falling and sustaining an injury requiring stitches. 3. Fall #3 The SBAR form dated 9/17/21 documented Resident #38 sustained a witnessed fall in the MCU dining room on 9/16/21 at 6:41 p.m. It documented the resident fell after slipping on water, falling to her knees and brushing her forehead against the dining room wall. The progress note dated 10/5/21 documented the IDT met with Resident #38 after her fall. It documented the resident stated she did not remember what occurred, but denied pain or injury. It documented formal education was provided to staff about keeping the residents' environment clear and safe. The IDT post fall review dated 9/21/21 documented the fall occurred at 7:00 p.m. and Resident #38 sustained no injury. It documented another resident pulled a pitcher of water off the counter top and the water spilled on the floor. Resident #38 went over to help catch the pitcher and wipe up the water and ended up slipping on the floor. IDT recommended staff education to keep the MCU environment clean and clear for resident safety and to check the environment frequently. It was documented staff should frequently encourage the resident to use her walker due to her cognitive barriers with dementia. The facility failed to supervise and re-direct Resident #38 away from the spilled water in the MCU dining room, causing Resident #38 to fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. Fall #4 The situation, background, assessment and recommendation (SBAR) communication form and progress note dated 10/4/21 documented Resident #38 sustained an unwitnessed fall on 10/4/21 at 10:25 p.m. It should be noted the fall was documented here as occurring approximately five hour later than was noted in the elopement documentation (See above). It documented Resident #38 had eloped outside the facility and fell on the sidewalk. It documented the resident had been exhibiting new or worsening behavioral symptoms. The assessment was Resident is an active exit seeker. It documented, per the progress note dated 10/5/21 at 9:32 a.m. (See below), the resident had no pain or injury other than bruising of her right knee. The progress note dated 10/5/21 documented the interdisciplinary team (IDT) met with Resident #38 after her fall. She said she fell on the street, but denied having any pain or injury at the time. It documented all staff education was to take place. The IDT post fall review dated 10/6/21 documented the resident hit her right knee on the sidewalk and said it was hurting. She had a history of falls and cognitive deficit. The summary of the interdisciplinary team was the secured back gate was left unlocked and the resident went through the gate. It documented education was to take place related to gate checks, when the gate was to be locked and monitoring of the residents in the area of secured patio gate in the MCU. Maintenance was to inspect the gate and apply a spring for automatic closure and ensure proper latching of the gate. The facility failed to provide adequate supervision and re-direction for Resident #38 to prevent the resident from eloping from the facility and sustaining a fall in the community after she eloped. F. Family interview A family member of Resident #38 was interviewed via telephone on 11/11/21 at 10:40 a.m. He said it had been about two months since he had seen his mother due to COVID-19 restrictions. He said he wished he could see her more often. He said he did not receive a phone call earlier in the day on 10/4/21 prior to his mother eloping from the facility. He said he wished he had received a call and maybe he could have calmed her down so she did not escape and fall, but said he was almost proud of her for trying to get to her family. G. Staff interviews The director of nursing (DON) was interviewed on 11/11/21 at 1:52 p.m. She said Resident #38 was able to escape from the facility because staff had been using the back gate in the secured MCU's patio, the gate did not latch properly and no one noticed this until after the resident eloped. She said Resident #38 had been reported as a missing person on 10/4/21. She said the spring on the gate was replaced and all staff were educated about no longer using that gate to enter and exit the facility. She said normally the doors to the MCU were left open during the summer months and the facility assumed the secured area of the MCU patio was safe for residents. She said it was not until Resident #38 eloped from the facility when they realized there was a safety issue. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nursing home administrator was interviewed on 11/11/21 at 3:50 p.m. She stated Resident #38 was reported to the state portal as a missing person on 10/4/21. She said after the elopement, the facility placed hinges and springs on the gate, causing it to self-latch after the gate had been opened. She said she did not believe staff were outside with the resident when she eloped because they had the doors between the facility and the secured patio open to let fresh air in. She said staff did not feel they needed to be outside with her because of the secured gate. She said the reason staff came through the secured gate earlier that day was because the staff was afraid to enter through the main door to the MCU through the facility because that was the door Resident #38 had been trying to exit seek through most of the day. She said right before Resident #38 eloped, she had calmed down a bit and when staff saw her go outside, they just let her be. She said, Luckily, they went out to check on her about five or six minutes later. The NHA said staff were educated the day following the elopement, on 10/5/21, about any staff using the gate, to ensure the gate was completely shut and the magnet