STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065249	A. Building B. Wing	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Care Center	2050 S Main St Delta, CO 81416

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on resident and staff interviews and record review, the facility failed to promote resident dignity and respect one resident (#16) out of 12 residents reviewed for dignity out of 26 sample residents. Specifically, the facility failed to: -Ensure Resident #16 treated and spoken to in a dignified manner; and, -Ensure Resident #16's bodily privacy was maintained and personal space respected. Findings include: I. Facility policy The Dignity policy, revised February 2021, was provided by the director of nursing (DON) on 10/3/22 at 4:23 p.m. via email. The policy read in part: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Residents are treated with dignity and respect at all times. Residents' private space and property are respected at all times. Staff speak respectively to residents at all times, including them and dressing them by name. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and didn't during treatment procedures. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example, helping the resident to keep urinary catheter bags covered. II. Resident status A. Resident #16 Resident #16, age under 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included personal history of transient ischemic attack (TIA) and cerebral infarction (stroke), chronic pain, urinary incontinence, difficulty walking, unsteadiness of feet, cognitive communication deficit, overactive bladder and need for assistance with personal care. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the 7/28/22 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for a mental status score of 15 out of 15. The MDS assessment indicated the resident was independent in activities of daily living (ADLs). The MDS assessment identified the resident had a catheter. B. Resident interview and observation Resident #16 was interviewed on 9/27/22 at 9:04 a.m. She said sometimes she did not feel staff treated her with respect and dignity. Resident #16 said certified nurse aide (CNA) #3 had spoken to her in a very mean manner. Resident #16 said recently CNA #3 told if she wanted a shower, she needed to get her (expletive) down there right now. The resident said she personally would never use that language and felt belittled when it was used toward her. Resident #16 said she had asked CNA #3 You don't like me do you? She said the CNA said Not when you are late. She said she told CNA #3 she did not appreciate that way she talked to her but CNA #3 just Blew it off. She said when someone talks to her like that she would not forget it. She said she told other staff but was not sure who. She said she did not feel it was abusive but was not treating her with dignity. Resident #16 said CNA #3 just had a more of a gruff personality. Resident #16 said she was admitted to the facility because she needed assistance and no longer could care for herself, but felt she should not be treated that way. The resident said she knew had been a CNA for years but she did not like how she spoke to her or the tone in her voice during other interactions. Resident #16 said she had felt ignored and disrespected by CNA #9. She said she had felt ignored at times by CNA #9. She said the CNA also had passed gas in her room two or three times and did not excuse herself and giggled about it. Resident #16 said she would never not excuse herself in a similar situation and felt the giggling and repetition was disrespectful to her personal space. Resident #16 said staff did not have assistance with routine catheter care (cross-reference F690 catheter care). Resident #16 said staff were often busy taking care of other residents. (Refer observation below.) C. Observation Resident #16 was observed on 9/27/22 at 9:04 a.m. The catheter bag was observed laying on the floor uncovered, exposing the fluid in her catheter bag. Resident #16 was observed on 9/29/22 at 9:26 a.m. Her catheter bag was attached to her walker. There was not a cover over her bag for privacy. D. Record review The choices care plan, initiated on 3/11/19, read staff would ensure the resident's privacy and dignity. The depression care plan, initiated on 3/11/19 directed staff to provide support and reassurance. E. Staff interview (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #3 was interviewed on 9/28/22 at 9:50 a.m.The CNA said staff had monthly in-services and have had annual online training on a computer based system. The staff had gone over tips on how to interact with dementia residents, right rights, dignity and abuse. She said it would never be appropriate to use swear words or be demanding of a resident. She said she asked the residents to tell her when she rushed or if she did something they did not like. She said they would usually tell her if there was a concern. CNA #9 was interviewed on 10/3/22 at 10:11 a.m. She said she has had dignity training through the facility's online program. She said the training taught her to interact and provide activity of daily living care (ADLs) with kindness. She said staff needed to make sure residents always felt comfortable. The social service director (SSD) was interviewed on 10/5/22 at 9:31 a.m. The SSD said the facility has had training on resident rights. She said the facility was the residents' home and they had the right to voice their concerns. The SSD said everyone should be treated with dignity and feel they are treated with respect. She said the perception of a resident mattered. She said staff needed to get to know the residents and how to interact with them so the residents did not have their feelings and pride hurt. The SSD said Resident #16 had not express concerns to her specific about CNA #3. The SSD said CNA #3 could exhibit tough love meaning a little rough around the edges in manner when interacting with residents. The SSD said this mannerism could potentially offend or hurt the feelings of a resident and possibly make the resident feel like they have done something wrong. The CNA comment was shared with the SSD. The SSD said if the same comment was said to her she would also feel belittled. The SSD said there was no excuse for a CNA to speak to a resident in that manner. She said she would follow up with Resident #16 to check on how she was feeling, validating her feelings of concern. The SSD said Resident #16 had not express concerns to her specific about CNA #9. She said CNA #9 sometimes could become easily side tracked which residents could take personally because they could feel ignored. The SSD said a resident's room was a resident's personal space and all they have for themselves. She said the resident's room and personal space should be treated with respect. The SSD said if a CNA had to pass gas in a resident's room, the CNA should excuse themselves and apologize. She said CNA #9 did not always handle herself professionally. The SSD said on 10/3/22 Resident #16 told her she would like to talk about a CNA. The SSD said she had not been able to follow up with the resident or know which CNA the Resident #16 or what it was regarding. The SSD said normally she would meet the resident right away or at least within the same day of the request however, she said she had not been available to meet with Resident #16 yet but would as soon as possible. The SSD said the facility had training on resident rights. She said she did not recall if it was part of their new hire orientation but it was included in an online training and review. She said the facility used to have in person training which was more helpful in understanding the perspective of a resident. She said all staff were involved in the in-person training and it encouraged staff participation and teamwork.

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F 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. 20287 Based on observations and interviews, the facility failed to ensure residents received notices orally and in writing which included a written description of their legal rights. Specifically, the facility failed to post a list of names, addresses and telephone numbers of all pertinent State Agencies in the facility. Findings include: I. Group interview The group interview was conducted on 9/28/22 at 1:35 p.m. The group consisted of six alert and oriented residents selected by the facility. All six residents (#3, #16, #20, #22, #31 and #33) said they did not know where the facility posted information in regard to pertinent State Agencies' contact information. II. Observations Observations throughout the building revealed there was a posting which was located to the right of the front door. The posting was approximately five feet and five inches inside a glass case. The print was between a 12 and 14 font. The phone number to the State Survey Agency was incorrect and no email address was provided. Although there were mailing addresses and telephone numbers of pertinent State Agencies there were no email addresses. In addition, there was a posting of the ombudsman information on D hallway, which was in Spanish. An English version was not found hanging in the facility. II. Interviews The social service director (SSD) was interviewed on 9/5/22 at 9:49 a.m. The SSD confirmed, the posting of the pertinent agency information was not in a location which could be easily seen reasonably because of the height and the font of the posting. She was not aware the residents were not aware of where to find the information. The SSD said she was not aware the email address needed to be included and that that the phone number was incorrect.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on record review and interviews the facility failed to fully ensure residents had the right to formulate advance directives by not keeping advance directives updated and current for two (#12 and #27) out of 16 residents reviewed for advance directives out of 26 sample residents. Specifically, the facility failed to: -Ensure Resident #12 had the proper legal representation in the record and the medical orders for scope of treatment (MOST) form, the facility utilized for advance directives, was signed appropriately; and -Ensure Resident #27's physician order matched her wishes as signed on the MOST. Findings include: I. Professional reference The Colorado Advance Directives Consortium, Guidance for Health Care Professionals website, dated [DATE], retrieved on [DATE] from http://www.coloradoadvancedirectives.com/wp-content/uploads/[DATE]-MOST-Booklet-REV-2015.pdf read in pertinent part, If the individual resides in a nursing facility, the facility staff are responsible for keeping the MOST form updated. Staff should complete MOST forms for all current residents before the next scheduled quarterly care plan meeting and review the form automatically before each resident's quarterly assessment. For current residents, complete or review at quarterly conference(s). For section A of the form, cardiopulmonary resuscitation (CPR), selecting ' Yes CPR ' requires choosing Full Treatment in section B. The form must be dated. A revised MOST form automatically supersedes all previously completed MOST forms. The MOST form must be completed by a healthcare professional with sufficient expertise to discuss medical conditions, treatments, risks and benefits with the individual. This professional should be competent and comfortable with conducting this kind of conversation. The form must be signed by a physician (MD or DO), advanced practice nurse, or physician's assistant and the individual, assuming the individual has decisional capacity. II. Resident #12 A. Resident status Resident #12 , age 85, was admitted to the facility on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included type II diabetes mellitus with diabetic nephropathy, essential primary hypertension, acute and chronic respiratory failure with hypoxia (low blood oxygen), diabetic chronic kidney disease, dementia, and unspecified visual disturbances. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for a mental status score (BIMS) of two out of 15. She required extensive assistance of one person with bed mobility, dressing, eating, and personal hygiene. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The care plan, initiated [DATE], identified that the resident had impaired cognitive function/dementia or impaired thought processes related to age and dementia. An intervention was put into place to ask the resident yes/no questions to determine the resident's needs. The [DATE] CPO included the following, both starting on [DATE]: Advance Directive: do not resuscitate (DNR) The resident is not capable of understanding her rights, reason: Dementia. The MOST form was signed by Resident #12 on [DATE], followed by the physician signature on [DATE]. -The medical record did not have any legal authority for medical decisions. However, in the computerized medical record a letter of conservatorship-adult dated [DATE], appointed an attorney as a conservator for the resident on [DATE]. The conservatorship had no authority on medical decisions. -No documentation noted for Resident #12 having a medical durable power of attorney. C. Interviews The social service director (SSD) was interviewed on [DATE] at 9:22 a.m. The SSD said the resident was severely impaired cognitively since admission. She said she scored a two on the BIMS assessment. She said an attorney acts on her behalf. The SSD was not aware the attorney did not have medical decision authority. She reviewed the conservatorship letter and confirmed it did not include medical decisions. She said due to the residents severe cognitive impairments, she should have not signed her MOST form. Certified nurse aide (CNA) #3 was interviewed on [DATE] at 12:21 p.m. CNA #3 said the resident's cognitive status was impaired. She said that she was not able to make daily decisions. She said there had been no change in her cognitive status since admission. 20287 III. Resident #27 A. Resident status Resident #27, age less than 60, was admitted on [DATE]. According to the [DATE] CPO diagnoses included, osteoporosis and depression. The [DATE] MDS assessment showed the resident did not have any cognitive impairments with a score of 15 out of 15 on the brief interview for mental status. The resident was independent in activities of daily living. B. Record review (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] plan of care note showed the MOST form was changed to a do not resuscitate. The MOST form was signed on [DATE] by the resident for a do not resuscitate. The physician signed the form on [DATE]. The physician order in the computerized record on [DATE] showed the physician order was for CPR full code status. C. Interview The director of nurses (DON) was interviewed on [DATE] at 8:57 a m. The DON said that the physician's order was updated to match the MOST form. She said she did not know how the change in the MOST form was missed. She said the physician order should always match the resident's wishes with the MOST form. She said that the physician was contacted and the order was changed to a do not resuscitate.