STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on record review and staff interviews the facility failed to ensure appropriate information was communicated to the receiving health care institution for two residents (#117 and #58) of three out of 62 sample residents. Specifically, the facility failed to ensure: -Resident #117's transfer form had accurate and required information documented to the receiving facility. -Resident #58 was not provided a 30 day notice for nonpayment while her medicaid eligiblity was pending. Findings include: I. Facility policy and procedure The Discharge Planning policy and procedure, last revised 2018, was provided by the director of nursing (DON) on 9/8/21 at 3:00p.m.; it read in pertinent part, If the resident is being discharged to a hospital or other facility, ensure that a transfer summary is completed and a telephone report is called to the receiving facility. Assess and document resident's condition at discharge. II. Resident status Resident #117, age 74, was admitted on [DATE] and discharged on [DATE]. According to the June 2021 computerized physician orders (CPO), diagnosis included unspecified dementia without behavioral disturbances. The 5/7/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. The resident expected to remain in the facility long term. -There were no behaviors documented. III. Record review (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident transfer form dated 6/18/21 was reviewed. It documented the resident was discharged to home (inaccurate information). It did not document the following: reason for discharge, primary diagnosis, physician contact information, social worker contact information, behaviors and that report was called into the receiving facility Cross-reference F623 for discharge notice, F660 for discharge planning process, and F661 for discharge summary. IV. Staff interviews Licensed practical nurse (LPN) #6 was interviewed on 9/7/21 at 11:00 a.m. He said the nurse who was taking care of the resident at the time of discharge should complete the transfer form. He said the form should include the reason for transfer and all pertinent information to the receiving facility. He said all information on the transfer form should be accurate and completed to enable the receiving facility to provide quality care for the resident. The DON was interviewed on 9/8/21 at 4:00 p.m. She said it was the responsibility of the nurse to complete the transfer/discharge form before the resident leaves the facility. She said it was important to have all pertinent information documented on the transfer form so the receiving facility knew what to do to care for the resident. She said she was not aware that Resident #117's transfer form did not have all the pertinent information. She said education would be provided to the nurses on what information needed to be documented on the transfer form. 44949 2. Resident #58 A. Resident #58 status Resident #58, age 68, was admitted on [DATE]. According to the September 2021 computerized physician orders, diagnoses included chronic obstructive pulmonary disease, cellulitis, adjustment disorder, and cognitive communication deficit. The 7/10/21 minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview of mental status score of 15 out of 15. It indicated the resident required limited assistance for activities of daily living. B. Resident interview Resident #58 was interviewed on 8/30/21 at 10:00 a.m. She said she was given a 30 day notice recently and received a bill. She said the nursing home administrator provided these documents to her. She said she was confused why she received a bill as she thought Medicare and Medicaid covered her services. She said she suffers from post traumatic stress disorder (PTSD) and the interaction was upsetting. She said she is not ready to move and is unsure where she can go as she was homeless prior to moving to the facility. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #58 was interviewed on 9/1/21 at 11:54 a.m. She said social services had not been by to see her and discuss discharge plans. She said there was no discharge planning at admission. She said according to the 30 day notice, she was to be discharged in the next several days with no discharge planning. C. Record review NHA completed a progress note on 8/25/21. It indicated the NHA went to Resident #58 ' s room to drop off packages. Resident #58 became upset. The note indicated the resident had been off Medicare services since 7/30/21 and was Medicaid pending. It indicated the resident should be paying her social security minus the allowable amount but has not paid. The note indicated the ombudsman would be notified of issuing a 30 day notice of eviction for lack of payment. The medical record failed to show any discharge planning was occuring for Resident #2 D. Staff interviews The social services director (SSD) was interviewed on 9/7/21 at 2:26 p.m. She said the 30 day notice that was sent to Resident #58 was for non payment. She said she has sent out referrals to other facilities. The business office manager (BOM) was interviewed on 9/7/21 at 4:15 p.m. She said she sent in Resident #58 ' s medicaid application on 8/17/21 and was now medicaid pending. She said on 8/1/21, Resident #58 should have begun paying as her Medicare services ended in July. She said Resident #58 refuses to talk to her. She said Resident #58 should have filled out a Medicaid questionnaire at admission and they admission director (AD) would have the form. The AD was interviewed on 9/7/21 at 4:20 p.m. He said there was no Medicaid questionnaire form for Resident #58. He said he could not provide her admissions forms as she had never signed them. The NHA was interviewed on 9/7/21 at 4:00 p.m. He said Resident #58 has applied for Medicaid and she was currently Medicaid pending. He said that he has talked to her about her bill but she conveniently gets PTSD anytime I talk to her about it. He said that she has completed her therapy and would need to move off the step down unit. The NHA was interviewed on 9/8/21 at 11:25 a.m. He said he was not aware that a resident cannot be discharged for non-payment while Medicaid is pending.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39260 Based on record review and staff interviews, the facility failed to have a complete discharge summary that included a recapitulation of the stay for one (#117) of three out of 62 sample residents. Specifically, the facility failed to ensure a discharge summary was completed for Resident #117 to include the following: -A recapitulation of the resident's stay, final summary of the resident's status and post discharge instructions. Findings include: I. Facility policy and procedure The Discharge Planning policy and procedure, last revised 2018, was provided by the director of nursing (DON) on 9/8/21 at 3:00p.m.; it read in pertinent part, The resident should be consulted about the discharge. If the resident is being discharged to a hospital or other facility, ensure that a transfer summary is completed and a telephone report is called to the receiving facility. Assess and document resident's condition at discharge. II. Resident status Resident #117, age 74, was admitted on [DATE] and discharged on [DATE]. According to the June 2021 computerized physician orders (CPO),diagnosis included unspecified dementia without behavioral disturbances. The 5/7/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of four out of 15. The resident expected to remain in the facility long term. There were no behaviors documented. -The resident resided on the secured memory unit while at the facility. III. Record review The discharge care plan revised on 5/11/21 revealed that the resident was to remain at the facility for long term care (LTC). Interventions included an assessment of the resident/family needs will begin on the day of admission and continue to be assessed throughout their stay, utilize assistance from family to provide a home like environment in room and establish comfortable routine for the resident. Review of the discharge summary dated on 6/18/21(the day the resident was discharged) revealed it was incomplete. It did not include the recapitulation of the resident's stay, the final summary of the resident's status, the post discharge instructions and the name of the facility the resident was transferring to. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross-reference F622 for transfer/discharge requirements, F623 for discharge notice, and F660 for discharge planning process. III. Staff interview The social service director (SSD) was interviewed on 9/7/21 at 2:30 p.m. She said she was not responsible for documenting the recapitulation and the final summary of the resident's stay. She said she believed the nursing department was responsible for completing that section. The director of nursing (DON) was interviewed on 9/8/21 at 4:00 p.m. She said the discharge planning began upon admission with the interdisciplinary team (IDT). She said a discharge summary should be completed for a resident prior to discharge. She said it was important to complete a discharge summary for continuity of care. She said each department was responsible to complete the discharge summary. She said Resident #117's discharge summary should include the recapitulation of the resident's stay, the final summary of the resident's status and post discharge instructions. She said she was not aware that the discharge summary was not completed. She said she would educate the IDT regarding completing each section on the discharge summary.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure one (#17) out of five residents reviewed out of 46 sample residents received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. Specifically, the facility failed to ensure Resident #17 was repositioned timely to assist with the prevention of possible skin injuries, according to the residents care plan. Findings include: I. Professional reference National Pressure Injury Advisory Panel (2016), Pressure Injury Prevention Points, retrieved from https://npiap.com/page/PreventionPoints (retrieved on 9/16/21) It read in pertinent part, the process for turning and repositioning residents included the following steps: -Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. -Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual ' s preferences. -Consider lengthening the turning schedule during the night to allow for uninterrupted sleep. -Turn the individual into a 30-degree side lying position and use your hand to determine if the sacrum is off the bed. -Avoid positioning the individual on body areas with pressure injury. -Ensure that the heels are free from the bed. -Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface. -Continue to reposition an individual when placed on any support surface. -Use a breathable incontinence pad when using microclimate management surfaces. -Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs. -Reposition weak or immobile individuals in chairs hourly. II. Resident #17 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #17, age 79, was admitted on [DATE]. According to the September 2021 computerized physician order (CPO) diagnoses included, Alzheimer ' s disease, and osteoporosis. The 6/5/21 minimum data set (MDS) assessment showed the resident had memory impairments and had severely imparied decision making skills. The resident required extensive assistance with two person assist for bed mobility, transfers, and all activities of daily living. The resident was at risk for pressure ulcers. III. Observations 8/30/21 -At 9:47 a.m., the resident was seated in her wheelchair and at 10:30 a.m. the resident was still in the same position; -At 11:00 a.m., the resident was assisted to the dining room while still seated in her wheelchair, no assistance was offered to reposition; -At 1:30 p.m., the resident continued to be seated in her wheelchair; and,at 2:37 p.m., the resident remained in the same position. 