was engaged. She said the facility thought about permanently closing off the gate, but families used that gate to come and visit their loved ones on the MCU. The NHA said, in relation to Resident #38's falls, she did not like to see any of the residents fall. She said there should not have been water on the floor when Resident #38 fell in the water on 9/16/21. She said if Resident #38 needed to use a walker, she should and it should have been within the resident's reach, but most of the time the resident chose not to use the walker. At this time, approximately 4:05 p.m., the vice president of operations (VPO) entered and joined the interview. She said the facility had opportunities for improvement with resident falls and the facility now had a performance improvement plan (PIP) for falls, which they just developed on 11/8/21, the day the recertification survey began. She said education was provided to the IDT earlier that week and the facility's next step was to roll the information in the PIP out to the nursing department. She said, with the facility's recent change in corporate management and confusion related to the reporting process, the facility did not currently have a systemic approach related to falls and they would be working on this. The VPO brought the DON into the interview when discussing why it took so long to review the 8/4/21 fall in IDT, as it was not reviewed until 8/16/21. The same issue was seen in documentation for the 7/29/21 fall being reviewed on 9/2/21. (See fall investigations above). The DON said she knew they did review these falls and did not know what happened when the assessments were locked. The DON checked to see if new interventions were in place after 8/4/21 fall and said she did not see any new interventions in place after that fall. She said she thought the problem was not officially reviewing the falls in a timely manner and closing them out. III. Resident #72 A. Resident status Resident #72, under the age of 65, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), diagnoses included malignant neoplasm of the cervix, cirrhosis of the liver and anxiety disorder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The 9/7/21 MDS assessment identified the resident's cognition was moderately impaired with a BIMS score of eight out of 15. The resident has a wandering behavior that occurred one to three of the days during the assessment look back period. The MDS revealed Resident #72 ' s wandering placed her at significant risk of getting to a potentially dangerous place, such as stairs or outside of the facility. According to the MDS, Resident #72 required minimal assistance for all of her activities of daily living (ADLs) with supervision of ADLs with set up help only. The MDS did not identify exhibited behaviors physically or verbally or directed at others. B. Record review The 9/9/21 facility investigative report for Resident #72 was provided by the NHA on 11/10/21. The report revealed Resident #72 eloped from the facility on 9/9/21. The resident was reported missing between 3:50 p.m. and 4:20 p.m. Resident #72 was found by staff a few blocks away from the facility without injury. The report identified the resident was under one on one supervision of a certified nursing aide (CNA) prior to the elopement. According to the report, the CNA sat at the nurses station and watched the resident through a slightly ajar door. The CNA could not see the restroom door or the window from her position. The CNA believed the resident entered the restroom in her room at 3:40 p.m. She did not see the resident return from the restroom. A nurse entered the room of Resident #72 and identified the resident was not in her room and the room window was open with the screen removed. The report revealed the resident had attempted elopement several times. The facility determined the elopement attempts were related to agitation and her end-of-life decline. The investigative report for Resident #72 indicated facility policies and procedures were not followed. According to the report the SBAR (situation, background, assessment and recommendation was incomplete, the care plan did not include elopement or wanderguard, and sliding door/window locks were not in place, allowing the window to be opened more than six inches. Resident #72 was a new admission to the facility from the hospital. The hospital medication orders, signed on 9/1/21, read Resident #72 was admitted to hospice with an expected decline. The care plan for behavior initiated on 9/7/21 read Resident #72 had anxiety with agitation related to EOL (end of life). She exhibited pacing and wandering to the point of exhaustion with exit seeking behavior. Interventions included to anticipate and meet the resident ' s needs, encourage her to express her feelings appropriately and staff to provide opportunities for positive interaction and attention by stopping and talking with Resident #72 as they pass by. The care plan for elopement risk/wandering was initiated on 9/10/21. -The care plan was not initiated after the risk was identified on 9/5/21 or on 9/8/21, after continued exit seeking and elopement attempts. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	According to the care plan, Resident #72 was at risk for elopement and wandering due to a confusion related to malignant cancer. The care plan read the resident had a recent elopement where she jumped out of her bedroom window. The care plan identified the resident was on one-on-one supervision with interventions and needed emotional and psychological support, orientation to environment and re-orientation with validation and redirection as needed. The 9/5/2021 nursing note read Resident #72 observed walking outside in front of the facility door. Staff in the parking lot observed the resident and assisted her back inside the facility. According to the note, the resident was confused, wandering throughout the hallway and needed constant redirection to her room. The note revealed Resident #72 attempted to go out the front door twice prior to this incident. The note indicated a wanderguard was activated after she was found outside and staff would continue to monitor the resident. The note did not identify when the resident attempted to exit through the front door prior to the identified incident. The 9/5/21 phone order written at 3:19 p.m. identified orders to check the wanderguard for placement and function at every shift for wandering. The 9/8/2021 behavior note read Resident #72 was observed by a CNA on the phone behind the nurses station. The resident was crying and wanted to call the police. The CNA informed the resident she could not be behind the nurses station. According to the behavior note, the[TRUNCATED]

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12905 Based on observations, record review and interviews, the facility failed to provide catheter care in a sanitary manner to prevent infection and promote comfort for one (#52) of one resident reviewed for catheters out of 34 sample residents. Specifically, the facility failed to ensure nursing staff used the proper technique and products in keeping with professional standards when providing indwelling Foley catheter care for Resident #52. Findings include: I. Facility policy The Catheter Care policy, undated, was provided by the director of nursing (DON) on 11/10/21 at 1:39 p.m. The policy included the following: -Catheter care will be performed every shift and as needed by nursing personnel. -Empty drainage bags when bag is half-full or every 3 to 6 hours. -Compliance guidelines for catheter care: Gently separate the labia to expose the urinary meatus. Wipe from front to back with a clean cloth moistened with water and perineal cleaner (soap). Use a new part of the cloth or different cloth for each side. With a new moistened cloth, starting at the urinary meatus moving out, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. Dry the area with a towel. II. Resident status Resident #52, age 74, was admitted on [DATE]. According to the November 2021 computerized physician orders (CPO), pertinent diagnoses included abnormalities of gait and mobility, need for assistance with personal care, acute respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction (paralysis following stroke) affecting left non-dominant side, sepsis, and bladder-neck obstruction. According to the 10/21/21 minimum data set (MDS) significant change assessment, Resident #52 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15, with no behavioral symptoms and no rejection of care. She required extensive two-person assistance for activities of daily living (ADLs) including bed mobility, transfers, toilet use, dressing and bathing. Ambulation did not occur. She had an indwelling catheter and was always incontinent of bowel. III. Resident interview (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 was interviewed on 11/9/21 at 9:51 a.m. She said she had a Foley catheter for incontinence and wound healing. She said she had some discomfort from the catheter, and had asked them to remove it but they said they could not. She said she had sores between her legs, and the catheter was inserted so they could heal. (Cross-reference F686 pressure ulcers.) IV. Observation and interviews On 11/10/21 at 10:16 a.m. certified nurse aides (CNAs) #4 and #5 were observed providing peri care and catheter care for Resident #52. Using Pro Care wipes, CNA #4 cleansed the resident's catheter from distal to proximal (toward the resident's skin). Both CNAs said they got training online and in person upon hire and periodically. Resident #52 was telling staff that her left leg hurt and saying, Ow, ow. The catheter had not been changed, and the bag had never been changed per Resident #52. The CNAs said they were not sure how often it should be changed but admitted they did not think it had been changed. The catheter tubing was hazy and lined with straw-like sediment. The resident's urine was cloudy straw color. On 11/10/21 at 10:33 a.m., licensed practical nurse (LPN) #2 was observed changing Resident #52's catheter bag and tubing. However, she did not cleanse the connector with alcohol. She said she would have cleaned the connector with alcohol if it was not a brand new bag. V. Record review The resident's care plan dated 6/11/21 identified, I have an indwelling catheter related to bladder outlet obstruction. The goal was, I will show no s/sx (signs/symptoms) of urinary infection through review date. Interventions included: -Anchor catheter to prevent excess tension. I often prefer not to wear my leg strap due to it rubbing against my other/opposite leg. (Cross-reference F686) -Catheter: Change 16FR indwelling urinary catheter monthly and PRN (as needed). -Check tubing for kinks with every assist with repositioning and each shift. -Hand washing before and after delivery of care -Observe for s/sx (signs/symptoms) of discomfort on urination and frequency. -Observe/document for pain/discomfort due to catheter. -Observe/record/report to MD (medical doctor) for s/sx UTI (urinary tract infection): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. -Perineal care as indicated. Notify nurse of any redness or irritation at insertion site. Physician orders included the following: (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide catheter cleansing and perineal hygiene daily and PRN if soiled every shift, start date 6/26/21. -Monitor for potential complications of indwelling urinary catheter use such