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 47351 Based on observations, record review, and interviews, the facility failed to make information on how to file a grievance or complaint available, maintain records of grievances and complaints, or to make prompt efforts to resolve grievances the resident(s) may have had. Specifically the facility failed to ensure: -Resident group grievances were resolved; and, -Individual resident grievances were resolved; Findings include: I. Facility policy and procedure The Grievance and Complaints policy and procedure, revised in April 2017, was received from the director of nursing (DON) on 10/4/22 at 10:30 am, read in pertinent part, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations. The investigation and report will include, as applicable, date & time of the incident, circumstances and location of the incident, the witnesses, the residents and the employees account of the incident, and corrective actions. The Grievance Officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log with the same information. The Resident Grievance/Complaint Investigation Report Form will be filed with the administrator within 5 working days of the incident. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions within ___ (no time frame filled in) working days of the filing of the grievance or complaint. The grievance officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. A copy of the :Resident Grievance/Complaint Investigation Report Form must be attached to the Resident Grievance/Complaint Form and filed with the business office. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident. II. Resident group interview (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident group interview was conducted on 9/28/22 at 1:35 p.m. The group consisted of six alerts and oriented residents (Resident #3, #16, #20, #22, #31 and #33) selected by the facility. The residents stated the following: Certified nurse aide (CNA) #9 had long fingernails which jabbed the residents during care. The residents were told to fill out a grievance form prior to the resident council meeting, so that the issue was not brought up in the council meeting. No staff gets back to counsel with resolutions from complaints. No staff told the council why the grievance was not addressed. The staff came to the answer call light but turned it off and did not return for 10-15 minutes. III. Record review The Resident Council minutes from June 2022 to August 2022 were reviewed and revealed: Call lights were being shut off and no staff returning to provide the care; CNAs not providing care when they should; and, using personal cell phones during work hours. In regards to nurses and CNAs, Still need to work on past grievances IV. Resident reports regarding CNA #9 A. Facility policy and procedure The Rules of Conduct policy, undated, was provided by the nursing home administrator on 10/4/22 at 5:21 p. m. The policy read in pertinent part, fingernails must be clean, neatly trimmed and not extend beyond the end of the finger for safety and infection control. B. Observations Throughout the survey starting on 9/26/22 through 10/5/22 CNA #9 was observed to work the A hallway. She had long artificial nails which were nearly an inch over the nail bed. C. Resident interview Resident #36 was interviewed on 9/26/22 at 4:41 p.m. He said CNA #9 long nails sometimes pinched him if she was providing occasional care assistance. D. Interview (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The SSD was interviewed on 10/5/22 at 10:46 a.m. She said residents have submitted a formal complaint about CNA #9's nails. She said the residents wanted her to cut her nails, they were too long. The residents said her nails would jab/poke them during cares. The SSD said the grievance form, submitted by residents about a month ago, was somewhere in her paper piles. She said the form was only partially completed because she was told by management that the nails were an appropriate length. She said there was no attempted resolution to the concern that she was aware of. V. Call lights A. Record review The facility was unable to provide any grievance form or audit which was completed to show the grievance was followed up on. B. DON interview The DON was interviewed on 10/4/22 at 11:00 a.m. The DON said the call lights should be answered by any staff member, but if care was needed the call light needed to remain on. VI. Additional interviews The SSD was interviewed on 10/5/22 at 9:00 a.m. She explained the activity director (AD) was responsible for the resident council and grievances/complaints. She said there should be a response within 72 hours. She has created a form for residents to use to file a complaint or grievance. She said she was not familiar with how the grievance process worked in the entirety. She said she had not heard the call light issue. The SSD said residents should always be informed of any follow up on their grievance. The AD was interviewed on 10/5/22 at 2:00 p.m. The AD confirmed residents were asked to file a grievance prior to the resident council, as that way the complaint could be handled at an earlier date. She said she had not filled out any grievance forms from the resident council. She said she was not familiar with the policy. 40467

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and staff interviews, the facility failed to ensure two (#17 and #31) of three residents reviewed for abuse out of 26 sample residents were kept free from abuse. Specifically, the facility failed to ensure Resident #17 and #31 were kept free from abuse by Resident #4. Cross-reference F744, dementia care. Findings include: I. Facility policy The Abuse and Neglect policy, revised September 2018, was provided by the director of nursing (DON) on 9/29/22 at 4:05 p.m. It documented the following, in pertinent part, Every resident has the right to be free from verbal, sexual, physical, and mental abuse; corporal punishment; neglect; explotation; involuntary seclusion; and any physical or chemical restraint not required to treat the resident's medical symptoms or conditions. The administrator was responsible for the oversight and implementation of the Abuse, Neglect, and Exploitation Prohibition and Prevention Program. If the allegation involved another resident, the residents were separated, and other reasonable measures, as appropriate (such as a psychiatric evaluation), were put into place, pending the outcome of the investigation. II. Resident-to-resident altercation involving Resident #4 and Resident #31 on 6/27/22 The facility documentation from 6/28/22 revealed Resident #4 was in another resident's room. Residents #31 heard a resident scream and went to her room. He saw Resident #4 standing in the room so he took Resident #4 by hand to escort him out of the resident's room and into the hallway like the staff had done. Resident #4 said something that Resident#31 did not understand and he responded, We are going down here. Resident #4 swung his arm and Resident #31 blocked it with his left arm. Resident #4 ended up on the floor. Resident #31 had a bruise to his posterior forearm. -The facility unsubstantiated that abuse occurred. III. Resident #4 A. Resident status Resident #4, age 92, was admitted on [DATE]. According to the September computerized physicians orders (CPO), the diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, depression, and generalized anxiety disorder. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/20/22 minimum data set (MDS) assessment revealed, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of four out of 15. He had inattention and disorganized thinking. He required supervision with dressing and was independent with all other activities of daily living (ADL). He had no behaviors and did not reject care. He wandered daily which placed him at risk of getting into a potentially dangerous place. He received anti anxiety medication daily. B. Record review The mood care plan, revised 7/7/22, documented the resident had alterations in mood and behaviors as evidence by outburst. The goal was to have fewer episodes of outburst of anger. Pertinent interventions listed were to administer medications as ordered and monitor/document side effects and effectiveness, anticipate and meet the residents needs, minimize potential for the resident's disruptive behaviors by offering tasks which divert attention, provide a program of activities that is of interest and accommodates resident status, and provide positive reinforcement/praise of the resident's progress/improvements/control in behavior. The dementia care plan, revised 7/7/22, documented the resident may have days where he became physically and/or verbally towards staff and others due to poor impulse control. Pertinent interventions listed were to speak to him in a calm, quiet voice and activities. The September 2022 behavior monitoring documented five episodes of grabbing, hitting or pushing others, expressing anger or agitation and three episodes of wandering. There were no progress notes nor interdisciplinary team (IDT) notes in the resident's medical record. IV. Resident #31 A. Resident status Resident #31, age 77, was admitted on [DATE]. According to the September CPO, the diagnoses included chronic obstructive pulmonary disease with acute exacerbation, acute and chronic respiratory failure with hypoxia, dyspnea (difficulty breathing), anxiety disorder, and depressive disorder. The 8/30/22 MDS assessment revealed, the resident was cognitively intact with a BIMS score of 15 out of 15. He had no behaviors and did not reject care. He was independent with all his ADLs. B. Record review The elopement care plan, revised 5/5/22, documented the resident was an elopement risk and wandered. Pertinent interventions listed were to personalize his room with familiar objects, make staff aware of elopement risk, and utilize check in/out log. -There were no progress notes nor IDT notes in the resident's medical record. V. Resident-to-resident altercation involving Resident #4 and Resident #17 on 6/30/22. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility documentation from 6/30/22 revealed Resident #4 was standing in front of Resident #17's room entrance where he was sitting in his wheelchair. A nurse heard Resident #17 yelling and when she exited the nurses station she saw Resident #4 swing his arm to hit Resident #17. The nurse yelled to Resident #4 to stop. Resident #4 walked away, entered and exited an empty room, and exited down the hallway. The nurse went to escort Resident #4 from the area. Resident #4 shoved the nurse in her left shoulder with his right shoulder as she approached. Another staff member intervened and escorted Resident #4 off the east wing and back to the west wing where his room was located. Resident #17 stated Resident #4 had hit him. A red mark was noted to Resident #17's neck, which faded in a short time. Resident #4 was placed on one-on-one monitoring (during the investigation) and then every 15 minute checks thereafter. -The facility unsubstantiated that abuse occurred. VI. Resident #17 A. Resident status Resident #17, age 95, was admitted on [DATE]. According to the September 2022 CPO, the diagnoses included major depressive disorder, cognitive communication deficit, conductive hearing loss, spinal stenosis, chronic respiratory failure, weakness, and dementia. The 7/28/22 MDS assessment revealed, the resident was unable to complete the BIMS. He had short and long term memory problems. His cognitive skills for daily decision making were severely impaired. He had inattention and disorganized thinking. He required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. He had no behaviors and did not reject care. He wandered one to three days out of the seven day look back period. B. Record review The dementia care plan, revised 12/2/21, documented the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. Pertinent interventions listed were to administer medications as ordered and monitor/document for side effects and effectiveness. Ask yes/no questions in order to determine the resident's needs. The 6/30/22 nurse progress note documented Resident #17 was sitting in his wheelchair in the doorway to his room, when Resident #4 walked up to him and hit him on the left cheek and neck area. It documented there were three red marks on the left side of his neck. There were no other injuries noted. VII. Staff interviews (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #5 was interviewed on 9/29/22 at 3:52 p.m. He said Resident #4 wandered and tried to hug and kiss other residents and staff. He said Resident #4 had altercations in the past and wandered into other resident's rooms. He said the staff tried their best to keep him out of other resident rooms. CNA #5 said on one occasion Resident #4 swung at him as he attempted to escort him out of a resident's room. He said on one occasion Resident #4 walked into a female resident's room and she started screaming because she was fearful of him. So, he escorted Resident #4 out of her room. He said they were doing every 15 minute checks and some of the residents have a stop sign across their door. Licensed practical nurse (LPN) #1 was interviewed on 9/29/22 at 4:07 p.m. She said Resident #4 had dementia and if you argued with him he would get aggressive. She said the staff tried to redirect him by giving him something to read or write. She said she had only been working at the facility for a month and had not seen him in any altercations. She said sometimes Resident #4 would wander into other resident rooms and the other residents would get angry and ask the staff to remove him from their room. She said Resident #4 was on every 15 minute monitoring. The executive director (ED) was interviewed on 10/4/22 at 2:50 p.m. She said the 6/27/22 resident to resident altercation was not substantiated because where the bruise was located on Resident #31's arm was not consistent with where he would have been injured from blocking the swing. She said Resident #4 acted that way when he felt threatened or when yelled at. She said he was at risk for becoming a victim and would defend himself. -However, the abuse should have been substatied because Resident #31 had a bruise on his forearm after the altercation. She said the 6/30/22 resident to resident altercation was not substantiated because during the investigation, the nurse said she was not sure if contact was made or not. The ED said the residents involved did not remember the incident and the nurse stated Resident #4 did not shove her but had bumped into her. She said Resident #4 was placed on one-to-one supervision until the initial investigation was completed and then placed on every 15 minute monitoring. She said the staff had educated the other residents about his wandering. She said residents were offered stop signs to place in their doorways if they did not want Resident #4 to wander in. She said they increased staff awareness of his wandering to the east wing. -However, the abuse should have been substatied due to the resident's report that he was hit and had marks on his neck.