9/2/21 The resident was observed continuously from 8:25 a.m to 12:30 p.m. -At 8:25 a.m., the resident was lying in bed. -At 8:29 a.m., the resident was assisted out of bed and assisted into her wheelchair. -At 8:55 a.m., the resident continued to be seated in the same position in her wheelchair. -At 9:37 a.m., Resident #17, continued to be seated in her wheelchair in an upright position as she was sleeping. -At 10:29 a.m., the agency certified nurse aide (CNA) #8 went into the room to get the roommates dinner order, but nothing was said to Resident #17. Resident #17 was not offered by staff to be repositioned or have her weight offloaded at this time. -At 10:38 a.m., the CNA #16 went in to take the roommate's order for lunch as the prior observation was for dinner. -At 11:17 a.m., the CNA #14 assisted the resident to the dining room. She was not assisted to be repositioned or off loaded. -At 11:30 a.m., she was seated in the dining room at the table awaiting her meal. -At 11:59 a.m., the resident was served her pureed meal. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 12:10 p.m. the resident was assisted back to her room. -At 12:13 p.m. CNA #14 assisted the resident to bed. The CNA failed to check the resident ' s incontinence brief to ensure she did not have an incontinence episode or need assistance with her skin care. During this continuous observation on 9/2/21 from 8:29 a.m.,the resident was not offered or assisted with reposining, although she was at risk for skin breakdown. IV. Record review The care plan was initiated on 5/18/2020 and updated on 9/8/21 identified the resident had a potential/actual impairment to her skin integrity related to impaired mobility, range of motion, and incontinence care. Pertinent approaches include to check and change frequently throughout the day, moisture barrier cream after incontinent episodes for skin protectant. -Even though the care plan was updated on 9/8/21 it failed to include when the resident was to be repositioned. V. Interview Licensed practical nurse (LPN) #2 was interviewed on 9/2/21 at 12:30 p.m. The LPN #2 said the resident was unable to move herself while she was either in bed or in the wheelchair. She said the resident was at risk for pressure ulcers, and she should be repositioned every two hours if not more frequently. The LPN said when the CNA laid the resident down the brief should have been checked to see if she needed to be assisted with a new one. The director of nursing was interviewed on 9/3/21 at approximately 7:45 a.m. The DON said residents who were at risk for pressure ulcers, needed to be repositioned according to the plan of care, or at least every two hours.

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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** 44998 Based on observations, interviews, and record review the facility failed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for three (#218, #99 and #73) of three sample residents. Specifically the facility failed to: -Thoroughly assess, timely consult the physician, obtain orders, develop interventions and render treatments for pressure ulcers developed at the facility for Resident #218. The facility's failure contributed to the resident developing an unstageable pressure ulcer to her and one stage four pressure ulcer. Resident #218 was admitted to the facility without pressure injuries. The resident developed a stage III pressure injury to the coccyx while at the facility. The pressure injury was discovered on 7/16/21. The documentation and interviews showed the resident did not have any other skin issues. However, when she was admitted to the hospital on 7/20/21 the hospital diagnosed a right heel unstageable pressure injury. The documentation showed, the resident was seen at the hospital by the emergency room physician within six minutes of arrival. -Furthermore the DON confirmed the nursing staff had not had any training on how to identify and report pressure injuries which was consistent with not identifying pressure injuries as evidenced by Resident #218, # 99 and #73 pressure injuries to the heels; and -Identify a pressure injury for Resident #73 stage II pressure injury to the right heel; and -Identify Resident #99's stage II pressure injury to right heel and stage I to left heel. Findings include: I. Professional reference The NPUAP Pressure Injury Stages | The National Pressure Ulcer Advisory Panel - NPUAP. The National Pressure Ulcer Advisory Panel NPUAP. Web. (undated) http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages reads: A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence as a result of pressure, or pressure in combination with shear. The updated staging system includes the following definitions: -Stage 1 Pressure Injury: Intact skin with a localized area of non-blanchable erythema. (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. 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. -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. 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. 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 was removed, a Stage 3 or Stage 4 pressure injury will be revealed. B. According to the National Pressure Ulcer Advisory Panel (NPUAP), Pressure injury prevention points, updated 2016, revealed in part Consider bedfast and chairfast individuals to be at risk for development of pressure injury; Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within eight hours after admission); Use heel offloading devices .on individuals at high risk for heel ulcers. II. Policy The facility policy Skin Assessment Monitoring Guidelines were requested and delivered by the DON on 8/31/21 at 4:36 p.m. The policy states, all residents will be assessed upon admission, quarterly and with a significant change in condition to identify risk factors that may lead to impaired skin integrity. Designated assessment tools will be utilized by the nursing stall to identify residents at risk to ensure consistency and accuracy of collected data. All residents identified at risk will be reviewed by the Interdisciplinary Team to ensure that all efforts to implement preventive measures have been addressed. Purpose: to prevent skin impairment by assessing risk factors in a timely manner; to gather accurate, objective and consistent data for the purpose of implementing an individualized Plan of Care designated to meet the residents needs; to ensure consistency in implementation of prevention measures to assist with maintaining skin integrity; to evaluate outcomes. III. Facility matrix The facility matrix was received on 8/30/21 from the director of nurses (DON). The facility matrix indicated there was no pressure injuries in the building. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 9/2/21 at 3:25 p.m. The DON said that to her knowledge there were no other residents in the building that had pressure injuries. IV. Avoidable pressure injury for Resident #218 1. Resident #218 A. Resident Status Resident #218, age 78, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic kidney disease stage 3, mild protein calorie malnutrition, anxiety disorder, major depressive disorder. The minimum data set (MDS) assessment dated [DATE] revealed the resident was cognitively intact with moderately cognitive impairment with a brief interview for mental status score of seven out of 15. She required extensive assistance with one to two persons for ADLs. The care plan revised on 4/9/21 identified that the resident had impaired skin integrity and required turning and positioning every two hours to three hours to prevent skin breakdown. Pertinent interventions included an air mattress, weekly skin checks and reminders to the resident to turn and reposition. B. Development of a pressure injury coccyx The 7/5/21 skin assessment documented the resident did not have any wounds or skin issues, heels- no identifiable skin issues noted. The 7/12/21 skin assessment documented that the resident had no skin issues, heels-no identifiable skin issues noted. The 7/16/21 nurse progress note documented, the resident was seen by the wound clinic. The documentation showed, the resident had a stage III coccyx pressure injury and measured at 3.4 x 6.7 x 0.1 with 60% granulation and 40% epithelial; minimal serosanguinous drainage; periwound edema, bruised, red. The new order was for the coccyx to be cleaned with wound cleaner, pat dry, skin prep periwound, apply medihoney to wound bed, cover with foam dressing. Change every day. Power of attorney and primary physician were involved in the plan of care. The 7/16/21 documentation from the wound physician did not identify any other skin issues. The wound nurse was interviewed on 9/3/21 at approximately 12:00 p.m. The wound nurse said Resident #218 was being treated by the wound physician for the coccyx pressure injury stage III. The wound nurse said the resident did not have any wounds on her heels. C. Change of condition (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The 7/20/21 progress note showed the resident had an increased lethargy and vital signs that had changed slightly from the previous assessment resident was tachycardia. The resident was transferred to the emergency room for evaluation. The facility did not have a skin assessment completed prior to the resident leaving for the hospital. The resident arrived at the hospital on 7/20/21 at 5:33 p.m. The registered nurse triaged her at 5:35 p.m., and the emergency room physician exam was at 5:39 p.m. The hospital record progress note dated 7/20/21 documented the resident was admitted to the intensive care unit. The hospital records showed the diagnoses were as follows: -septic shock from E. coli urinary tract infection; -obstructing