as redness, irritation, signs/symptoms of infection, obstruction, urethral erosion, bladder spasms, hematuria, or leakage around the catheter every shift, start date 6/26/21. -There was no designation on the November 2021 treatment administration record (TAR) to document catheter, tubing and bag changes. -There were no nursing notes from admission to 11/11/21 regarding catheter care, complications, observations, or tubing/bag changes. VI. Staff interviews The staff development coordinator/infection preventionist (IP) was interviewed on 11/11/21 at 9:55 a.m. She said they did annual competency check-offs for CNAs and nurses. Most of the training was done on Relias (online education), some was in person, and staff had to demonstrate skills to be checked off. She was unable to answer whether staff were required to be checked off with return demonstrations before they were allowed to perform care. She said when they did the checkoffs they also used training videos sometimes, however was unable to provide what video was used for catheter care education. She said both nurses and CNAs could do catheter care. The IP stated they educated staff to use wipes for catheter care. She did acknowledge that the catheter should have been wiped from the meatus down the tube away from the resident. She said she would check on how often overnight (catheter) bags should be changed. She said she would also provide catheter training for the CNAs mentioned above. A customer service representative from the manufacturer of Pro Care peri wipes was interviewed by phone on 11/11/21 at 12:27 p.m. She said she did not believe Pro Care adult washcloth wipes were appropriate for catheter care and they had been recommending that they not be used near any opening. The IP was interviewed a second time on 11/11/21 at 1:00 p.m. She said for catheter and peri care, nursing staff should use Pro Care peri wipes or mild soap and warm water. She said training was done on hire and annually and competencies were annual. She said she was not sure when the last training was done for all nursing staff, but they would be doing another one soon. VII. Facility follow-up On 11/11/21 at 12:26 p.m., the IP provided evidence of one-to-one education via phone on 11/11/21 for CNAs #4 and #5. The education was in response to inappropriately performing catheter care and cleaning. The in-service included, While performing catheter care always wipe from perineal area down towards catheter bag. Ensure to provide pericare and routine hygiene protocol. Training was also provided for CNAs #4 and #5 for indwelling urinary catheter care and management standards of care, which included thoroughly cleansing the meatus and peri area, properly cleaning the catheter tubing and using mild soap and water instead of wipes which could be irritating to the skin.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31797 Based on observations, interviews and record review, the facility failed to provide food and drinks that were palatable, attractive and served at appetizing temperatures in four of four resident hallways. Specifically, the facility failed to: -Ensure food was prepared in a palatable manner, including over-cooking certain foods, especially meat; -Ensure foods such as green beans were seasoned in a flavorful manner; and -Ensure resident's choices of beverages were being honored. Findings include: I. Facility policy and procedure The Food: Quality and Palatability policy and procedure, revised 9/2017, was provided by the nursing home administrator (NHA) on 11/11/21. It documented the policy was created to ensure food would be prepared by methods that conserve nutritive value, flavor and appearance. Food would be palatable, attractive and served at a safe and appetizing temperature. It documented the dining services director and cook (s) were responsible for food preparation. It documented that menu items would be prepared according to the menu, production guidelines and standardized recipes. It documented the cooks would prepare food in accordance with recipes and the season for the region and/or ethic preference, as appropriate. It documented that cooks should use proper cooking techniques to ensure color and flavor retention. II. Resident interviews The following residents were interviewable by the facility and assessment: Resident #12 was interviewed on 11/8/21 at 2:18 p.m. He said the quality of the food varied because the facility only had one good cook. He said the oatmeal was either too watered down or too thick. He said the toast was served hard and cold. He said that most of the temperatures of the food was just warm to cold. He said the kitchen was getting better with new help, but was still a work in progress. Resident #39 was interviewed on 11/8/21 at 2:24 p.m. He shrugged and said the food in the facility could be better, which is why he ordered out for his food often from local restaurants. He said the food served in the facility was kind of bland and all tasted the same. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #65 was interviewed on 11/8/21 at 3:26 p.m. She said she had received both raw food and burnt food in the facility. She said nothing they served was fresh. She said the facility would change the names of the food to sound fancier, but it was actually the same boring vegetable. She said one morning she never received breakfast at all. She said another time during lunch, she was served fish and offered no substitute entree, even when the resident said she did not like fish. Resident #30 was interviewed on 11/8/21 at 3:38 p.m. He said all the facility food was not very good and was mediocre at best. Resident #21 was interviewed on 11/8/21 at 4:04 p.m. She complained about the facility serving plain white rice with no sauce or butter at all. She said the zucchini was soggy and the meat was tough, especially the chicken breasts. She said she had to shred the chicken herself to even be able to eat it. Resident #58 was interviewed on 11/9/21 at 8:52 a.m. He said he did not receive the food he ordered for breakfast that morning. He said he ordered eggs and pancakes and was delivered one small pancake and two pieces of bacon. Resident #32 was interviewed on 11/9/21 at 9:14 a.m. She said the food was overcooked and the meat was hard to cut. She said it showed disrespect to the residents to be served burnt food. Resident #52 was interviewed on 11/9/21 at 9:21 a.m. She said she did not like the facility's French fries or tater tots because they always tasted like fish or they were rancid tasting. She said the frozen hamburger patties tasted odd. She said the chicken noodle soup tasted like hot water with spaghetti noodles. She said everything was unappetizing. Resident #61 was interviewed on 11/9/21 at 11:09 a.m. She said, The food is awful. The food stinks. The green beans have sticks in them, so I know they're not quality. You need to season things a little bit. It's just so bland. The food needs something to pep it up a little bit, give it some flavor. She also said the coffee was terrible in the facility and she would love to have a Keurig coffee maker in her room. She said she was tired of hamburgers and would occasionally like a tender steak with mushrooms. She said the roasts and meats the facility served was hard as a rock. You can't even chew it. It stinks. She said even a cheeseburger with a little red onion would be an improvement. She said they only served bacon one day a week and would like it more often but once they served her a slice of bacon that was raw. Resident #52 was interviewed again on 11/10/21 at 1:05 p.m. about the lunch she just received. She said she would have preferred fried chicken instead of baked chicken. She said she did not get what she ordered for breakfast earlier that day; she said she requested Raisin Bran, but was served oatmeal and the French toast bake. She presented the tray card from that meal, which was as stated. Her tray card did show the resident was allergic to shellfish. Resident #39 was interviewed again on 11/10/21 at 2:49 p.m. about his impressions of the facility food that week. He said he did have the meatloaf on 11/9/21 and it was good, but the vegetables were watery and his bread was soggy. III. Resident council group interview (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident council group interview was conducted on 11/9/21 at 10:00 a.m. in the facility's activity room. The following related to food palatability was shared by the residents attending this group interview: The group said their biggest grievance currently was no longer receiving soda for beverages per their preferences, as discussed in the regularly scheduled resident council the past few months (See below). They stated after the facility decided to stop using the soda fountain, they began serving small cans of Shasta soda and they did not like the taste of that brand of soda. They said they were offered limited flavors and were told by the facility they would no longer receive sodas of their choice because it was a money issue. They shared the following issues with palatability of the food: the scrambled eggs were cold and served in small portions, the toast was served cold, overall the food needed more seasoning, the green beans were cold and were often bland and unflavorful and the orange juice has been watery tasting. They said the variety of vegetables served had been very limited and they were tired of eating broccoli, peas and carrots, and beans. IV. Facility test tray A test tray was requested from the facility for the lunch served on 11/10/21, which consisted of a maple Dijon chicken thigh, baked potato, herbed green beans, pear crisp and a dinner roll. The tray was delivered at 12:42 p.m. There was no butter or sour cream on the tray for the potato and the roll was missing. The food sampled tasted fine except for the green beans, which were not herbed at all and had an unusual, unidentifiable taste. The regular green beans tasted quite different from the pureed beans and both had an unpleasant taste. V. Record review A. Resident council meeting minutes The resident council meeting minutes, provided by the activity director (AD) on 11/11/21 at 4:00 p.m. documented the following: The September 2021 resident council meeting minutes, which was undated: Meat is always dry. The October 2021 resident council meeting minutes, which was undated: Dietary: Meals are coming to us late. Kitchen staff are not reading tickets, we are not getting what we ask for. They seem to run out of things a lot. Food is often cold. Oatmeal is either runny or hard/chewy and that is the same with toast; it is cold or burnt. Residents have requested fresh, hand-pressed hamburger patties and if the hamburgers could be grilled instead of fried. The resident council concern follow-up form dated 10/6/21 documented the facility's response to the October 2021 resident council concerns was, These are things we as a kitchen in whole are working on and will continue to work on. We are re-training staff. We are hoping to provide better meals that are hot and delivered on time. I will advise dietary to provide certain ticket items. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The November 2021 resident council meeting minutes, dated 11/3/21, documented the nursing home administrator (NHA) was in attendance. The NHA discussed the facility would no longer be using the soda fountain, but the kitchen would be providing small, canned Shasta sodas. She stated if a resident desired choice or a different named brand, they could give money to a facility staff who would purchase the soda for them. B. Resident food committee minutes The resident food committee minutes, provided by the district dietary manager (DDM) on 11/11/21 at approximately 11:30 a.m., documented the following: -8/4/21: Resident concerns included the coffee being too weak, watermelon served had no flavor, desserts being crammed into bowls instead of attractive presentation on small dessert plate, wanting to use other food vendors for variety into their meals, flavorless cornbread and soups and the rind on the ham being too hard to chew. The facility said they were having trouble with their current coffee supplier, would cut the rinds off the ham and would spice up the soups for more flavor. -8/27/21: Resident concerns included the rotation of the menu and that the food served was always the same, requests for fresh (not frozen) hamburger meat, re-training nursing staff to ensure alternate entrees were offered to the resident and to ensure orders for meals were written down correctly to ensure residents receive what food items were requested. The facility said they would request meat options through their contracted food provider. C. Winter menu The four weeks of the 2021-2022 winter menus, provided by the DDM on 11/11/21 at 3:40 p.m., documented the facility offered the residents either broccoli, peas and carrots, or beans 52 times out of a possible 96 opportunities. D. Facility plans related to resident's desire for soda The facility ideas for addressing the residents' request for soda was provided by the NHA the morning of 11/11/21. It documented some ideas as follows: 1. Add sodas to activities one to two times per week. We could pass with a drink cart as a treat. 2. Purchase generic soda from the store and see if residents enjoy them more. If so, we can purchase the generic soda versus the Shasta. 3. Give each resident ten soda tickets for the month and they can use them as they choose. 4. Stock soda in the activity store and use Bingo bucks. Residents can purchase a six-pack when the store is open We can run this resident Council or do a one-on-one resident poll and have them all take votes. VI. Staff interviews (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DDM, dietary manager (DM) and registered dietitian (RD) were interviewed together on 11/11/21 at 11:23 a.m. They said they attended the food committee as part of the monthly resident council meeting the first Wednesday of every month, as well as the stand-alone resident food committee conducted on the third Tuesday of the month. They said they missed the meetings in September 2021, but were able to attend the October 2021 and November 2021 meetings. The DDM said some of the above resident comments came from either residents she did not know very well or from residents who voiced continuous issues with the food. She said, for the residents with frequent complaints, those complaints need to be addressed immediately and sometimes the residents were just looking for someone to talk to. She said other residents who continually complain about the food were not eating a lot of the main entrees because of the poor quality of food being served by the kitchen in the past. She said some residents were not giving the new DM and cooks a chance. She said she would go in and begin talking up the new staff and new kitchen situation to the residents. She said she felt changing the stigma from where the kitchen was to having most of the residents try the new food and give it a chance would take a year. She said the old kitchen was failing with no direction, but with a bit more direction the facility has had in the kitchen in the past three month, things have been slowly improving. She said there was new kitchen staff and cooks who have now been taught different methods of cooking meats other than boiling it and have been instructed to follow corporate recipes. The DDM said the facility had been having difficulty with food deliveries from their contracted provider due to the nation-wide supply chain problems. Some said some products were better, like some frozen foods, but the residents were not used to these new products. She said delivery was inconsistent and they were trying to balance quality with what the provider was delivering. She said the facility had begun trying to obtain needed food locally rather than relying solely on the weekly delivery. The DDM said, in relation to the test tray on 11/10/21, neither she nor the cook tasted the green beans, either regular or pureed. She said she should have added onion powder to the recipe, but followed the recipe due to corporate instructions. She said last year's winter menu looked just like this year's winter menu and when you keep serving the same things over and over, the residents just want something different. She said the new cooks were good and knew what they were doing and just needed to be empowered to feel confident about using some spices. The RD said she and the DM would be working together on changing the ingredients in the food on the menu. She said the two of them had begun meeting weekly to discuss resident's likes and dislikes. The DM said she felt limited about what she could change and the RD said they could start looking at the menu as a whole to begin to address issues with the resident's palatability complaints. The DDM said they would be providing more hands-on training to the kitchen staff, as the kitchen staff had been steaming pork until new staff came on board three months ago. The DM said she could see things changing for the better and thought the residents could too. (continued on next page)

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