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews, the facility failed to ensure the minimum data assessment (MDS) accurately reflected the residents' status for four (#5, #26, #33 and #34) of 12 out of 26 sample residents. Specifically, the facility failed to ensure the MDS for Resident #5, #26, #33 and #34 were completed accurately to include their dental status. Findings include: I. Resident #5 A. Resident status Resident #5, age 82, was admitted on [DATE] and readmitted on [DATE]. According to the September 2022 computerized physicians orders (CPO), the diagnoses included paraplegia (paralysis lower body), cognitive communication deficit, age related physical debility, repeated falls, and unsteadiness on feet. The 9/21/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. She had no behaviors and did not reject care. Section L (Dental) documented Resident #5 did not have mouth or facial pain, discomfort or difficulty with chewing. B. Family interview Resident #5's power of attorney (POA) was interviewed on 9/28/22 at 6:07 p.m. She said Resident #5 had been having mouth pain and was losing weight. She said Resident #5 had seen the dentist who suggested a mechanical soft diet due to her age and the pain of pulling all of her lower teeth and giving her dentures. She said once the diet was changed to mechanical soft, she started gaining weight. C. Record review The care plan, initiated 6/30/18 and revised on 7/10/18, identified the resident had upper dentures and her own lower teeth. D, Staff interviews Certified nursing aide (CNA) #5 was interviewed on 10/1/22 at 4:32 p.m. He said Resident #5 had upper dentures and her own lower teeth. He said he had never heard her complain of mouth pain, and she received a mechanical soft diet for chewing difficulties. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The executive director (ED) was interviewed on 10/5/22 at 2:30 p.m. She reviewed Resident #5's medical record and acknowledged section L of the MDS was not recorded accurately. She said when the MDS was completed, they were to visibly assess the resident and review the documents to make sure the medical record was accurate. 47349 II. Resident #26 A. Resident status Resident #26, age 73, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, other fracture of first lumbar vertebra, and repeated falls. The MDS assessment on 8/17/22, revealed that the resident was cognitively intact on the brief interview for mental status (BIMS) with a score of 15 out of 15. The MDS revealed the resident needed limited assistance to extensive assistance with activities of daily living (ADLs). B. Observations and interview Resident #26 was interviewed in her room on 9/27/22 at 10:08 a.m. She said she was not using her upper denture because it needed to be realigned. She said it slipped so she did not use it. C. Record review The 8/10/22 MDS assessment for dental was not completed. The 8/17/22 MDS assessment for dental did not identify any dental problems with Resident #26. -However, the loose fitting denture should have been coded. III. Resident #33 A. Resident status Resident #33, age 85, was admitted on [DATE]. According to the September 2022 CPO, diagnoses included age-related osteoporosis, osteoarthritis, essential (primary) hypertension and type 2 diabetes mellitus with diabetic polyneuropathy. The MDS assessment on 3/3/22, revealed that the resident was cognitively intact with the BIMS score of 15 out of 15. The MDS revealed the resident was independent with ADLs. B. Observations and interviews On 9/30/22 at 9:46 a.m., the resident ' s mouth exhibited missing and broken natural teeth. The resident reported that she only has four of her bottom teeth, and no teeth on the top. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The care plan, initiated on 5/24/21, identified the resident as having missing teeth on both the upper and lower portion of mouth. The 3/3/22 MDS assessment was assessed as the resident having no dental problems. -However, the MDS should have been coded as having some natural teeth and tooth fragments. IV. Staff interviews The nursing home administrator (NHA), who is a registered nurse, was interviewed on 10/5/22 at 2:30 p.m. The NHA said the MDS coordinator was not available. She reviewed the MDS for Resident ' s #26 and #33. The NHA confirmed the dental portion of the assessments were not completed accurately. 47351 V. Resident #34 A. Resident status Resident #34, age 93, was admitted on [DATE]. According to the September 2022 CPO diagnosis included Alzheimer's disease. The 6/5/22 MDS showed the resident had severe cognitive impairments with a score of two out of 15 for the brief interview for mental status. The resident required limited assistance with activities of daily living. B. Observations On 9/27/22 at approximately 12:00 p.m., the resident had both upper and lower natural teeth, although some were missing and some were fragments. C. Record review The MDS inaccurately coded the dental for Resident #34.The MDS indicated she had no natural teeth, whereas, she did have natural upper teeth with missing incisors bilaterally, and a lower partial.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on interviews, observations, and record reviews, the facility failed to provide an ongoing program to support residents in their chosen activities, designed to meet the interest of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for two (#9 and #12) of five out of 26 sample residents. Specifically, the facility failed to: -Offer and provide personalized activity programs for Resident #12 and Resident #9; and, -Offer evening and activity outings. Findings include: I. Facility policy and procedure The Activities Program policy, effective 9/1/14, was received from the director of nurses on 10/3/22 at 4:23 p. m. It was documented in the pertinent part, The community will encourage participation in independent or self-driven activities, as well as offer activities at least three times per week. II. Resident #12 A. Resident status Resident #12, age 85, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (low blood oxygen), dementia, and essential primary hypertension. The 7/8/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a score of two out of 15 on the brief interview for mental status (BIMS). The MDS assessment coded that the resident required extensive assistance with activities of daily living, and that she did not have an altered level of consciousness. The preference for activities documented, the resident reported that being around animals and performing her favorite activities were somewhat important to her. B. Resident observations On 9/26/22 at 2:05 p.m. the resident was lying in bed awake, the television was on, but on a static channel (just showing snow). No other meaningful activities taking place. On 9/29/22 at 8:50 a.m. the resident was lying in bed with the television turned off. C. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plan, dated 5/5/22, documented as a goal is that the resident would participate in a one-to-one program, three times a week, noting the resident enjoyed watching television. It was identified that on 8/3/22 the resident was dependent on staff for her emotional, intellectual, physical, spiritual and social needs. With a goal that she will maintain involvement in cognitive stimulation and social programs. The resident's activity log, received from the activities director (AD) on 9/30/22 at 4:19 p.m., revealed that for the week of 8/28/22 to 9/3/22, the resident was only offered an activity on one day, 9/1/22. The medical record failed to show the resident was on a one-to-one program. D. Staff interviews The AD was interviewed on 10/4/22 at 9:01 a.m. She said that when she went into the resident's room, she ensured the television was on. She said the resident had declined music in the past. The AD reported that she could probably do better with activity visits. She said she was training staff on documentation. 47351 III. Resident #9 A. Resident status Resident #9, age 78, was admitted on [DATE]. According to the September 2022 CPO diagnoses include, adult failure to thrive, unsteadiness to feet and hypertension. The MDS assessment on 6/29/22 revealed he refused to complete the BIMS score. The resident required limited assistance with activities of daily living. He had no behaviors and did not reject care. B. Resident interview Resident #9 was interviewed on 9/26/22 at 9:45 a.m. The resident said it was his choice to not wear a mask and he did not feel that the facility liked him because he refused to wear a mask or to get vaccinated. He said they made him stay in his room because he did not want to wear the mask. He said when he had attended a music event he was asked to leave as he did not have a mask on. The resident said he did get lonely because he was alone in his room the majority of the time. The resident stated he enjoys watching western movies and reading western books as it reminds him of growing up on a farm. The activity director (AD) was notified of the resident's interests after the interview. The resident was interviewed a second time on 9/27/22 at 9:00 a.m. The resident said he did not get any individualized activities offered to him. In the resident's room, were a few books provided by the AD. C. Record review (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan dated 6/30/22 identified the resident has little or no programming involvement related to disinterest, physical limitations, and poor adjustment to the facility/unit/community, The resident wishes not to participate and can participate in activities of his choice. Goals: 1) participate in programs of interest when I choose, 2) establish and record the residents prior level of programming involvement and interests by talking with the resident, caregivers, and family on admission and as necessary, 3) the resident has a TV in his room if he cares to watch it, 4) the resident likes to watch wild life out his window, 5) the resident prefers to visit with others in small groups, 6) the resident socializes with friends and family D. Staff interview The activity director (AD) was interviewed on 10/4/22 at 9:01 a.m. The AD said she was not all that familiar with the resident. She said that when she had attempted to visit with him, he had asked her to leave his room. She said she had not been able to get a good activity assessment due to his refusal to answer questions. The AD stated the resident had calmed down a little but he's not happy with his situation and cannot participate in activities without a mask. She said the resident was lonely, needed a friend and stimulation but did not currently have a one-on-one program. IV. Resident group interview regarding activities A. Resident group interview The resident group interview was conducted on 9/28/22 at 1:35 p.m. The group consisted of six alert and oriented residents (#3, #20, #22, #31, and #33) selected by the facility. The residents stated the following: -They would like to have more evening activities; and -They would like to have more outings. The residents said the van had two spots for wheelchairs, but in reality it was only one, as it was too small for two residents. They said that not much was happening in the evening. B. Record review The activity calendar for August, September and October 2022 showed the following: July 2022 -An outing was scheduled for Wednesdays. The outing for 7/13/22 was canceled. -Bingo at 6:30 p.m. three times in the month. -Yard games at 6:30 p.m., one time for the month. August 2022 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-An outing was scheduled for two Wednesdays and 8/9/22. The 8/9/22 outing was canceled. -Yard games at 6:30 one time a week for three weeks. -Bingo at 6:30 p.m. once a month. September 2022 -An outing was scheduled for 9/7 and 9/14/22. The 9/14/22 outing was canceled. -Yard games at 6:00 p.m. one time a week for two weeks. -Bingo at 6:30 p.m. twice a month. C. Staff interview The AD said that she wrote the activity calendar and she made sure she had an evening activity once a week. She said outings were also scheduled once a week and on Wednesdays, however, the van was having issues and it has been broken. She said it had been broken for a couple of weeks. She said as the van only held one resident then the residents in wheelchairs who can not transfer into a van seat needed to take turns. She said she would talk with the residents to ask what type of evening activities they would like.