ureteral stones, -acute kidney injury, -acute respiratory failure secondary to sepsis; and -multiple decubitus ulcers on the coccyx, and right posterior shoulder. The ICU notes dated 7/20/21 documented she arrived to the ICU at 8:24 p.m., and it showed she had a stage III coccyx pressure injury, and right heel was unstagable pressure injury. The wound care physician at the hospital was consulted on 7/21/21at 6:41 a.m. for the sacral (coccyx) wound which was staged as a state IV pressure injury with measurements 4 x 5 cm with tunneling that required surgical debridement by plastic surgeon. The right heel was an unstageable pressure injury. D. History of Resident #218 Resident#218 was having increased complications related to chronic kidney disease and renal calculi which required surgical placement of nephrostomy tubes on 3/19/21. There was resolution of the renal calculi however more renal calculi developed in April 2021 which required surgery on 4/7/21. Resident#218 returned to the facility and was placed on the interdisciplinary team (IDT) for weekly review for nutritional status tracking due to weight loss. The RD had placed Resident#218 on multiple nutritional supplements for weight loss. Resident#218 had been successfully treated for moisture associated skin damage (MASD) and had a care plan for risk for skin integrity problems and to be turned and positioned every two to three hours. The RD was interviewed on 9/2/21 at 2:20 p.m., stated that the resident demonstrated the ability to recover from the MASD and they were supplementing her nutritional needs to promote wound healing. E. Failure to identify right heel pressure injury (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The hospital record progress note dated 7/20/21, showed the resident had an unstageable right heel pressure injury. The facilities records failed to identify the right heel pressure injury. The skin assessments showed that on 3/20/21 the resident was readmitted from an overnight hospital stay for surgical procedure. The nurse skin assessment documentation noted that the resident had very dry heels. There was no further mention or documentation of continued care for the dry heels from 3/20/21 through 7/20/21 when the resident was admitted to the emergency room for a change in condition-lethargy. The electronic medical records do show that skin assessments were being conducted and documented however not on a weekly basis until 4/2/21 when the wound nurse practitioner identified a moisture associated skin damage (MASD) to the left buttock but there was no indication of right heel pressure injury. The care plan revised on 4/9/21 identified the resident was at risk for skin integrity problems and to be turned and positioned every two to three hours. F. Skin assessments The electronic records show that weekly skin assessments were being documented with no changes in skin condition to include the right and left heels. The nurse progress notes document that the resident refused to be turned and positioned multiple times however the interview with LPN #4 stated that the resident would not refuse but would become anxious with the turning and repositioning. On 7/16/21 when the facility wound care physician identified the sacral (coccyx) wound there is no documentation of a right heel injury. G. Nutrition interventions The electronic record shows that the resident was on a care plan related to increasing nutritional needs due to weight loss. The RD had added enriched cereal three times a day (TID); Boost pudding twice a day (BID); Breeze nutritional supplement TID; fluids were encouraged in addition to house made shakes (supplemental nutrition) 240 ml TID between meals for hydration. Staff were monitoring the percentage of meal that was eaten by Resident t#218 consumed. H. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 8/31/21 at 2:09 p.m. LPN #4 said Resident #218 used to reside on the hall he worked. He said she was beginning to have a change in condition and she was not as verbal as prior. He said they would reposition her, and she would moan. He said she did not refuse, however, she was more anxious about it. He said she did sit up in her chair and attend meals in the dining room. He said he could not remember if she had any pressure ulcers. She was discharged to the hospital on 7/16/21. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Registered dietician (RD) was interviewed on 9/2/21 at 2:20 p.m. The RD said the resident ' s nutritional status intakes were variable 50-75% and sometimes 0-26%. The RD reviewed the medical record and said Resident #218 was hospitalized on [DATE]. She said she did have a weight loss from 139.5 to 134 pounds. At this point she was on weekly weights then started trending down so she was placed on weekly weights. She said she added 750 calories per day the breeze and then house made shake. The RD said the resident was also offered a substantial snack multiple times per day (half a sandwich, cookie with yogurt). The RD said that prior to hospitalization she was treating the resident for a pressure ulcer on her coccyx. She said the resident was consuming the health shakes and she increased protein calories and carbohydrates to promote wound healing. The RD said she was notified of new pressure wounds through weekly rounds, interdisciplinary team (IDT) conferences. In general nutritional supplements were reserved for residents with venous wounds and diabetic ulcers. The amount of pain and pain medications could have led to her early satiety and decreased PO intake but her nutritional needs would remain the same. States that this resident also had chronic constipation. Feels like she gets updates on resident changes in condition both from nurses and her own investigation of the residents records in PCC. If meals are missed and the resident can make their needs known they are able to get a replacement meal or supplement but if they cannot make their needs known then she relies on nursing and ancillary staff to catch this and then provide a meal alternative. The director of nursing (DON) was interviewed on 9/2/21 at 3:25 p.m. The DON said she was aware of Resident #218 coccyx pressure wound and that the wound was discovered on the day that the wound care doctor was rounding on residents. She stated that a new care plan was put into place by the wound care doctor. She was not aware the resident had also an unstageable right heel pressure injury. The DON further stated, that the licensed nurses had not had any training on pressure injuries, since October 2020. She said the staff lacked knowledge on how identify, and report the pressure injuries. 43950 2. Resident #73 A. Resident status Resident #73, age 50, was admitted on [DATE]. According to the August 2021/September 2021 computerized physician orders (CPO), diagnoses included schizoaffective disorder, bipolar type (a mental health condition including schizophrenia and mood disorder symptoms), and morbid obesity. The 7/28/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance with one person physical assistance for bed mobility, transfers, and dressing. Limited assistance with one person for walking in the room, locomotion on unit with an electric wheelchair, eating, toilet use, and personal hygiene. Bathing/showering requires physical help limited to transfer only. No behavioral symptoms or rejection of care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The MDS further documented that the resident was at risk of developing pressure ulcers/injuries. No pressure ulcers/injuries at time of admission. B. Resident observation and interview On 9/1/21 at 10:02 a.m., Resident #73 reported he had a right heel blood blister that had popped. He said he got the blister three to four days ago. The resident's right heel had a white bandage at the right heel. Theresident had slippers on both of his feet. The resident said his right heel hurt, and the nurses usually changed the bandage once per day. He said he was mad because he asked them to change the bandage that morning and they said they would do it later. The resident said the blister had developed on 8/28/21 or 8/29/21. On 9/1/21 at 4:26 p.m., the resident ' s right heel was observed with a registered nurse (RN #1). The RN #1 said she was the charge nurse and worked regularly with the resident. She said the resident was not currently seen by the wound clinic. The resident told RN #1 that the pressure injury happened four days ago. The RN #1 did not respond to the answer. After observing the wound RN #1 said there was no drainage as it was intact and they were permitted to use a dry bandage. She said the resident would see the wound physician when it opened up. Resident #73 said it was open, and it drained on his bed last night. He said it was a big blister and it had been draining. RN #1 said the wound physician would be here Friday. RN #1 said she did not know if the wound was reported to the physician. Resident #73 said I told you this morning and you changed my bandage. RN #1 said she should have reported to the physician and wound nurse right away. RN #1 said she had not done an assessment beyond looking at it. On 9/3/21 at 7:28 a.m., the resident ' s heel was observed with the wound care nurse practitioner specialist (WCN). The resident ' s heel was laying directly on the bed. The WCN removed the dressing from his right heel. The dressing was wet, and the heel wound was macerated. The WCN measured the wound and said it was 8 X 10 X 0. She said the pressure injury was a stage II. The WCN painted it with betadine. The WCN gave the order to keep a dry dressing on the pressure wound. She also said to order [NAME] boots (pressure relieving boots). While the WCN was cleaning the wound, the resident said it hurt and grimaced his face. The WCN asked the resident if he moved his foot in bed a lot, the Resident #73 said yes, and the WCN said that was probably how he got the pressure wound. On 9/5/21 at 10:43 a.m., the resident was sitting in his electric wheelchair in the common area. The resident ' s right heel was sitting directly on the foot rest on an incontinence pad. The resident said they had not received the pressure relief boots as of yet. On 9/6/21 at 9:58 a.m., the resident was observed to have his right heel directly on the foot rest. The resident said he was only offered to offload his heel while in bed. He said they continue to not have the pressure relief boots as of yet. On 9/7/21 at 9:30 a.m., the resident was observed sitting in his eclectic wheelchair. Observed the resident ' s right foot bandage, it was marked 9/7/21. There was a drainage pad on the foot rest under his foot, but no pressure relief boot or heel offloading was observed. C. Record review (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the August/September 2021 computerized physician orders revealed there were no physician orders