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on observations, record review and interviews, the facility failed to ensure two (#3 and #5) of three residents with limited mobility reviewed for range of motion (ROM) received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion, out of 26 sample residents. Specifically, the facility failed to establish a consistent restorative nursing program within the facility to ensure Resident #5 and Resident #3 did not have a potential decline in activities of daily living (ADL). Findings include: I. Facility policy The Restorative Nursing Services policy, revised July 2017, provided by the director of nursing (DON) on 9/29/22 at 4:05 p.m., read in pertinent part: Restorative nursing care consists of nursing intervention that may or may not be accompanied by formalized rehabilitative services (physical, occupational or speech therapies). Restorative goals and objectives are individualized, resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: -Adjusting or adapting to changing abilities; -Developing, maintaining or strengthening his/her physiological and psychological resources; -Maintaining his/her dignity, independence and self-esteem; and -Participating in the development and implementation of his/her plan of care. II. Resident #5 A. Resident status Resident #5, age 82, was admitted on [DATE] and readmitted on [DATE]. According to the September 2022 computerized physicians orders (CPO), the diagnoses included paraplegia (paralysis of lower limbs), cognitive communication deficit, age related physical debility, repeated falls, and unsteadiness on feet. The 9/21/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 14 out of 15. She had no behaviors and did not reject care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident had left and right sided impairment of both the upper (shoulder, elbow, wrist, hand) and lower extremities (hip, knee, ankle, foot); did not walk; and required extensive assistance with bed mobility and dressing; and was totally dependent on staff with transfers, eating, toilet use, personal hygiene and physical help in part of bathing. According to the MDS assessment, the resident did not receive restorative nursing services. The last time the resident received physical therapy services was from 7/26/22 to 8/11/22 and occupational services from 6/27/22 to 8/3/22. B. Observations and interview Resident #5 was observed on 9/26/22 at 11:23 a.m. Resident #5 was observed sitting in her wheelchair with her right arm flaccid laying in her lap. She did not have any type of splint on her right arm/wrist to prevent contraction. The resident was able to answer a few questions with yes and no answers. Resident #5's power of attorney (POA) was interviewed on 9/27/22 at 12:42 a.m. The POA said the resident's right arm had started to get limp and the physician assessed her and determined she had a stroke. She said the physician ordered her to work with physical therapy (PT). She said the physical therapist had left a few months prior and had no therapy since then. She said the restorative certified nurse aide (RCNA) was a good CNA but did not have time for her restorative duties. C. Record review A review of the physician orders for July and August 2022 revealed the following relevant orders: -7/26/22 P.T. to evaluate and treat 20 treatments in 60 days for therapeutic activities, therapeutic exercises, neuromuscular re-education, manual techniques, and group therapy. -7/27/22 Occupational therapy order: continue occupational therapy services from 7/25/22 to 8/21/22. -8/3/22 Patient has been discharged from OT services at this time due to max progression. Patient will be set up on a restorative program to maintain progress. Occupational therapy plan of care dated 6/27/22 revealed the reason for referral was Resident #5 presented with a decline in ADL's of self care, functional mobility and transfers due to decreased ROM, strength, and coordination in right upper extremity (RUE). She required skilled therapy to improve safety, function and strength. Her discharge plan was to remain in the skilled nursing facility (SNF) with a functional maintenance program. Physical therapy discharge summary dated 8/11/22 revealed Resident #5 was discharged from therapy and that the goals were partially met. Her discharge plan was to remain in the skilled nursing facility (SNF) with a functional maintenance program. D. Staff interviews (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The regional therapy director (RTD) was interviewed on 9/28/22 at 11:15 a.m. He said that when PT/OT discharged a resident from their program, they meet with the facility restorative nurse who contacts the physician for an order to receive restorative services. He said he did not know who the restorative nurse was at that time. He said if the resident was to remain in the facility with a functional maintenance program, the resident should be receiving restorative services from the facility. The admission nurse (AN) was interviewed on 9/29/22 at 4:14 p.m. She said the restorative nurse passed away in July 2022 so the RCNA was in charge of the restorative program. The occupational therapy assistant (OTA) was interviewed on 9/30/22 at 10:29 a.m. She said Resident #5 had been discharged from their program. She said therapy had a daily morning meeting where they discussed discharges from therapy, falls and residents they were going to pick up for therapy. She said the director of nursing (DON) communicated the discharged residents from therapy with the restorative department. She said the RCNA had been handling the restorative program. The RCNA was unavailable for interview after many attempts were made. The DON was interviewed on 10/4/22 at 2:11 p.m. She said Resident #5 did not have any restorative notes in her medical record. She said Resident #5 was discharged from OT on 8/3/22 but there was no physician order for the restorative care program. She said there was no formal restorative program at the facility. 47351 III. Resident #3 A. Resident status Resident #3, age 73, was admitted on [DATE]. According to the September 2022 CPO diagnosis included muscular sclerosis. The 6/19/22 MDS showed the resident had severe physical limitations in ability to transfer and ambulate. He was unable to stand or walk and is wheelchair bound. B. Resident interview Resident #3 was interviewed on 9/27/22 at 9:20 a.m. The resident said he had severe limitations in his ability to transfer and ambulate due to muscular sclerosis. He did not receive any restorative services, and no range of motion. He said he thought it was due to staffing shortages. He said his physical and occupational therapy was discontinued earlier in the year. C. Record review The care plan dated 2/3/22 per rehabilitative services, identified the resident had limited range of motion and recommended a restorative program for 1) at least 15 minute assist to setup with ADLs and allow the resident to complete as much as he can.2) Restorative strengthening program: for lifting his water cup up/down 5 times and repeating 3 more times, make a fist then straighten his fingers out 5 times. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The occupational therapy notes dated 8/1/22 revealed the occupational therapist discharged him to a restorative program, focusing on strengthening the right upper extremity during self feeding and activities of daily living tasks. -The medical record failed to show any evidence that the resident received any range of motion services as part of the restorative program. C. Observation On 9/27/22 at 9:20 a.m., the resident was sitting in his electric wheelchair. The resident had limited mobility on both of his upper and lower extremities. At 12:15 p.m, the resident was at the dining room table. The resident was receiving assistance from a certified nurse aide with eating due to his limited upper extremity mobility. D. Staff interview The DON was interviewed on 10/3/22 at 4:10 p.m. The DON said there was no official restorative program available at this time. She said CNA #4 was assigned to the role but works three days a week. She said CNA #4 was currently on leave. The DON said a restorative program was currently in the works.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 40467 Based on interviews, observation, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible. Specifically, the facility failed to ensure staff were prepared for a potential threat of fire. The lack of preparation resulted in residents scared, anxious, removed from their beds at night, placed outside in parking lots with smoke filled air, and for some, without supplemental oxygen as needed during a facility wide evacuation on 9/23/22. The lack in preparation for a potential emergent threat, included the failure to have a complete and thorough emergency preparedness training program, specifically fire training, to identify when residents should be evacuated and when residents should be placed behind closed fire doors. According to interviews with management the staff panicked and overreacted. The absence of adequate training, resulted in a chaotic situation as identified by a resident family member, referring to the evacuation on 9/23/22. The facility was also unprepared to handle residents' supplemental oxygen needs in an event of an emergency. The facility failed to establish an efficient oxygen management system in place to ensure residents who required supplemental oxygen and/or had chronic obstructive pulmonary disease (COPD) with a need for continuous oxygen, had it available to them as required and on demand as needed. The facility did not routinely fill portable oxygen tanks or effectively monitor the oxygen levels in the portable tanks. Further investigation identified the portable oxygen tanks were difficult to fill, time consuming, and the liquid oxygen would often freeze up during the filling of the tanks. These failures resulted in some of the residents who needed the supplement oxygen, did not have it available to them for a for extended amount of time during the evacuation on 9/23/22, causing residents unnecessary physical and mental stress, specifically Resident #7. Resident #7 had a physician's order for the continuous use of oxygen related to acute and chronic respiratory failure with hypoxia. The resident also had a long history of COPD with acute exacerbation. (Cross-reference F695 respiratory care.) During the 9/23/22 evacuation, Resident #7, along with three other residents (Resident #20, #23, and #26) were assisted outside of the facility without means to obtain supplemental oxygen timely. Resident #7 had a portable oxygen tank attached to her walker during the evacuation; however, the portable oxygen tank was empty. The above identified accident hazard failures created the likelihood of a serious adverse outcome for all of the residents in the facility. Furthermore, Resident #12 was admitted on [DATE] to the facility. She had severe cognitive impairment with a score of two out of 15 for the brief interview of mental status. The resident was identified as a fall risk as she had falls prior to entering the facility. The intervention which was put into place was encouraged to use the call light. The resident experienced the first fall on 7/8/22 and the bed was put into the low position and fall mat, she fell a second time on 7/9/22 which resulted in a fractured hip. The facility failed to timely initiate fall precautions for Resident #12. These failures contributed to her falling and fracturing her hip. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 had an unwitnessed fall on 9/28/22. Resident #1 was picked up off the floor and placed in her wheelchair before she was appropriately assessed. A registered nurse was not contacted or present for the resident's assessment for injury prior to the resident being moved by the licensed practical nurse and the certified nurse aide. Resident #30 had a history of falls and diagnosis of Parkinson's disease. He had two falls in just over a week apart. Resident #30 fell on [DATE] and again on 9/19/22. The fall documentation identified contributing factors to the falls included unsteadiness on his feet, weakness, and increased shuffling of gait. The last fall care planned intervention was on 4/25/22. The care plan was not updated to reflect new interventions to prevent potential future falls based on the assessment of the 9/11/22 and 9/19/22 falls. In addition, the facility failed to: -Consistently follow fall precautions and implement effective fall interventions for Resident #34; and, -Ensure the staff utilized two staff when utilizing a mechanical lift for Resident #3. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy A lack of a system in place to ensure the staff followed the facility emergency plan regarding evacuation procedures for potential fire. Staff reported and demonstrated a lack of training with the emergency preparedness plan which had a high likelihood to result in an accident hazard. On the night of 9/23/22, smoke entered the facility from outside of the facility. The source of smoke was off the property and fire was not an immediate threat to the facility. The staff, unprepared to handle an emergent situation, and not able to locate the fire or determine if the fire was inside the facility or outside the facility, contacted the director of nursing and reported fire was everywhere. The director of nursing instructed the staff to evacuate outside. As a result, residents were unnecessarily evacuated with several residents reporting they were scared and felt increased anxiety. One resident was reported as crying. At least four residents who required oxygen were evacuated without it. The cold air and smoke in the air with the lack of oxygen made breathing difficult. B. Imposition of Immediate Jeopardy Based on interviews and record review, which revealed policies and protocols were not followed to ensure staff were prepared for a potential threat of fire with comprehensive fire training and lack of training on required medical equipment, the nursing home administrator (NHA) was informed on 9/29/22 at 3:32 p.m. the facility failures above created the likelihood of serious harm for all of the residents in the facility if the failures were not corrected immediately. C. Facility plan to remove immediate jeopardy (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/4/22 at 10:18 a.m. the facility submitted the final plan to remove immediate jeopardy. The plan read: 1. Staff education All staff scheduled to work beginning 9/29/22 were educated on the community's emergency plan to include fire procedures which includes RACE (rescue, alarm, contain, evacuate) and PASS (pull, aim, squeeze, sweep), evacuation procedures, central command, who directs the emergency and essential medical supplies and devices needed to ensure the safety of the residents. The training also included, who is central command during normal business hours and after hours, central command will call 911 and initiate the call to management, evacuation decision is in coordination of central command and first responders/fire department to determine if evacuation is needed based on each situation. The executive director was educated by the regional director of operations on 9/29/22, the maintenance director was educated by the regional environmental director on 9/29/22. The regional director of operations and the regional environmental director provided verbal reeducation after the evacuation on Friday 9/23/22 to the ED (executive director). Staff training included: -Fire alarm; -How to check the fire panel to ensure it is functioning properly and clearly identifies where the fire is located; -When to evacuate commanded by the appointed designee comand control who is the East station licensed nurse and first responders. The east station assumes command control until the highest ranking manager arrives. The East station licensed nurses have been educated on their duties as a command control; and, -When to be contained in the facility. Education was provided to all staff who were currently working in the facility, was provided in person, and written education was provided to all staff that were working in the community at the time the IJ was placed on 9/29/22 by executive director (ED) and maintenance director (MTD). Education was provided as follows: -On 9/29/22 at 5:30 p.m., at 6:40 p.m. to all staff present in the facility by the executive director. -On 9/29/22 at 10:00 p.m. prior to staff starting shift by the maintenance director. -On 9/30/22 at 5:30 a.m., 6:00 a.m., 7:00 a.m., 7:40 a.m. prior to staff starting shift by the executive director. -On 9/30/22 at 10:00 a.m. and 1:00 p.m. for staff not on duty that were called to come in for education and staff coming on shift prior to their shift by the maintenance director. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On 9/30/22 at 5:45pm for staff on duty at the time of second immediacy plan reeducation was provided by executive director. -On 9/30/22 at 6:40 p.m. prior to staff starting shift by executive director. -On 10/1/22 at 5:45 a.m., 6:05 a.m., 6:20 a.m., 6:40 a.m, 7:00 a.m., 1:00 p.m. prior to staff starting shift by executive director. -On 10/2/22 at 9:00 a.m., 2:00 p.m., by executive director. -On 10/2/22 at 5:45 p.m., 10:00 p.m. prior to starting shift by the maintenance director. -On 10/3/22 at 6:00 am prior to the starting shift by executive director. All staff that have not been educated were notified by their department managers to attend training sessions scheduled for 9/30/22 at 10:00 a.m. or 1:00 p.m. Staff who have not been trained, will not work their shift until completed the training from the ED or MTD. Newly hired staff will receive training on the day of hire during their orientation. Education attendance sheets will be reconciled by the Executive Director to ensure all staff had been trained on emergency preparedness. Education attendance reconciled as of today 10/3/22, education is continuing to ensure all staff are educated. 2. Education will be monitored for effectiveness Fire drill will be conducted on each shift by the maintenance director on Monday 10/3/22. -Fire drill conducted on 9/30/22 at 3:30pm; -Fire drills will be held monthly on different shifts, which equates to quarterly per shift; and, -Safety team who consists of maintenance director, business office manager, medical records director, director of nursing, head chef and executive director will evaluate at monthly safety meetings the drill response and staff competencies during drill to identify opportunities for improvement. 3. Communication during a emergency The facility will have walkie talkies available for use. They will be in effect on 10/7/22. The maintenance director is responsible to provide training and to ensure the walkie talkies are kept ready to use. The facility utilizes the resident report sheets and daily schedules to ensure all are accounted for by the incident command control at the time. 4. Competencies (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Oxygen portable tanks will be checked at bedtime and filled if indicated; -Oxygen portable tanks will be checked PRN at resident request and filled if indicated; and, -The facility has a list of residents who require oxygen. Compliance will be monitored with random checks during meal times and nursing/administrative rounds five days a week. The director of nursing (DON)/NHA will designate staff members to complete random checks and any issues identified will be reported immediately to DON/NHA and re-educated as indicated. Any issues identified are addressed with retraining and education on the spot. C. Removal of immediate jeopardy On 10/4/22 at 11:00 p.m., the NHA and the DON were notified the immediate jeopardy was removed at 10:18 a.m., based on the plan above. However, deficient practice remained at an E level, a pattern with the potential for more than minimal harm. II. Facility policy The If You Discover A Fire In Your Area policy and procedure, dated June 2012, was provided by the nursing home administrator (NHA) on 10/4/22 at 8:49 a.m. The policy read in pertinent part: Remove anyone in the room while calling out 'Code red, location .' for assistance. Close the door to the fire room and any room connecting doors. Activate the fire alarm and make overhead page announcements of the fire location. Close all remaining doors and windows in the fire zone, placing residents into rooms. Evacuate remaining rooms in the smoke compartment if directed to do so by the person in charge. The Charge Nurse fire procedures were provided on 10/4/22 at 8:49 a.m. According to the procedures, the charge nurse was to initiate the following steps in a fire was on their unit they needed to ensure: -The fire room had been evacuated; -The door to the fire room had been closed and marked; -Fire alarm had been activated and a page announcement of the fire location made; -All residents had been removed from the corridor with doors and windows closed; and, -All equipment had been removed from the hallway. The charge nurse fire procedures directed the charge nurse to make a decision regarding further evacuation by using the following guidelines: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-If the fire has been extinguished, no further evacuation is necessary. Instruct the staff to reassure residents while awaiting arrival of the fire department; -If the corridor smoke conditions would not be tolerable for residents, do not evacuate. Inform the fire department of smoke concerns upon their arrival. -If the fire had not been extinguished and the corridor conditions were tolerable begin evacuation by moving the residents from the fire compartment to the adjacent side of the fire/smoke doors as identified in the evacuation diagram. Instruct staff to evacuate rooms adjacent to the fire room first, followed by the room opposite of the fire room. The remaining rooms in the compartment should then be evacuated. -Mark the door to the room with a pillow in front of the door to indicate that the room had been evacuated. For this purpose the orange tape is stored in each medication room. -Account for residents and staff once all are relocated. Be prepared to report results to the control station. According to the charge nurse fire procedures, the charge nurse was responsible for: -Directing appropriate staff to respond to the fire area; -Directing remaining staff in securing unit by moving residents into rooms, closing windows and doors, and clearing corridors; -Directing staff to make rapid rounds, checking on and reassuring residents Once the unit was secured; - Directing staff in the preparation of receiving residents by clearing space for the arriving residents from the evacuated unit. Position one staff member at the entrance of the unit to direct staff arriving with evacuated residents to the appropriate areas of the receiving unit. -Ensure initial care of residents who have been evacuated if applicable. The charge nurse fire procedures identified the East nurses station charge nurse with activation of the fire alarm was to: -Check the fire alarm panel to determine location of alarm; -Make overhead page announcement of alarm location; and, -Place a backup call to the fire department (911). The Action Plan procedure pertaining to facility evacuations, dated July 2017, was provided by the NHA on 10/4/22 at 8:49 a.m. According to the policy, to evacuate the full building evacuation plan, the decision to evacuate should be made with input from emergency service agencies. The action plan identified agencies to be notified included emergency services (911), Delta County/ State Office of Emergency Management, and the Colorado Department of Public Health and Environment. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	III. Events of 9/23/22 1. Electrical panel fire A. Observations On 9/26/22 at 11:47 a.m. the hall lights went out of the B hall. At 11:49 a.m. the door alarm started to sound. A staff member walked down the hall towards the door and said the breaker was not working. The activity director (AD) following the staff member said it was not working last night either (9/25/22). B. Staff interview Licensed practical nurse (LPN) #3 was interviewed on 9/26/22 at 1:56 p.m. The LPN said the morning of 9/26/22 she was conducting a fire watch around the facility because the fire panel was not working again. She said the panel has now been fixed and she was no longer conducting a fire watch. The LPN said during the past weekend someone did a temporary fix on the panel and it was in working order so she did not conduct a fire watch over the weekend. The NHA was interviewed on 9/26/22 at 2:55 p.m. The NHA said on the morning of 9/23/22, the breaker to the electrical panel became too hot and wires were melted. An electrician was contacted and was able to temporarily repair the system but determined a new breaker had to be installed. She said the breaker was not in stock and had to be ordered for a 9/26/22 arrival and installation. She said some of the alarm systems had to be turned off momentarily during the installation. The maintenance director (MTD) was interviewed on 9/29/22 at 2:37 p.m. The MTD said the facility was old and recently had an electrical fire in the panel on the morning of 9/23/22. The electrician temporarily fixed it on 9/23/22. The electrical technician completed the repair process on 9/26/22 and 9/27/22 with new components. He said the fire panel was officially fixed on 9/27/22. The MTD said he had no issues with the panel before 9/23/22. He said the electric company said the breaker had burned up and fused itself. The electrical technician was going to send the breaker to a specialist to see why the breaker burned up. 2. Facility evacuation in response to a potential fire A. Staff interviews The DON was interviewed on 9/26/22 at 3:04 p.m. with the NHA. She said she received a call from a certified nurse aide (CNA) that there was a fire somewhere in the building. She said she saw smoking outside the backdoor. The DON said LPN #1 was the charge nurse on 9/23/22. The DON said by the time she arrived, the residents were evacuated. The fire department conducted three sweeps of the building before it was all clear. She said the alarm sounded just before 9:00 p.m. and residents were back inside and in bed by 11:00 p.m. She said residents were provided blankets and separated in small groups to be supervised by staff. The NHA and DON said they felt staff did well during the evacuation but should have sheltered the residents in place so they would educate the staff and review the policy with the staff. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LPN #1 was interviewed on 9/28/22 at 7:45 p.m. The LPN said both her and LPN #4 were considered the charge nurses at the time of the evacuation on 9/23/22. The LPN said she was responsible for the west side of the facility and LPN #4 was responsible for the east side. She said a CNA told her that staff could smell smoke on the east side of the facility and staff saw smoke coming from the basement. The LPN said the staff believed the smoke was coming from the boiler area. LPN #1 said smoke alarms were not triggered/sounding at the time. She said earlier on the day of 9/23/22, fuses had burned and assumed it was smoke from the burned fuses. LPN #1 said LPN #4 decided to evacuate her residents on the east side outside, so she started evacuating her residents on the west side. The residents were divided up in two parking lots on different sides of the facility. She said the NHA was called but the residents were already being evacuated outside. She said the maintenance director (MTD) was called. She said she thought CNA #1 called 911 and then emergency vehicles arrived. CNA #1 was interviewed on 9/28/22 at 8:20 p.m. CNA #1 said she said the night of the evacuation she smelled smoke and saw thick smoke from the floor to the middle of the hallway. The CNA said she told the other staff they had to go outside. The other CNAs said they also saw smoke from the basement. CNA #1 said LPN #4 told the staff they were to evacuate the residents outside. The CNA said one other CNAs called 911. She said the other staff helped residents outside while she stayed with the residents who wandered until she could get more assistance. She said the air conditioner was drawing smoke inside the facility. She said the night of 9/23/22 she thought the facility had to evacuate because there were residents who had chronic obstructive pulmonary disease (COPD). She said the alarm was going off and smoke was already in the facility so they evacuated. The director of nursing (DON) was interviewed on 9/29/22 at 11:03 a.m. The DON said she was contacted by staff on the night of 9/23/22 and was told there was a fire and the building and smoke was everywhere. The DON said that she had instructed the staff to evacuate the entire facility if there was fire and smoke inside and bring them to the parking lot. She directed the staff to evacuate the residents first then if possible go back inside the building to get oxygen and medication carts.The DON said she asked if the fire panel was checked and where the location of the fire was. She said they checked the fire panel but could not hear where the location of the fire was because she was in a bad phone service area. The DON said when she arrived at the facility at approximately 9:25 p.m. She said the smoke was not visible. The DON said if there was smoke outside it would not have been a good idea to take them outside. She said the smoke could make the residents sick. She said NHA was in charge of the facility and would normally be the one to make the call to evacuate. She said staff should have contained the residents to one area in the facility away from any identified smoke. She said if it happened again, staff should move residents to the other side of the building. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Care Center	2050 S Main St Delta, CO 81416