for wound care to the resident ' s right heel. The August and September 2021medication administration records (MAR) and treatment administration records (TAR) revealed no wound care orders. The care plan dated 8/15/2021 failed to identify that the resident was at risk for a pressure injury, therefore there was no plan in place. The weekly head-to-toe skin assessment dated [DATE] at 8:10 p.m., revealed there was no documentation of a heel blister. It specifically documented that the heel was intact with no blister. Resident #73 said the heel blister had developed on 8/28/21 or 8/29/21. Review of progress notes dated from 8/27/21 to 9/1/21 revealed no documentation of a heel blister in the progress notes. After the pressure injury was brought to the nurse's attention, progress notes revealed the first documentation on the wound/blister was on 9/1/21 at 4:42 p.m. It read, Nurses note: Right heel blister: dressing changed twice this shift, second time, colorless fluids dripping on the floor with no noted odor upon opening old dressing, skin still there. Right heel was cleaned with a wound cleanser, pat dry then dry dressing was applied. No sign of facial grimacing noted. Resident appeared comfortable with the procedure. D. Staff interviews RN #2 was interviewed on 9/1/21 at 4:46 p.m. She said she could not recall Resident #73 being added to the wound care list, she looked up on the computer record and confirmed that he had not been. She said she had not received any report of a skin issue or wound on his heel. She said if he had a big blister on his heel that the nurse staff should notify her and his physician right away. The RD was interviewed on 9/2/21 at 2:20 p.m. She said she was informed about wounds at morning meetings, looking at the wound log, 24 hour report, and from the wound physician/nurse rounding once per week. She said the pressure injuries were staged by the wound care physician. She said she was not currently addressing Resident #73 ' s skin issue because it was a blister, and she had not been made aware of prior to yesterday. She said they use protein for wound healing, and nutritional supplements are mainly used for pressure wounds. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The DON was interviewed on 9/2/21 at 3:09 p.m. The DON said she first heard about Resident #73 ' s right heel wound/blister yesterday. She said she trained her staff to do a skin assessment, document in the risk management system and notify the physician. She said the risk management system included measuring the wound, alert charting to check for redness/infection, and follow up with the wound. She said we would notify RN #2 (wound nurse) through texting her, or writing on a paper wound log. She said she had not seen Resident #73 ' s wound/blister yet. She said they did an interdisciplinary team (IDT) meeting today and Resident #73 was observed rubbing his right foot on the power chair. She said he either wears socks or slippers. The DON said at this point he was not putting on a lot of pressure because of how he was reclined in his electric wheelchair, so they were not off-loading his heel. The DON said she wished she knew where the system failed when it was not reported when it first occurred. She said her staff had been educated ad nauseam. She said she gave the staff an example of how notes should look. She said at this point it was going to have to be a weekly education. She said the nurses should be documenting each shift about wounds/blisters. The DON acknowledged that Resident #73 had a wound/blister for four days and the nurses were treating it with a dry dressing but it had not been assessed or documented. The DON acknowledged the failure to identify wounds, or pressure injuries, whether stage one or worse. She said it was concerning to her also. 44949 3. Resident #99 A. Resident status Resident #99, age 70, was admitted on [DATE]. According to the September 2021 computerized physician orders (CPOs), diagnoses included fibromyalgia, muscle weakness, and spinal stenosis. The 7/30/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 13 out of 15. The resident required extensive, two person assist, for activities of daily living. It indicated the resident was at risk of developing pressure injuries. B. Resident interview Resident #99 was interviewed on 8/30/21 at 2:59 p.m. She said she had a broken back and preferred to stay in bed. She said her back itched frequently and the staff applied cream to it regularly. She said she was supposed to wear boots on her feet but that staff did not put them on her. She was not wearing the boots at the time. C. Observations On 9/1/21 at 9:35 a.m., care for Resident #99 was observed. Certified nurse aide (CNA) #1 and CNA #12 brought in a hoyer lift, sling, and a shower chair to initiate a transfer. The CNAs rolled Resident #99 onto her side and her back was observed with a white tint due to barrier cream previously applied. A dark purple circular spot, approximately two centimeters in diameter was observed on her right heel. The right heel was not being floated nor had a pressure relieving boot on either foot. D. Staff interviews (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Licenced practical nurse (LPN) #2 was interviewed on 8/31/21 at 1:48 p.m. She said there were no pressure injuries on the hallway. She said skin checks were completed at admission and then weekly. She said a risk management assessment was completed should any skin issues be observed. Staff development coordinator (SDC) was interviewed on 8/31/21 at 3:45 p.m. She said she had not provided any recent training on pressure injuries. She said she went over all the different types of assessments with the nurses upon hire LPN #2 was interviewed on 9/1/21 at 4:17 p.m. She said Resident #99 had a pressure-like injury on her heel that was healing and the wound nurse was notified when the wound was first identified. She said it was a blister and it had now popped. She said the resident should have boots on in bed to prevent an injury. She said the resident refuses care frequently and has her own preference for positioning in bed. Registered nurse (RN) #2 (facility wound nurse) was interviewed on 9/1/21 at 4:46 p.m. RN #2 said she was the facility ' s wound care nurse. She said when a skin issue was observed, she was notified or the director of nursing (DON) was notified. She said the nurse would write a note as well. She said if a wound or skin issue was not brought to her attention, she would not know about the wound. She said she was not aware of a wound for Resident #99. The DON was interviewed on 9/2/21 at 3:09 p.m. She said she was not aware of Resident #99 having a wound on heel. She said according to documentation, an interdisciplinary team meeting was conducted on 8/3/21 regarding a new skin issue for Resident #99 on the right heel. She said risk management was done and a palliative consult was offered but the resident declined the consult. She said a border gauze was applied on 8/3/21 to the right heel, but that it was not an order. She said the nurse should have obtained an order for wound care to the heel. She said the wound nurse was notified on 8/10/21 according to documentation. Although the facility had identified the right heel pressure injury on 8/3/21, the facility failed to obtain physician order, and failed to continue to treat the pressure injury. The resident was not referred to the wound clinic for further treatment. D. Record review The skin care plan was last updated on 5/14/2020, identified Resident #99 had the potential for altered skin integrity related to decreased mobility, pain, and incontinence. It indicated the therapy department had offered different pressure relieving equipment with resident refusing. A weekly skin assessment was completed on 8/3/2. It indicated redness on the right heel. A nursing progress note was completed on 8/3/21. It indicated a foam border gauze applied to the right heel. It noted the DON and the physician were notified. An interdisciplinary team progress note was completed on 8/4/21. It indicated Resident #99 had a blister on right heel. It noted a palliative consult would be offered. A nursing progress note was completed on 8/4/21. It indicated a possible pressure wound on the right heel. No treatments noted. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note was completed on 8/5/21. It noted redness was observed on heels. It indicated resident refused to float heels. A nursing progress note was completed on 8/6/21. It noted redness was observed on heels. It indicated the resident refused to float heels and was uncooperative with repositioning. A nursing progress note was completed on 8/7/21. It noted the resident was cooperative with skin treatment and allowed heels to be floated. The weekly skin assessment from 8/10/21 indicated a blister-like area on the right heel. The note indicated the wound nurse was notified. The weekly skin assessment from 8/17/21 indicated the blister on the right heel popped. The note indicated the skin was not torn and there were no signs of infection. The weekly skin assessment from 8/24/21 indicated blister on the right heel. The weekly skin assessment from 8/31/21 indicated a blister on the right heel and that it was healing progressively. The resident had no physician orders for wound care to the heel. E. Wound care observation Wound care rounds were observed on 9/3/21 at 7:40 a.m. Wound care was completed by RN #2 and the wound care nurse practitioner (WCN). Resident #99 was observed in bed with a boot on her right foot. WCN removed the boot. WCN said she observed a two inch by one and a half inch deep tissue injury on right foot and she staged it as a stage II pressure injury. She treated the wound and ordered daily wound care. She then lifted the resident ' s left foot. Resident #99 cried out in pain. WCN said she observed a red spot on the left malleolus. She said it was a stage I pressure injury. She asked RN #2 to order an air mattress and have an order for heels to be floated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44949 Based on observations, interviews, and record review, the facility failed to provide an environment free of accidents and hazards for five (#7, #17, #34, #66 and #35) out of eleven out of 62 total sample residents. Specifically, the facility failed to: -Monitor the smoking area and prevent Resident #7 from smoking with oxygen tank; -Monitor and assess behaviors for Resident #66 in order to ensure safety of resident and others; -Use fall mat for Resident #17 and #34; -Safely transfer Resident #17 from wheelchair to bed; -Monitor wanderguard system for Resident #35. Findings include: I. Smoking with oxygen tank in smoking area 1. Facility policy The smoking policy was provided by the nursing home administrator (NHA) on [DATE] at 6:00 p.m. It read, Oxygen use is prohibited in smoking areas. Residents must be supervised by staff while smoking during approved time frames only. 2. Resident #7 A. Resident #7 status Resident #7, age 67, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPOs), diagnoses included chronic obstructive pulmonary disease, respiratory failure, and dependence on supplemental oxygen. The [DATE] minimum data set (MDS) assessment indicated the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. It indicated the resident was independent with all activities of daily living. B. Resident interview Resident #7 was interviewed on [DATE] at 4:30 p.m. The resident said he was allowed to go outside and smoke when he wished too, as he was safe. He said he was allowed to keep his own cigarettes and lighter. C. Observation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The smoking area was located off the dining room of the 700 hallway. The doors leading to the smoking area failed to have signage which indicated oxygen was not allowed in the smoking area. On [DATE] at 5:25 p.m., Resident #7 was observed in his power wheelchair going out to the smoking area. He had his oxygen tank with him and the cannula was in nose. Resident #7 was seen sitting outside in his power wheelchair. At 5:30 p.m., Resident #7 was seen behind lattice fence panel smoking a cigarette with nasal cannula in nose and oxygen tank sitting on his wheelchair between his legs.The director of nursing (DON) was notified immediately. The DON walked outside and removed the oxygen tank and placed it inside. The resident said he turned off the oxygen tank prior to smoking. On [DATE] at 12:06 p.m., the cigarette cart was left unattended and unlocked. The DON was notified and she instructed the activities director (ACD) to lock the cart. On [DATE] at 1:02 p.m., the ACD was observed during smoking hours. She lit cigarettes for four residents and then immediately returned inside the building. She watched the residents from inside the building. C. Staff interviews The DON was interviewed on [DATE] at 5:35 p.m. She said Resident #7 was aware that oxygen cannot be in the smoking area. She said they have 11 to 13 residents who smoke. She said the smoking times were posted and the different department heads take people out for smoking breaks and monitor. Licenced practical nurse (LPN) #2 was interviewed on [DATE] at 9:13 a.m. She said all residents were supervised during the smoking times. The social services director (SSD) was interviewed on [DATE] at 4:33 p.m. She said all residents should be supervised while smoking. She said a staff member should be outside with the residents while they smoke. The activities director (ACD) was interviewed on [DATE] at 4:53 p.m. She said all smoking materials including cigarettes and lighters are kept in a locked cart and residents are given two cigarettes during the smoking times. She said different departments would supervise the smoking times but that has led to other departments being short staffed. She said the activity department supervised three of the smoking times. She said staff members do not usually sit outside with the residents while they are smoking. She said she can observe the smoking area through the window in the dining room. She said the residents voted on the smoking times and that all residents were to be supervised during those times. She said she has seen Resident #7 with his oxygen tank in the smoking area before and she had educated him on where to leave it prior to going to the smoking area. The nursing home administrator was interviewed on [DATE] at 7:00 p.m. He said the smoking program was a work in progress. He said the facility went smoke free in [DATE], except for the residents who were grandfathered in. He said the ground crew ensure the cigarette butts are picked up and the residents who do smoke are assessed and have a smoking plan. He said the smoking times were to be supervised by a staff member and the staff member needed to be outside with the residents. The NHA said he was not aware that supervision was not happening. He said in [DATE] he met with all the residents and reviewed the policy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Record review The smoking care plan was last updated on [DATE]. It indicated the resident was an independent smoker and he had been educated to appropriate smoking areas. A smoking assessment was completed on [DATE]. It indicated the resident was on supplemental oxygen and could safely smoke without supplemental oxygen during smoking times. It indicated the resident did not have a history of smoking related incidents. The assessment noted staff reviewed the smoking policy with the resident. II. Resident #66 behaviors and safety for resident and others (Cross Reference F 600) A. Resident #66 status Resident #66, age less than 50, was admitted on [DATE]. According to the [DATE] CPOs, diagnoses included traumatic brain injury, anxiety, and dementia with behavioral disturbance. The [DATE] MDS assessment indicated the resident had moderately impaired cognitive skills for daily decision making and was unable to complete a brief interview for mental status assessment. It indicated the resident required extensive two person assists for activities of daily living. It indicated the resident had behaviors involving physical behavior symptoms towards self and others. B. Observations Resident #66 was observed in the dining room on [DATE] at 10:14 a.m. The resident was attending an activity and sitting next to a male resident. Residents were in a semi circle around the room with the activities assistant (AA) #2 in the center. Resident #66 had foot pedals on her wheelchair but was using her arm to propel the wheelchair. Resident #66 began to mumble and point to the male resident. She then propelled her chair into his legs. The male resident softly said ow and moved further away. Resident #66 briefly pointed at him and shook his head. AA #2 did not observe this. C. Record review The behavior care plan was last updated on [DATE]. It indicated Resident #66 had a history of increased behaviors following interactions with her family. The care plan indicated the resident ' s behaviors involved physical aggression, refusals to eat, throwing items, refusing care, and biting others. Approaches to manage behaviors included, behavior tracking every shift, re-approaching resident at a later time, obtaining labs as needed, positive praise, and validating feelings. A nursing progress note was completed on [DATE]. It indicated Resident #66 bit another resident. It noted a male resident entered Resident #66 ' s personal space while she was making a phone call and she bit him. A nursing progress note was completed on [DATE]. It indicated Resident #66 threw herself out of her wheelchair after calling a family member and they did not answer. It indicated the Resident grabbed onto another resident ' s leg while she was on the ground. Resident #66 hit her head and was on neurological checks. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing progress note was completed on [DATE]. It indicated Resident #66 was kicking the wall and attempting to choke herself following a phone call to family in which they did not answer. It indicated the resident attempted to throw self out of her wheelchair and was taken to her room and transferred to bed. A nursing progress note was completed on [DATE]. It indicated Resident #66 threw herself out of her wheelchair while in the dining room. It indicated the resident hit her head and neurological checks were initiated. D. Staff interviews LPN #2 was interviewed on [DATE] at 9:20 a.m. She said Resident #66 has a history of behaviors. She said the resident will swallow items, throw herself on the floor, scream, bite, and kick. She said Resident #66 was a risk of hurting other residents. LPN #1 was interviewed on [DATE] at 10:22 a.m. She said she thinks Resident #66 engaged in behaviors such as throwing herself out of her wheelchair because she was in pain, hungry, or upset when her family did not answer the phone when she called. She said Resident #66 will grab at other residents as well. She said the staff attempts to figure out why the behavior was occurring, separate the resident from others, and try to calm her down. Certified nurse aide (CNA) #14 was interviewed on [DATE] at 3:38 p.m. She said she did not receive any training on managing Resident #66 ' s behaviors. She said luckily the resident liked her. The social services director (SSD) was interviewed on [DATE] at 1:51 p.m. She said she monitored behaviors for residents and will reach out to the mental health provider as necessary. She said the aim of behavior tracking was to figure out what happened prior to a behavior to get to the root cause. She said Resident #66 had behaviors such as throwing herself out of her wheelchair, kicking, or throwing things. She said in the dining room at lunch, Resident #66 was throwing items. She said she asked the mental health provider to see Resident #66. She said the resident had behaviors when her family cannot talk to her on the phone. She said she has asked the family to let her calls go to voicemail, but that upset the resident. She said she has provided training with staff on deescalating when she sees the behaviors happening. She said she was working on a training for staff on how to keep other residents safe from Resident #66. The DON was interviewed on [DATE] at 5:00 p.m. She said the resident was having dental issues and had pain associated with this. She said the resident does have a history of behaviors but did not believe all behaviors were due to pain. She said Resident #66 has behaviors associated with interactions with family. She said the resident has scheduled visits and has gone out for visits. She said they do not tell the resident when her family is coming because they may not show up and this upsets the resident. 20287 III. Resident #17 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17, age 79, was admitted on [DATE]. According to the [DATE] computerized physician order (CPO) diagnoses included, Alzheimer's disease, and osteoporosis. The [DATE] minimum data set (MDS) assessment showed the resident had memory impairments and had severely imparied decision making skills. The resident required extensive assistance with two person assist for bed mobility, transfers, and all activities of daily living. The resident had not had any falls since the previous MDS dated [DATE]. 