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	CNA #5 was interviewed on 9/30/22 at 4:30 p.m. CNA #5 said he was present during the evacuation on 9/23/22. He said that he did not see smoke in the building, but he could smell a smoke odor in the building, but not too extreme. He said earlier in the day the circuit panel was not working properly, so he and CNA #9 went to look at the fire box outside of the building. He said while they were standing in the dark CNA #9 pointed toward the stairs and said she saw smoke. He said things went quick and they started to evacuate the building, he was not sure who had made the decision to evacuate. He said he was the muscle of the group, and he began to lift residents out of bed into wheelchairs, so the others could assist them outside. He said he remembered the oxygen portable for Resident #31 but that it was probably not a full tank. He said when outside, the residents had blankets and they waited for the fire department to direct them what to do. He said communication was hard, as he had no means to know what was happening outside, as he was inside. He said walkie talkies or some form of communication would help a lot. He said the NHA interviewed him last night about the evacuation, not any other time. CNA #9 was interviewed on 10/3/22 at 10:04 a.m. She said she started to smell smoke in the facility and went to the east side of the facility where LPN #4 was. She said she asked the LPN if she smelled smoke and they both proceeded to look for where it could be coming from. She said they checked near the electric panel and the boiler but the door was not hot. LPN #4 told CNA #9 to pull the fire alarm, shut all windows and doors and start evacuating. She said staff proceeded to evacuate all the walking residents, then the wheelchair resident and finished the evacuation with bed bound residents. The NHA was interviewed on 10/5/22 at 4:24 p.m. The NHA said she has not had a post incident review on the evacuation yet to review all that happened during the night of 9/23/22. She said she did not do the review because surveyors entered the facility on 9/26/22, the same day they were going to do the post-incident review. The NHA said the DON was told the building was on fire so they evacuated. She said she spoke with staff on the night of 9/23/22 while she was driving to the facility but was in a bad service area during the call and was not sure where the fire was located that prompted the evacuation. She said the facility had since discussed what to do when staff smell smoke, whether the source was inside the facility or coming in from the outside. She said the facility has also discussed when to evacuate the residents and when to contain the residents in their room. She said during the discussions she identified the failures as lack of training and fear. She said the facility had since learned the staff needed more fire training and they overreacted which inturn prompted the facility evacuation. B. Record review 1. Fire department report The fire chief's incident narrative and 9/23/22 incident report was provided by the NHA on 10/4/22 at 3:20 p. m. The 9/23/22 incident report identified the fire alarm record time as 9:05 p.m. The fire department arrived at 9:17 p.m. The fire department cleared the facility at 10:23 p.m. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The fire chief's incident narrative identified events observed and conducted by the fire department at the facility on 9/23/22. The narrative read: Paged to (facility) for a report of a fire in the basement. Upon arrival we found no fire at the facility. There was smoke in the air from a nearby fire that we were unable to locate. We cleared the entire building using a TIC (thermal imaging camera). We were unable to locate any spot fires or heat. Staff had informed us that there had been a fire earlier in the electrical panel outside at around 11:00 a.m. They had called an electrician to fix the panel but didn't have time to properly do the job and did a fix that 'would get them through the weekend.' I advised the head of staff to contact the electrician and have them come out tonight (9/23/22) and look at the wiring within the box, as the previous fire had compromised multiple wires inside. We were unable to reset the alarm panel and advised the supervisor to do a firewatch throughout the night. They were going to try to reset the panel themselves. They evacuated all the residents of the facility during our arrival. They were allowed to enter the home once we were unable to locate any fire. 2. 9/23/22 incident notes The 9/23/22 incident notes with a staff attendance record were provided by the NHA on 10/3/22 at 10:40 a.m. The notes identified the fire panel was triggering an error message and could not be reset so the panel was taken offline. The notes also provided a timeline when management was contacted and when they arrived at the facility on 9/23/22. -At 8:58 p.m. the DON was called by staff; -At 8:59 p.m. the MTD was called; -At 9:00 p.m. the NHA was called; -At 9:30 p.m. the DON arrived onsite; and, -At 9:58 p.m. the NHA arrived onsite. IV. Resident impact A. Resident and family interviews Resident #7 was interviewed on 9/26/22 at 9:47 a.m. The resident said she needed to be on oxygen at all times because of her COPD. She said her portable oxygen was usually empty and staff needed to fill it up (cross-reference F695 for respiratory needs). The resident stated staff often did not make sure her portable was filled at night which became a problem on 9/23/22. Resident #7 said she was assisted outside during a facility evacuation on 9/23/22 after she was told by staff they smelled smoke in the facility. She had her portable oxygen tank attached to her walker but the oxygen tank was empty. Resident #7 said the cold air outside made it even harder to breathe. She said she did not receive oxygen until the paramedics arrived and provided it to her. Resident #7 said she was outside for 45 minutes to an hour, much of the time she was outside without oxygen. She said she has had COPD for years and knows when her oxygen saturation levels drop. She said during the evacuation and without continuous oxygen, she became light headed and started seeing fire works. The resident said she normally had some anxiety and she became very anxious without the needed oxygen during the evacuation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #35 was interviewed with her family on 9/26/22 at 12:09 p.m. The family member said an electrical panel burned out on 9/23/22 during the day. Resident #35 said on the night of 9/23/22, the fire alarm sounded and staff slid her out of bed, placed into a wheelchair, and was taken outside. The resident said she was outside for about an hour. Resident #3 was interviewed on 9/27/22 at 9:34 a.m. The resident said the facility evacuated from the building on the previous Friday (9/23/22). He said he was in bed for the night when the CNA came in and told him they needed to evacuate the building. He said he was manually lifted out of bed with two certified nurse aides. He said he received a skin tear on his right elbow as they got him out of bed. He said he was usually transferred with a mechanical lift. He said it all went so fast. The resident's right elbow had a bandage on it. Resident #20 was interviewed on 9/28/22 at 11:45 a.m. The resident said that the facility evacuated from the building on Friday 9/23/22. She said that she was awoken from sleep and told that they needed to get her out of the building as they were evacuating the facility. She said that when she was assisted outside, she was taken outside without her oxygen. She said that she was having trouble breathing. She said the fire department provided her with oxygen 45 minutes later. Resident #20 was interviewed a second time on 9/28/22 at 1:35 p.m. The resident said when she was awoken from bed, she was told by the two CNAs to jump from her bed. She said she could not and that she was scared. She said the CNAs said they would catch her. She said the bed needed to be lowered, then she would have been able to step off of the bed easier. She said she had to jump from the bed, which was approximately ten inches from the floor. Resident #23 was interviewed again on 9/29/22 at 12:30 p.m. The resident said that on Friday (9/23/22) he was informed that the facility had to evacuate. He said he had been sleeping and he said he grabbed his hat and nothing else. He said he left the facility without his oxygen. He said he could not recall the length of time he went without his oxygen. He said without his oxygen he had grasped for his breath. He could not recall when he received oxygen. He said he was told someone was burning trash outside and the air conditioning sucked in the smoke. The family member of Resident #26 wa[TRUNCATED]

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on observations, staff interviews, and record review the facility failed to consistently provide catheter care, treatment and services to minimize the risk of urinary tract infections for two (#11 and #16) of two reviewed for catheter care out of three residents with catheters. The facility failed to ensure Resident #11's urinary catheter down drain bag was kept from dragging on the floor and the urinary catheter bag was kept below the bladder. There were no physician orders on how to clean the area around the suprapubic catheter site. Due to the facility's failures, Resident # 11 suprapubic urinary catheter line to drag on the floor and no order to cleanse the site, contributed to an infection as evidenced by the purulent (pus) drainage from the catheter exit site which caused pain to the resident. In addition, the facility failed to: -Ensure Resident #16 was provided catheter care assistance with emptying her catheter bag and monitoring catheter fluid level to ensure timely empting of her catheter bag; and, -Ensure Resident #16 had proper placement of her catheter bag. Findings include: I. Facility policy and procedure The Catheter Care, Urinary policy and procedure, revised September 2014, was provided by the director of nurses (DON) on 10/4/22 at 10:30 a.m. With instructions, be sure the catheter tubing and drainage bag are kept off the floor. Along with The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. II. Resident #11 A. Resident status Resident #11, older than age 60, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO) diagnoses included retention of urine, unspecified and urinary tract infection, site not specified. The7/12/22 minimum data set (MDS) assessment showed the resident had minimal cognitive impairment with a score of 13 out of 15 on the brief interview for mental status (BIMS). The MDS coded the resident as requiring no assistance with activities of daily living. The resident had a catheter. The MDS incorrectly coded the resident as always continent. B. Observations (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	On 9/26/22 at 12:50 p.m. the resident was walking down the hall. The resident's catheter tubing was dragging on the floor. The catheter bag hung on the walker. On 9/28/22 at 8:05 a.m. the resident's suprapubic urinary catheter tubing was dragging on the floor as she walked in the hallway. On 10/3/22 at 10:37 a.m. the resident's suprapubic catheter insertion site was observed with the licensed practical nurse (LPN) #5. The insertion site was noted with greenish, thick colored drainage, the resident denied pain at this time. LPN #5 said the previous shift nurse reported that the site didn't look good. She said the insertion site had purulent drainage. There was no documentation noted in the chart of the findings and there was a failure to notify the doctor of the change of the resident's condition. LPN #5 reported that the leg drain bag should not be left on the resident's leg throughout the night. On 10/4/22 at 3:25 p.m. the resident's suprapubic catheter insertion site was observed with the LPN #5. The insertion site had thick, cream colored drainage. LPN #5 obtained a culture of the drainage, afterwards wiping the area with a tissue and cleaning with one betadine (antiseptic) swab, not allowing the betadine to dry, then placing resident's undergarment over the area, no dressing was placed over site. During the cleaning with the betadine swab, the resident pulled back and winced in pain. The resident said she had pain around the site. C. Record review The September 2022 CPO, a physician order was entered on 4/1/22, stating: cleanse stoma site twice daily, check skin for redness or drainage, and notify MD (medical doctor) of skin changes from baseline. The September 2022 treatment administration record (TAR) revealed, starting on 4/2/22, the stoma site was to be cleaned daily and as needed. Discontinue date of 9/23/22. On 9/23/22 a new treatment was added to cleanse stoma twice daily. -There was documentation that stoma site was being cleaned, but no documentation of how it was being cleaned. The care plan initiated on 4/1/22 identified the resident had impaired urinary elimination pattern and the need for a suprapubic catheter. Some days the resident may choose to use a leg bag and other days a larger drainage bag; their preference. -There was no documentation in the resident's chart showing that she was offered this preference and what the preference was daily. The goal added on 9/29/22 (during the survey), for the resident to have a decreased risk for developing complications associated with catheter usage such as a urinary tract infection. The care plan documented that the suprapubic catheter should maintain a position of the catheter bag and tubing below the level of the bladder. Interventions were added on 9/30/22 (during the survey) to the care plan to ask the resident if a leg bag or down drain foley catheter bag was to be used based on their preference, along with observing and reporting for s/s of an infection-strong odor, cloudy, and urgency. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	LPN #5 faxed the primary doctor the change of the resident's condition on 10/3/22, there was no documentation noted in the chart of this action. She reported that after no response she called at 2:00 p.m. and 3:30 p.m. both attempts went to an answering machine. There was no documentation of this in the chart. The resident had a urine culture lab test, collected on 10/4/22 at 3:12 p.m. the preliminary results on 10/5/22 9:56 a.m. noting an organism present: presumptive E. coli greater than 100,000 CFU/ml. D. Staff interviews Registered nurse (RN) #1 was interviewed on 9/29/22 at 10:30 a.m. RN #1 said the catheter tubing should not drag on the floor, as it could cause an infection. She said she would assess to determine if a leg bag could be used. RN #1 was interviewed a second time on 9/29/22 at 11:06 a.m. RN #1 said the resident agreed to try a leg bag. She said the leg bag was in place. Certified nurse aide (CNA) #3 was interviewed on 10/3/22 10:13 a.m. CNA #3 said the resident was using the leg bag, however, the leg bag was not being changed at night for a larger drain bag and it was staying on the resident's leg throughout the night, which could result in the leg bag not being below the bladder. LPN #5 was interviewed on 10/3/22 at 10:37 a.m. LPN #5 said the leg drain bag should not be left on the resident's leg throughout the night. LPN #5 confirmed nothing was documented in the resident's medical record and that she had forgotten. LPN #5 said she faxed the medical director the change of the resident's condition. She said after no response she called at 2:00 p.m. and 3:30 p.m. both attempts went to an answering machine. -However, there was no documentation of this in the resident's chart. LPN #5 was interviewed again on 10/4/22 at 10:12 a.m. She reported that she had forgotten to document notifying the physician. She reported that the nursing staff have been wiping the drainage from the site with a tissue, then cleaning the area around the suprapubic catheter with betadine. -However, no physician order was found for the betadine. She reported that the drainage is white in color and that the resident reported redness and pain at the site. LPN #5 said that she had forgotten to document any information about the infection. The DON was interviewed on 10/4/22 at 10:31 a.m. The DON said that the on-call doctor should have been called on 10/3/22 when the facility was unable to reach the resident's doctor. She said the leg bag should not have been left on the resident's leg through the night, it should have been changed to a larger drain bag hanging below the resident's bladder. She said that she would educate the nursing staff. 