1. Fall mat a. Record review The care plan last updated on [DATE] identified the resident as being at risk for falls. Pertinent interventions were to have the bed in the low position and to have a fall mat while she is in bed. b. Observations On [DATE] at 2:00 p.m., the resident was lying in bed. The bed was not in the lowest position and she did not have a floor mat on the floor. On [DATE] at 8:25 a.m., the resident was lying in bed. The bed was not in the lowest position. She did not have a floor mat on the floor while she laid in bed. -At 12:13 p.m., the resident was assisted to bed, the certified nurse aide (CNA) #14 failed to place the floor mat on the floor after she was assisted to bed. The CNA then proceeded to enter the dining room to assist other residents from the dining room. -At approximately 2:00 p.m., the resident remained in bed. The floor mat was on the floor next to the bed. The mat was placed by LPN#2 see interview below. c. Interview Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 12:30 p.m. The LPN said Resident #17 was to have a fall mat on the floor. The LPN searched the room for the fall mat and she was unable to locate the mat. 2. Transfers a. Record review The care plan last updated on [DATE] identified the resident had activities of daily living (ADL) deficits related to a stroke. Pertinent interventions was Resident #17 was to be transferred by the mechanical lift for all transfers. b. Observations (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 8:29 a.m., CNA #14 was observed to lift the resident out of bed, by placing his arm under her neck, and then his other arm under her legs. He then lifted her and sat her into her wheelchair. On [DATE] at 12:13 p.m., CNA #14 was observed to lift the resident out of wheelchair, by placing his arm under her neck, and then his other arm under her legs. He then lifted her and laid her in the bed. c. Interviews CNA #14 was interviewed on [DATE] at 12:31 p.m. The CNA said he worked with Resident #17 on a regular basis. He said he always transferred the resident into the bed or wheelchair by lifting her as observed (see above). He said he did not know she was to be lifted with a mechanical lift. He said he had not seen anyone use a mechanical lift with Resident #17. Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 12:30 p.m. The LPN #2 said the resident had a decline, and she was not able to stand and she was to be transferred via a mechanical lift. She said she was not aware the resident was not transferred with the mechanical lift. The director of rehabilitation (DOR) was interviewed on [DATE] at approximately 4:00 p.m. The DOR said she had heard about how Resident #17 was transferred. She said she provided training to the CNAs on the 700 hall that the mechanical lift needed to be used. She said the way the CNA #14 transferred the resident could of hurt both the resident and the CNA. 39260 IV. Resident #34 A. Resident status Resident #34, age 79, was admitted on [DATE]. According to the [DATE] computerized physicians orders (CPO), diagnoses included dementia with behavioral disturbance and chronic kidney disease. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. The resident required extensive assistance with bed mobility and transfers. The resident was coded for falls. C. Record review of past falls and care plan interventions The nurse progress note dated [DATE], documented the resident was found on the floor in her room. It documented the resident sustained a bruise to her right side of head, right check Note and skin tear to right elbow. The care plan revised on [DATE] revealed the resident had falls related to poor balance and weakness, psychotropic drugs use. Interventions included, bed in low position with fall mats, keep my pathway free of clutter and keep needed items within reach. Example water, bed control and television (TV) control. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The [DATE] nurse progress note, documented the resident was observed to have a golf ball size bump to the middle of the resident ' s forehead. It further documented the resident said she fell and got herself up. B. Observations of fall mat not in place according to care plan The resident was observed on [DATE] at 1:49 p.m. The resident was lying in bed. The bed was in the low position. There was no fall mat placed by the residents bed as indicated in her care plan. The resident was observed again on [DATE] at 3:24 p.m. The resident was lying in bed. The bed was in the low position. There was no fall mat placed by the resident bed as indicated in her care plan. D. Staff interviews Certified nurse aide (CNA) #5 was interviewed on [DATE] at 4:30 p.m. She said she was from an agency. She said no one told her that the resident needed a fall mat by her bed when she was lying in bed. She said she would go to the physical therapy departement to get a fall mat. She got a fall mat and placed it in front of the resident ' s bed. Licensed practical nurse (LPN) #6 was interviewed on [DATE] at 4:35 p.m. He said whenever Resident #34 was in bed, the fall mat should be by the resident ' s bed. He said he would remind the CNAs to put the fall mat by the resident ' s bed when she was in bed. The director of nursing (DON) was interviewed on [DATE] at 4:45 p.m. She said it was important to have the fall mat by Resident #34 ' s bed when the resident was in bed. She said the resident was found on the floor in her room. She said she would provide education to the staff to ensure a fall mat was by the resident ' s bed at all times while she was in bed to prevent injury. 43950 V. Wander guard 1. Facility policy and procedure The Wandering, Unsafe Resident policy and procedure, revised Quarter 3, 2018, was provided by the maintenance director (MTD) on [DATE] at 12:30 p.m. It read in pertinent part, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering.The resident ' s care plan will indicate the resident is at risk for elopement or other safety issues. Interventions to try to maintain safety, such as a detailed monitoring program will be included. 2. Resident #35 A. Resident status (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35, age 85, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included encephalopathy (brain disease that alters brain function), chronic kidney disease, stage four (severe), and hypertension (high blood pressure). The [DATE] minimum data set (MDS) assessment revealed the resident was not given a brief interview for mental status because the resident was rarely/never understood. The staff assessment for mental status documented short and long term memory problems, the resident was not able to recall, and that cognitive skills for daily decision making were moderately impaired (decisions were poor, cues and supervision required). Behaviors present were inattention, and disorganized thinking. No rejection of care was present, and wandering behavior occurred daily. She required extensive assistance with one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Walking in rooms and corridors requires supervision and one person physical assistance. Eating required limited assistance with one person physical assistance. Bathing was total dependence with two person physical assistance. B. Resident observation On [DATE] from 9:03 a.m. to 12:45 p.m. Resident #35 was observed continuously as she wandered up and down the hallways of the facility. On [DATE] from 2:22 p.m. to 3:59 p.m. Resident #35 was observed intermittently, wandering aimlessly about the facility and up to the front office area. C. Record review Review of the computerized physician orders revealed orders to verify wanderguard placement one time per day. The wanderguard expired on [DATE]. Review of the wanderguard care plan, revised [DATE], revealed that Resident #35 was at risk for injury due to wandering and a wanderguard was in place. Provide Resident #35 with a safe place to wander if necessary. Wanderguard in place. Nursing to check placement daily and restorative to check function weekly. When wandering, redirect Resident #35 to another activity. Review of the progress notes reveals no documentation related to the wanderguard. The [NAME] Healthcare signaling device testing calendar and checklist for wander management was provided by the MTD on [DATE] at 12:30 p.m. It read in pertinent part, Test each signaling device daily. Failure to do so could result in injury or death. System maintenance: Staff members should regularly check band placement and look for signs of tampering and wear. Test all monitoring equipment weekly on each shift and with all surrounding power devices turned on and record the resting results. Test all tags daily and record the testing results. The wanderguard system checks logs for facility doors, provided by the MTD on [DATE] at 12:30 p.m., revealed a system check on [DATE]; [DATE]; [DATE] for one time per month. The wanderguard use report dated [DATE] at 3:57 p.m. revealed there were four residents using the wanderguard system, including Resident #35. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly wandering assessment was last conducted on [DATE] and indicated that Resident #35 was a moderate risk for wandering. D. Staff interview LPN # 2 was interviewed on [DATE] at 11:20 a.m. She said that Resident #35 did not exit the facility because she turned around at the doors. She said all the outer doors were alarmed with the wanderguard system. LPN #2 said she checked the wanderguard with a device that they used and pointed at the wanderguard or they brought her by the doors. The LPN was unable to locate the testing device. LPN #2 said they check Resident #35 wanderguard one time per week. LPN #2 was asked to check the physician orders. LPN #2 viewed the physician orders and read the orders, and said the orders expired on [DATE] and the wanderguard was to be checked one time per day per the order. LPN #2 said the Resident #35 wanderguard probably had not been checked the last couple of days. She said the social services and maintenance department process the wanderguard ankle bracelets. LPN #2 said she was not sure how long they would last. The maintenance director (MTD) was interviewed on [DATE] at 11:30 a.m. She said the wanderguard system was replaced a few months ago. She said all outer doors were alarmed. She said doors were tested monthly. The MTD activates a wanderguard and then checks the doors, the alarms activate. The MTD said the nurses checked on the residents with wander guards. The MTD said they only had one tester device for the building.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44997 Based on record review, observations and staff interviews, the facility failed to ensure six (#2, #17, #34, #35, #100, #218) of six residents reviewed for hydration, received sufficient fluids to maintain hydration and health. Specifically, the facility failed to ensure Resident ##2, #17, #34, #35, #100, and #218 fluid needs were met. Findings include: I. Professional reference According to [NAME] and [NAME] Munoz, (2016), Nutrition for the Older Adult (second ed.), page 363: Dehydration is defined as a decrease in total body water . Older adults are at greater risk of dehydration because of a number of factors; however, the decline in the total body water with aging may be the greatest influence. Seventy-five percent of an infant's body weight is water, and this slowly declines to approximately 55% in the older adult. Older adults can, therefore, be rapidly affected by a decrease in fluid intake or excess fluid losses from vomiting, diarrhea, and excess perspiration. II. Sufficient fluids not received 1. Resident #2 A. Resident status Resident #2, age 92, was admitted on [DATE]. According to the September 2021 computerized physician orders (CPO), the diagnoses included unspecified dementia with behavioral disturbances, delirium due to known physiological condition, anxiety disorder and unspecified protein calorie malnutrition. The 3/9/21 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for a mental status score of three out of 15. She required one person assistance with bathing, personal hygiene and dressing and supervision set up assistance with bed mobility, locomotion, toileting and eating. The resident resided on the secured unit. The August 2021 plan of care (POC) revealed the resident's height was 63 inches and weight was 115.5 pounds. B. Observations Memory care unit continuous observation completed on 9/2/21 from 8:32 a.m. to 1:18 p.m. -At 8:32 a.m., The activity assistant (AA)#1 provided coffee cart to the residents in the dining room; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:32 a.m., Resident #2 was walking down the hall talking loudly and not participating in the coffee cart; -At 9:56 a.m.,, Resident #2 was walking down the hall talking loudly and a certified nursing aide (CNA) offered coffee to Resident #2 and encouraged the resident to sit down. Resident took one sip of coffee; -At 11:37 a.m. Resident #2 was observed eating lunch and had one eight ounce cup of water and one eight ounce cup of juice was placed in front of her on the table. Resident was observed taking a drink of her juice and her water but did not finish either drink;. The resident consumed approximately four ounces of juice and four ounces of water during lunch. -The resident's room failed to show she had a water pitcher in her room. C. Record review A review of the resident's August 2021 medication administration record (MAR) revealed a physician's order to encourage 240 cc fluids (eight ounces) between meals daily three times a day for hydration with a start date of 8/9/21.The MAR revealed the resident was not provided the ordered daily amount of fluids 23 out of the 23 days reviewed. A review of the resident's September 2021 MAR revealed a physician ' s order to encourage 240 cc fluids (eight ounces) between meals daily three times a day for hydration. The MAR revealed the resident was not provided the ordered daily amount of fluids eight out of the eight days reviewed. The 6/4/21 dietary progress note revealed the resident ' s fluid intake need based on body weight to be 1500 milliliters of fluid a day. The 30 day look back hydration/snack task report dated 9/7/21 revealed Resident #2 participated in hydration/snack one time daily for 27 days out of the 30 days reviewed. The report did not provide intake amounts for daily hydration. The medical record failed to show evidence that fluid consumed was tracked. 3 Resident #100 A. Resident status Resident #100, age 94, was initially admitted on [DATE] with a re-admit on 1/28/19. According to the September 2021 computerized physician orders (CPO), the diagnoses included hypertensive heart disease with heart failure, unspecified dementia with behavioral disturbances, anxiety disorder, nutritional deficiency unspecified and unspecified protein calorie malnutrition. The 7/31/21 quarterly minimum data set (MDS) assessment revealed the brief interview for mental status was not assessed due to the Resident was rarely to never understood and not interviewable. The resident had both short and long term memory impairments. She required extensive assistance with one person assistance with eating, toileting, dressing, personal hygiene, mobility and transfers. The resident resided on the secured unit. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The September 2021 plan of care (POC) revealed the resident ' s height was 63 inches and weight was 118. 00 pounds. B. Observations Memory care unit continuous observation completed on 9/2/21 from 8:32 a.m. to 1:18 p.m. -At 8:32 a.m. Resident #100 was in bed sleeping with her door closed; -At 8:32 a.m. The activity staff provided coffee cart to the residents in the dining room; -At 9:07 a.m. Resident #100 was in bed with her door closed. Staff had not entered her room or offered her breakfast or fluids. The resident did not have a water pitcher in her room. -At 9:44 a.m. Resident #100 continued to be in bed with her door closed. Staff had not entered her room since observation started; -At 10:13 a.m. observed certified nursing aide (CNA) # 13 entered her room to check on her. CNA #13 stated she was still sleeping and has not been out of bed for the day because she did not sleep the night before; -At 10:48 a.m. the hydration cart arrived on the unit and was pushed into the nurses station to be served at lunch time. No one went to the resident to assist the resident with some fluid. -At 10:50 a.m. Resident #100 remained in bed. -At 11:07 a.m. The staff served drinks to the residents seated for lunch in the dining room; -At 11:25 a.m. The staff served lunch to the residents seated in the dining room; -At 11:55 a.m. Resident #100 in bed with her door closed. Staff have not offered breakfast, lunch or fluids during the observation. -at 12: 15 p.m. An outside physician entered the resident ' s room to visit with her roommate. The provider came out of the room and asked CNA #13 to assist Resident #100 with personal hygiene. -At 12:24 p.m. Resident #100 was brought out of her room in her wheelchair and assisted outside her room next to the dining room. -At 12:33 p.m. the memory care staff are observed leaving the unit to take their lunches. Resident #100 has not been offered breakfast, lunch or fluids since observation started at 8:32 a.m. -At 12:55 p.m. the activity assistant AA # 1 gathered some residents to the outside sitting area and started the ice cream social activity. AA #1 did not invite Resident #100 to the activity; (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 1:11 p.m. Licensed practical nurse (LPN) #5 was interviewed regarding the observations of Resident #100 not getting anything to drink or eat for the day. LPN #5 said she was not aware the resident was awake and out of bed. She said the CNA should have provided the resident with a meal or supplement shake when she got her out of bed and LPN #5 provided Resident #100 with a protein shake. The resident was observed drinking the entire shake. C. Record review A review of the resident ' s August 2021 MAR revealed the resident did not have an order for staff to encourage or monitor daily hydration intake. A review of the resident ' s September 2021MAR revealed the resident did not have an order for staff to encourage or monitor daily hydration intake. The 30 day look back hydration/snack task report dated 9/9/21 revealed Resident #2 did not participate in hydration/snack 30 out of the 30 days reviewed. The report did not provide intake amounts for daily hydration. lll. Staff interviews The LPN #5 was interviewed on 9/2/21 at 1:11 p.m. She said she was told during morning report that Resident #100 did not sleep well the night before and the resident was asleep during breakfast. She said the resident did have nights where she was awake and then would sleep longer in the morning. She said the resident slept through breakfast and lunch. She said when the process for residents who missed a meal was to offer them a meal or a supplement when they wake up. This should happen immediately. She said the CNA should notify the nurse or offer the resident something to eat or drink. She said she was not aware the resident was awake and therefore did not eat or drink the noon meal. She said she provided her a protein shake to the resident. The registered dietitian (RD) was interviewed on 9/2/21 at 2:23 p.m. She said the residents on the memory care unit do not have water cups in their individual rooms. She said the residents tend to wander in and out of each other's rooms and they do not want residents to drink from each other's water cups. She said the residents on the memory care unit rely on the staff to offer and encourage hydration through out the day. She said the standard fluid intake for a resident is 30 cc per kilogram of body weight. She said it may vary depending on if a resident has fluid restrictions. The RD said all of the residents on the memory care unit depend on staff for their hydration needs. She said staff should be tracking the hydration intake in the residents' individual charts. If there is an order for fluid intake then the staff would document in the resident ' s medication administration record (MAR). The RD said the hydration/snack task in the resident ' s plan of care is documented by the activity department and it only tracks resident participation and not the fluid intake amount. The director of nursing (DON) was interviewed on 9/8/21 at 5:26 p.m. She said staff should encourage fluids to residents every two hours especially if a resident is not able to obtain fluids on their own. She said the memory care residents do not have water cups in their rooms and depend on the staff to offer and encourage fluids throughout the day. She said there was a hydration cart in the nurses station for staff to offer and provide fluids to the residents. 43950 (continued on next page)

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	065248	A. Building B. Wing	09/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #35 A. Resident status Resident #35, age 85, was admitted on [DATE]. According to the September 2021 computerized physician orders (CPO), the diagnoses included encephalopathy (brain disease that alters brain function), chronic kidney disease, stage four (severe), and hypertension (high blood pressure). The 6/21/21 minimum data set (MDS) assessment revealed the resident was not given a brief interview for mental status because the resident was rarely/never understood. The staff assessment for mental status documented short and long term memory problems, the resident was not able to recall, and that cognitive skills for daily decision making were moderately impaired (decisions were poor, cues and supervision required). Behaviors present were inattention, and disorganized thinking. No rejection of care was present, and wandering behavior occurred daily. She required extensive assistance with one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. Walking in rooms and corridors requires supervision and one person physical assistance. Eating required limited assistance with one person physical assistance. Bathing was total dependence with two person physical assistance. B. Observation A continuous observation of Resident #35 on 9/2/21 from 9:03 a.m. to 12:45 p.m. -At 9:03 a.m., Resident #35 was observed to walk up and down the hall walking up and down the hall carrying a bag of pretzels. She continued to walk the 700 hall, 400 hall and to the front door. -At 9:37 a.m. CNA #10 assisted the resident to the bathroom. The bedroom door and the bathroom doors were open, unable to see the resident in the bathroom but could hear the conversation. CNA#10 assisted the resident with personal hygiene and had the resident wash her hands. CNA#10 said I will see you after lunch. CNA#10 told the nurse that she just changed the resident. Resident #35 starts walking down the hall and she had taken her roommates' cookies. During this personal care the resident was not offered anything to drink. The resident did not have a water pitcher in her room. -At 9:47 a.m., Resident #35 sat in a hallway chair. -At 9:51 a.m., Resident #35 was asked if she wanted to go to exercise class, however Resident #35 did not respond to the question so they continued without her. A CNA commented on her eating a cookie, however, did not offer any fluid to drink. -At 9:55 a.m., Resident #35 was standing in the dining area and a physical therapist assistant (PTA) comes up and puts a walker in front of the resident and puts a gait belt on and he says lets go walk for awhile. He walks down to the end of 200 hall and she sits down at the end of hall in a chair. - At 10:06 .am., she continued to walk with the PTA. -At 10:32 a.m., the PTA finished the session. Prior to him leaving, after the resident walked for nearly 30 minutes, she was not offered any fluid. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 10:34 a.m., the resident was walking up and down the 700 hall. -At 10:46 am., the staff development coordinator/infection preventionist (SDC) assisted the resident back to her room, from the front office. -At 10:47 a.m., she was left sitting in a chair by the nurses station. She was not offered any fluids. -At 11:14 a.m,. the nursing home administrator (NHA) walked Resident #35 back to the 700 unit, from the front offices. -At 11:20 a.m., the resident was assisted to the dining room by a CNA. -At 11:29 a.m. Resident #35 was served 240 cc of apple juice and a 240 cc glass of water and she drank some of each. -At 11:56 a.m., she was given an unopened can of soda with her lunch but no one had opened it for her. The resident finished the 240 cc of water and apple juice and took a bite of her dessert. -At 12:21 p.m. no one had helped the resident to open her soda yet. Resident #35 ate 100% of the food on the plate and her dessert. No water or juice refill was offered. At 12:27 p.m. a CNA said you are all done and moved the resident away from the table and said you must have been hungry. The soda was never opened for the resident and left at the table. -At 12::31 p.m., the resident was walking the halls once again until 12:45 p.m., the completion of the observation. C. Record review The care plan revised on 8/30/21 identified the resident had a potential for dehydration or potential fluid deficit related to vomiting, diarrhea. Pertinent approach was to encourage fluids. The medical record failed to show that the facility kept track of the amount of fluids consumed. Review of hydration/snack record for past 30 days revealed no data for activity participation. D. Staff interviews The registered dietician (RD) was interviewed on 9/2/21 at 2:57 p.m. She said she can assess dehydration by moisture of the lips, and mucous membranes; urinary tract infections; falls, and increased confusion. She said she also looks at labs and accesses the computer dashboard. She said she is on the IDT team. She said the dietary staff rely on nursing to take the initiative to offer food, nutrition and hydration. She said every resident should have a water pitcher cup at their bedside. She said her facility had discussed the need to develop a better system for hydration. She said she did some education/inservice training in March 2021 and recently for thickened liquids at an all-staff meeting. She said they should also be providing training to the agency's CNA's. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nursing (DON) was interviewed on 9/8/21 at 5:45 p.m. She said she expected the staff to offer fluid to residents at least every two hours for residents who cannot get it for themselves. She said Resident #35 was a resident that should be offered hydration. She said fluids should be encouraged also during mealtimes. She said there should be an updated care plan addressing hydration. She said Resident #35 could be vulnerable for dehydration. The DON acknowledged that she could not see that being addressed in the care plan. 20287 4. Resident #17 A. Resident status Resident #17, age 79, was admitted on [DATE]. According to the September 2021 computerized physician order (CPO) diagnoses included, Alzheirmer ' s disease, and osteoporosis. The 6/5/21 minimum data set (MDS) assessment showed the resident had memory impairments and had severely imparied decision making skills. The resident required extensive assistance with with eating, and all activities of daily living. The resident had problems swallowing, loss of liquids from mouth when eating, coughing choking during meals. The resident received thickened liquids. B. Observations 9/2/21 The resident was observed continuously from 8:25 a.m to 12:30 p.m. -At 8:25 a.m., the resident was lying in bed. The resident ' s breakfast tray was sittin at the bedside. The tray had one glass of 240 milliliters (ml) thickened orange juice. However, approximately 30 ml was consumed. -At 8:29 a.m., the resident was assisted out of bed and assisted into her wheelchair. The breakfast tray was removed from the room. -At 8:55 a.m., the resident continued to be seated in her room. The resident had no thickened liquid in her room. The room did have a small insulated cooler, however, it was empty. -At 9:37 a.m., Resident #17 continued to be seated in her wheelchair in an upright position as she was sleeping. -At 10:29 a.m., the certified nurse aide (CNA) #8 went into the room to get the roommates dinner order, but nothing was said to Resident #17. Resident #17 was not offered a drink. -At 11:17 a.m., the CNA #14 assisted the resident to the dining room. She was not assisted to have anything to drink. -At 11:30 a.m., she was seated in the dining room at the table awaiting her meal. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 11:59 a.m., the resident was served her pureed meal. The resident was served two 240 ml glasses of thickened liquid. The feeding assistant was observed to assist the resident with eating. -At 12:10 p.m. the resident was assisted back to her room. The resident did not drink any fluid at during the meal. During this continuous observation on 9/2/21 from 8:29 a.m. to 12:15 p.m. ,the resident was not assisted with receiving anything to drink. C. Record review The care plan last revised on 4/5/21 identified the resident was at risk for dehydration and that she had swallowing difficulties related to dementia, and dysphagia (swallowing problem). Pertinent approaches included, to offer fluids, encourage fluids, assist with meals, and provide fluids between meals. The computerized physician orders documented 7/6/21 an order to encourage 240 cc (ml) of fluid between meals three times a day. D. Interview The feeding assistant #1 was interviewed on 9/2/21 at 12:10 p.m. The feeding assistant said the resident was too sleepy and she was not eating, so she did not continue to assist the resident with eating. The feeding assistant confirmed that the resident did not drink any fluid during the meal. Licensed practical nurse (LPN) #2 was interviewed on 9/2/21 at 12:30 p.m. The LPN #2 said the resident was unable to drink on her own. She was unable to make her needs known. The LPN said the resident should be offered and assisted to drink fluid between meals. She said she should also have fluid in her room. The LPN observed the empty insulated cooler (see observations above). The registered dietitian was interviewed on 9/6/21 at approximately 11:00 a.m. The RD said the residents were to have fluids at the bedside, including Resident #17 was to have thickened liquid available in her room. She said she was providing education to the nursing staff on the importance of having the fluids in the room and should be offered between meals. 44998 5. Resident status Resident #218 Resident #218, age 78, was admitted on [DATE]. According to the August 2021 computerized physician orders (CPO), the diagnoses included chronic kidney disease stage 3, mild protein calorie malnutrition, anxiety disorder, major depressive disorder. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The minimum data set (MDS) assessment dated [DATE] revealed the resident was cognitively intact with moderately cognitive impairment with a brief interview for mental status score of seven out of 15. She required extensive assistance with one to two persons for ADLs to include set up assistance for meals and liquids as the resident could not independently get up to get a water cup or pitcher. B. Record review According to 4/7/21 Interdisciplinary team (IDT) progress note Resident#218 was placed on a weekly IDT meeting for nutrition and weight loss tracking due to unplanned loss of weight. According to 5/20/21 IDT weight progress note staff documented a .25% decrease in taking in oral fluids. According to the 6/10/21 IDT weight progress note, oral intake continues to decline by 0.25% and the physician was notified of the weight loss. Registered Dietician (RD) revises the care plan for the following Boost pudding, enriched cereal, breeze supplement, fluids to be encouraged, housemade nutrition shake, and an update to the current breeze supplement order. The care plan last revised on 6/10/21 identified the resident was at risk for hydration needs, goal was for Resident #218 to maintain adequate hydration and based the residents hydration/fluid needs at 1830 ml per day based on residents height, weight, and health condition. Pertinent approaches were to encourage fluids by staff throughout the day. The hospital record progress note dated 7/21/21 documented the resident was admitted to the Intensive Care Unit. The hospital records showed the diagnoses were as follows: septic shock from E. coli urinary tract infection, obstructing ureteral stones, acute kidney injury, acute respiratory failure secondary to sepsis, severe dehydration with a sodium level greater than 180 mmol/L. The medical record failed to show the residnet's fluid consumed was being tracked. C. Staff interviews Registered dietician (RD) was interviewed on 9/2/21 at 2:20 p.m. The RD said the resident ' s nutritional status intakes were variable 50-75% and sometimes 0-26%.