40467 (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	III. Resident #16 A. Resident status Resident #16, age under 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included personal history of transient ischemic attack (TIA) and cerebral infarction (stroke), chronic pain, urinary incontinence, difficulty walking, unsteadiness of feet, cognitive communication deficit, overactive bladder and need for assistance with personal care. According to the 7/28/22 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for a mental status score of 15 out of 15. The MDS assessment indicated the resident was independent in activities of daily living (ADLs). The MDS assessment identified the resident had a catheter. B. Resident interview and observation Resident #16 was interviewed on 9/27/22 at 9:04 a.m. She said staff did not assist her with the emptying of her bag. Resident #16 said they were often busy taking care of other residents. She said she had watched how they emptied her catheter bag before and then trained herself. The catheter bag was observed laying on the floor next to the resident's feet as she sat in her reclining chair in her room. The catheter bag was not hanging on her walker or another device to keep it off the floor and below her waist. The bag was not covered by a protective cover as it laid on the floor. The catheter bag was almost completely full with fluid. Resident #16 was observed on 9/29/22 at 9:26 a.m. Her catheter bag was attached to her walker. There was not a cover over her bag. The bag was more than half way full. The resident said she would have to empty the catheter bag in a little while. Resident #16 was interviewed on 10/4/22 at 3:20 p.m. She said it was hard to remember when to empty her catheter bag and when to check if the catheter bag needs to be emptied. She said she would like for more help from the staff to monitor her catheter and assist her in ensuring the bag was emptied timely. She said she was worried it might become too full and back up causing an infection. C. Record review The certified nurse aide (CNA) tasks sheet read Resident (#16) has a suprapubic catheter. Position bag and tubing below the level of the bladder. The CPO, initiated 4/6/22, directed staff to maintain Resident #16's suprapubic catheter site and clean as needed. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	The urinary catheter/UTI care plan last revised on 4/19/22, indicated the resident had an impaired urinary elimination pattern and continuous incontinence of urine. According to the care plan, the resident should have a decreased risk for developing complications associated with catheter usage such as urinary tract infections (UTIs). The care plan directed staff to provide Resident #16 catheter care q (every) shift, and as needed. According to the care plan staff should also ensure her foley strap was in place, not pulling off the catheter, and the foley was properly draining. The CPO for Amoxicillin (antibiotic) at 500 milligrams (mg) capsule, started 10/2/22, was ordered for the resident. D. Staff interviews CNA #1 was interviewed on 9/28/22 at 8:15 p.m. The CNA said she was new to the facility but has been working with Resident #16. She said staff told her that Resident #16 emptied her own catheter bag. She said Resident #16 needs frequent reminders to empty it. She said she has seen the resident's bag sometimes full because the resident has not emptied it yet. The nursing home administrator (NHA) and the director of nursing (DON) were interviewed on 10/4/22 at 3:05 p.m. The DON said all residents needed assistance with catheter care, including the emptying of the catheter bag and the monitoring of the fluid level. The NHA said some residents have been evaluated by therapy to determine if the resident could provide catheter care management such as emptying catheter bags themselves. She said the CNAs routinely monitor residents' catheter fluid level and would document the amount of fluid bag before it was emptied. The NHA reviewed Resident #16 medical record. The NHA said Resident #16 had not been evaluated or approved to empty her own catheter bag. She said the CNAs have not been charting the amount of urine output emptied from the resident's catheter bag. The NHA said staff should have been assisting Resident #16 with emptying her catheter bag and monitoring the resident's fluid level collected from her catheter. The NHA said staff should also ensure the catheter bag was properly positioned when the resident was sitting in her reclining chair in her room. The NHA said the bag should have been hung below the resident's bladder and never placed on the floor. The DON and NHA acknowledged placing the catheter bag directly on the floor could create a potential infection control concern. The NHA said staff needed to be responsible for the emptying and monitoring of the resident's catheter. She said would educate the staff to empty the resident's catheter bag, monitor and document the fluid level/output, and proper placement of the catheter bag when the resident was sitting in her room. Registered nurse (RN) #1 was interviewed on 10/5/22 at 3:39 p.m. She said Resident #16 had a new UTI, identified on 10/2/22. The RN said Resident #16 was now on antibiotics related to a UTI.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on observations, record review and interviews, the facility failed to ensure three (#12, #28 and #34) of six out of 26 sample residents received the care and services necessary to meet their nutritional needs and to maintain their highest level of physical well being. Resident #12 was admitted on [DATE] with diagnoses of dementia and diabetes. The resident was placed in hospice care on 7/8/22. The resident was weighed on 5/3/22 and again on 5/4/22 at 2:33 p.m., at 100.7 pounds (lbs). Then the resident was not weighed again until 8/1/22 and she was 99.2 lbs, and the last recorded weight was on 9/2/22 at 9:58 a.m. at 92.5 lbs., a loss of 6.7 lbs, which was a 6.5% weight loss over one month considered significant. The resident did not receive a nutritional assessment either after admission or after she sustained a severe weight loss. An intervention of Ensure was recommended on 9/16/22, however the facility did not implement it, until 9/18/22. In addition, the facility failed to: -Address Resident #28's significant weight loss timely; -Follow RD interventions for Resident #28; -Perform a comprehensive nutritional assessment for Resident #34; and, -Assess and provide adequate hydration needs for Resident #34. Findings include: I. Resident #12 A. Resident status Resident #12, age 85, was admitted to the facility on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included type II diabetes mellitus with diabetic nephropathy, essential primary hypertension, acute and chronic respiratory failure with hypoxia, diabetic chronic kidney disease, dementia, and unspecified visual disturbances. The 5/3/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for a mental status (BIMS) score of two out of 15. She required extensive assistance of one person with bed mobility, dressing, eating, and personal hygiene. The resident was under hospice care. The resident was not coded for weight loss. B. Observations (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The resident was served her noon lunch tray on 9/28/22 at 12:39 p.m. The resident was offered meal assistance three times, however, the resident refused. However, throughout the meal, the resident was falling asleep, and no staff attempted to wake her up. She only consumed 25% of her meal. And no alternative meal was offered. C. Record review In the resident's care plan initiated 5/3/22, and revised on 7/8/22, a goal was established of not incurring weight loss, through a dietary consult for a nutritional regimen and ongoing monitoring. The care plan was not updated to include the recent weight loss or to include the interventions which were put into place. Resident #12's weights since admission: -On 5/3/22 the resident weighed 100.5 lbs. -On 5/4/22 the resident weighed 100.7 lbs. -On 8/1/22 the resident weighed 99.2 lbs. -On 9/2/22 the resident weighed 92.5 lbs., a loss of 6.7 lbs, which equals a 6.5% weight loss over one month. The September 2022 CPO revealed the following: -The resident was admitted into hospice 7/8/22. -Ordered 9/16/22, Ensure original formula two times a day, however no specific amount was included in the order. Review of the September 2022 medication administration record (MAR) showed the facility failed to start the Ensure timely as it was started on 9/18/22. The MAR also failed to show the facility was tracking the amount consumed by the resident. The medical record failed to show that a initial nutritional assessment or a change of condition related to the weight loss was completed for Resident #12. There were no quarterly assessments completed since admission. The meal and supplement intake records from September 2022 revealed the following: -The resident typically consumed 51-100% of breakfast, lunch and dinner. -The resident was provided with Ensure twice daily but there was no documentation of intake percentages/amount. B. Staff interviews (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The hospice registered nurse was interviewed on 10/3/22 at 11:05 a.m. He stated that the resident has a review in thirty days and that a recommendation of discharge from hospice would be discussed as the resident was not meeting the criteria for hospice care. The registered dietician (RD) was interviewed on 10/4/22 at 4:40 p.m. The RD said she began employment at the facility on 9/16/22, and that her first meeting with the skin and weight team would be 10/7/22. Normally, she would come once a week to the facility for the meeting but has not been to the last two meetings, due to the fact that the director of nurses (DON) and the nursing home administrator (NHA) have been working on the floor. When she began employment at the facility she noticed that weights were not being charted on a regular basis, she stated, not having monthly weights hinders me. She reported the process that after entering an intervention, there should be a weekly progress note following up on the intervention. The RD reviewed the medical record and confirmed the resident had experienced a significant weight loss of over 6% in a month's time. She said it was her assumption that an Ensure consumption amount was 240 milliliters (ml), and that the intake amount should be tracked. She said when a resident eats less than 50% of the meal, alternatives need to be offered, and that the documentation needs to be accurate. The DON was interviewed on 10/4/22 at 5:37 p.m. The DON said when the resident ate less than 50% of her meal, then an alternative meal needed to be offered. She reported that the staff needed to return to check on the resident even if she refused the help, in order to monitor what the resident was eating. Her expectation was for an accurate meal percentage documentation so that the resident was accurately evaluated on what she was eating. She said she was aware of the resident's severe weight loss. II. Resident #28 A. Resident status Resident #28, age 78, was admitted to the facility on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included unspecified dementia, altered mental status, depression, repeated falls, and muscle weakness. The 5/22/22 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of two out of 15. The MDS coded the resident as requiring supervision with eating. B. Record review Weights since admission revealed the following: -On 5/9/22 the resident weighed 148.5 lbs -On 7/8/22 the resident weighed 135.5 lbs, a loss of 13 lbs., which equals an 8.75% weight loss -On 9/1/22 the resident weighed 134 lbs -On 10/3/22 the resident weighed 133 lbs (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The care plan dated 5/9/22 identified the resident as a potential for losing weight secondary to social isolation. With an intervention initiated on 5/25/22 of encouraging the resident to eat a healthy well-balanced meal. The September 2022 CPO revealed the following: -A physician order for the resident to be weighed daily for three days then weigh weekly for three weeks, ordered on 5/10/22. However, a review of the medical record showed the weights were not obtained according to the physician's order. -Fortified foods added on 9/8/22. The 8/25/22 nutrition note documented the resident was on a general diet order, mechanical soft texture, and thin liquids. Meal intakes have been between 76-100% of food and only approximately 240 ml of fluid intake. An estimation of daily nutrition needs for the resident were determined with the goal of 1550-1900 caloric intake and approximately 1600ml of fluid intake. Also, noted by the RD was a request for fortified foods at meals, and for updated weights. The 9/30/22 progress note documented due to the resident's significant weight loss since admission, she recommended fortified foods with every meal. C. Observation On 10/3/22 at 5:35 p.m., observed the resident's dinner tray being delivered to her room. On the tray were the following items: pasta, peas, pears and ice cream. No fortified foods were noted on the resident's tray. D. Staff interview The RD was interviewed on 10/4/22 at 4:40 p.m. She agreed that the dinner tray the resident received for 10/3/22 was not a fortified meal. She said examples of fortified foods were butter, brown sugar, mashed potatoes and heavy cream. The RD said that the facility did not have a specific menu for a fortified meal and that mashed potatoes should not be served with every lunch and dinner meal. 47351 III. Resident #34 A. Resident status Resident #34, age 93, was admitted on [DATE]. According to the September 2022 computerized physician order, diagnoses included Alzheimer's disease, depression, and anxiety. The 6/5/22 MDS assessment revealed the resident had had severe cognitive impairment with a score of two out of 15 on the brief interview for mental status. The resident was independent in walking and required limited assistance with all activities of daily living. It indicated the resident did not have a swallowing disorder. No dental abnormalities were noted. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	B. Observations 9/26/22 -8:30 a.m., the resident was at the dining room table awaiting her meal. The resident had a pitcher of water and a 120 milliliter (ml) cup on the resident table. However, she did not receive assistance to pour the water. -At 12:44 p.m., the resident received a total of 240 ml fluids (ice tea & water) however, drank approximately 120 cc tea. She did not consume or receive encouragement to drink the water. 9/27/22 -At 8:30 a.m., the resident drank coffee, approximately 50 ml of fluid. -At 12:30 p.m., the resident drank approximately 60 ml of ice tea. She was not encouraged to drink the remaining of the 120 ml of tea and did not have a glass of water. 9/28/22 At 12:30 p.m., the resident was served 120 ml of ice tea, however, she drank approximately 40 ml of the tea. She was not poured any water and received no encouragement to drink the remaining ice tea. 10/3/22 -At 8:18 a.m., the resident was served 120 ml of coffee, and although she was offered a second cup, she declined. She did not have any water poured from the water pitcher on the table. C. Record review The care plan last updated on 9/13/22 identified the resident was at risk for inability to maintain her nutrition. Pertinent interventions included, monitor intake and record each meal. -The care plan failed to include the amount of fluid the resident required each day. According to the RD interview, the resident did not have a nutritional assessment to indicate her daily fluid needs (see below). The hydration record for September 2022 was reviewed. The resident drank on average 240 ml at breakfast and 240 ml at afternoon meal. The dinner meal was not documented, only once at 100 ml. The snacks intake was not consistently entered with only 240 ml on five days. The observations and the documentation that the resident received less than 1500 ml a day (indicated by the RD, see below). D. Staff interview (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	CNA#3 was interviewed on 10/2/22 at 4:40 p.m. The CNA said she assisted the resident to eat her food by showing her what was on her plate. She said she made conversation with the resident as she was eating, asking the resident what she liked to eat and if she liked to cook. She said the resident was more inclined to eat when she encouraged the resident. The RD was interviewed on 10/5/22 at 4:40 p.m. The RD reviewed the record and confirmed that a nutritional assessment had not been completed for Resident #34. The resident should have an assessment which documented the resident's fluid needs. She said that minimally the resident required 1500 ml, however, she preferred to calculate out what the resident's specific needs were. The RD said the resident should have the water poured while at the table and receive encouragement to eat and drink.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467 Based on observations, record review and interviews, the facility failed to provide respiratory care and services in accordance with professional standards of practice, for three residents (#7, #12 and #26) of eight residents reviewed out of 26 sample residents. Specifically, the facility failed to: -Ensure Resident #7 had oxygen in her portable tank for mobility and readily available in an event of an emergency; -Ensure Resident #7 was placed on correct order setting for oxygen via nasal cannula; -Ensure Resident #12 had a physician order for specific nasal cannula oxygen requirements and for titration of oxygen requirements; and, -Ensure Resident #26 had a physician order for oxygen. Findings include: I. Facility policy The Oxygen Concentrator policy, effective 9/1/19, was provided by the activity director (AD) on 9/28/22 at 4:00 p.m. The policy read in pertinent part: This document sets forth general information and guidelines in regards to delivering oxygen to a resident using an oxygen concentrator. Once the oxygen concentrator has been set up and positioned properly, turn to proper flow rate as ordered by the physician. According to the policy, staff were to document in the resident's medical record after the oxygen setup adjustment was performed. The documentation should include: -The date and time of the oxygen administration; -The type of delivery system; -The rate of the oxygen flow; -The oximetry results (if ordered by the physician); -The resident's vital signs, skin color, and lung sounds; -The resident's response to therapy or any respiratory distress; -The date and time of physician/family notifications; and, -The signature and credentials of the individual who performed administration of the oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	II. Resident #7 A. Resident status Resident #7, age 77, was admitted on [DATE]. According to the October 2022 computerized physician orders (CPO), the diagnoses included acute and chronic respiratory failure with hypoxia (low oxygen blood levels), chronic obstructive pulmonary disease (COPD) with acute exacerbation, dementia, anxiety, schizoaffective disorder, and bilateral macular degeneration. The 6/22/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status score of 14 out of 15. She was independent in most of her activities of daily living (ADLs). The resident required one person physical assistance with supervision, proving oversight, encouragement or cueing. -The MDS assessment did not identify Resident #7 required oxygen therapy. B. Observations and resident interview Resident #7 was interviewed on 9/26/22 at 9:47 a.m. The resident said she needed to be on oxygen at all times because of her COPD. The resident said she should be on four liters of oxygen. Resident #7 wore nasal cannula attached to an oxygen concentrator. The concentrator was set at three liter per minute air flow. She said she could not adjust it because she could not see well so staff set her oxygen for her. She said her portable oxygen was usually empty and staff needed to fill it up for her but often did not. She said not having the portable oxygen tank filled made it difficult to use the restroom because the tubing on the concentrator would get caught on something or she would trip on it. Resident #7 said she spent a lot of time in her room but liked to walk down the halls for exercise. She said she could not leave her room when she did not have oxygen in her portable tank. The portable oxygen tank attached to her walker was observed. The tank was empty. The portable oxygen tank attached to the walker was the only portable oxygen tank in her room and within the resident's reach. The resident stated that staff often did not make sure her portable was filled at night which recently became a problem. Resident #7 said she was assisted outside during a facility evacuation on 9/23/22 after she was told by staff they smelled smoke in the facility. She had her portable oxygen tank attached to her walker but the oxygen tank was empty. She said she did not receive oxygen until the paramedics arrived and provided it to her. Cross-reference F689 accident hazards. -Resident #7 with COPD and acute and chronic respiratory failure with hypoxia was not provided oxygen continuously as prescribed in the CPO. Resident #7's oxygen concentrator and portable oxygen tank was observed on 9/27/22 at 4:15 p.m. The oxygen concentrator was set at three liters per minute and her portable oxygen tank was empty. The resident was not provided four liters of oxygen as prescribed in the CPO. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7's oxygen concentrator and portable oxygen tank was observed on 9/28/22 at 12:26 p.m. The oxygen concentrator was set at three liters per minute and her portable oxygen tank was empty. At 4:20 p.m. the resident's oxygen concentrator was set at three liters per minute and her portable oxygen tank was empty. At 7:40 p.m. the resident's oxygen concentrator was set at three liters per minute and her portable oxygen tank was empty. Resident #7's oxygen concentrator and portable oxygen tank was observed on 9/29/22 at 9:01 a.m. The oxygen concentrator was set at three liters per minute and her portable oxygen tank was empty. At 10:43 the portable oxygen was full. The resident said someone (later identified as the respiratory therapist) filled her tank. Resident #7's oxygen concentrator and portable oxygen tank was observed on 9/30/22 at 9:47 a.m. The resident's portable oxygen tank was full but the oxygen concentrator was still set at three liters per minute. Licensed practical nurse (LPN) #2 reviewed the oxygen orders for Resident #7 on 9/30/22 at 9:50 a.m. LPN #2 confirmed the resident has orders for continuous oxygen at four liters per minute. She said she was not aware of any current respiratory concerns or changes for Resident #7 related to her oxygen needs. She said oxygen orders needed to be followed as directed by the physician. The LPN observed the concentrator of Resident #7 and identified the contractor oxygen level was set at three liters per minute instead of the prescribed four liters per minute. The LPN said the oxygen setting needed to be adjusted. She set the concentrator to four liters per minute. Resident #7 was interviewed again on 10/3/22 at 9:50 a.m. She said she was able to exercise down the hallways on 10/3/22 because she had air in her portable oxygen tank. Additional observations on 10/3/22 and 10/4/22 identified the resident's portable tank was half full and her oxygen tank was set at four liter per minute. C. Record review The respiratory care plan, initiated on 3/15/21, read Resident #7 had the potential and/or actual altered respiratory pattern due to inability to maintain an effective airway clearance. According to the care plan, Resident #7 should maintain a clear, open airway and have decreased risks for associated breathing symptoms/complications. The care plan identified breathing symptoms/complications could include increased respiratory rate, complaints of shortness of breath, wheezing, increased coughing or difficulty breathing. Interventions directed staff to provide the resident oxygen via nasal prongs (nasal cannula) at four liters per minute, administer medications as indicated and monitor the effectiveness of respiratory treatments. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/27/21 CPO for Resident #7 identified the resident had an order for continuous oxygen at four liters per minute via nasal cannula at every shift related to her acute and chronic respiratory failure with hypoxia. The oxygen saturation record between 9/17/22 and 9/29/22 for Resident #7 indicated the resident saturation levels ranged between 90% and 98% on oxygen via nasal cannula. D. Staff interview Certified nurse aide (CNA) #1 was interviewed on 9/28/22 at 8:15 p.m The CNA said the oxygen portables should have been checked once a shift. The CNA said she was one of the CNAs that worked on 9/23/22, the night of the evacuation. She said several of the residents did not have their oxygen outside with them or it was with them but the tanks were empty. The director of nursing (DON) was interviewed on 9/29/22 at 11:03 a.m. The DON said physician orders for oxygen should always be followed unless the resident was in crisis. She said the respiratory therapist checked and filled the portable oxygen tanks every one to two weeks. She said the respiratory therapist filled resident portable oxygen tanks this morning (9/29/22). The DON said the CNAs should check the resident's oxygen tanks all the time throughout the day. She said the oxygen checks were not logged. The DON was informed of the above observations. She said staff should have been ensuring the resident's orders were followed and had her tank filled routinely and as needed. The DON said residents with COPD can experience shortness of breath, difficulty breathing, and respiratory distress. She acknowledged it could be scary for a resident with COPD not to have oxygen when it was needed. A staff member who requested to remain anonymous was interviewed on 9/29/22. The staff member said Resident #7 did not tell her about the oxygen concerns she had during the 9/23/22 evacuation but had requested the portable oxygen tank to be filled every night. The staff member said the oxygen portables should always be filled during the day at night. The staff member said the facility had a new oxygen supply company. The staff member said the portables were freezing up more often and depleting faster with the new equipment, causing staff to have to fill them more often. The staff member said when the portable oxygen tanks freeze up, it prevented the oxygen air flow. The staff member said she thought management was aware of staff complaints with the tanks freezing up but they had not personally told them. The staff member said the other staff and residents often complain about the tanks freezing and not immediately ready for use. The staff member said the tanks freeze all the time so they keep one filled in the oxygen storage room at all times. They would fill a tank, set the tank on the rack in the storage room and take the tank on reserve. The staff member said if there two residents needing oxygen at the same time, one of them would have to stay on the room concentrator until a portable oxygen tank was filled, thawed, and ready for the resident. The staff member said that the portable oxygen tanks took too long to fill and when the tanks were filled the portables would freeze up. The staff member said they were just worried someone could burn up while filling the tanks, referring to 9/23/22 evacuation. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The staff member entered the oxygen storage room. On a metal rack in the room were six portable oxygen tanks, five were empty and one tank was full. The staff member placed an empty portable on a large oxygen fill tank. The oxygen slowly entered the portable. After a couple of minutes, the staff member said it was taking too long to fill. The staff member switched the portable tank to a second large fill tank and attempted to fill the portable. One minute later, the oxygen was still filling. The staff member said they would feel bad if there was a resident waiting for the portable oxygen tank right now. After another minute, the staff member said the portable was starting to freeze up. The staff member said the portables usually freeze up about two out five times when trying them. The staff member said it was not good that the process for refilling tanks was so slow with new equipment and when they did fill, the portables would freeze up. RN #1 was interviewed on 9/29/22 at 5:15 p.m. The RN said she had just heard last week from a CNA that the portable oxygen tanks freeze up. She said she had not experienced that until last week. She said there were spare ones in the oxygen transfer room. RN #1 was interviewed again on 9/30/22 at 1:26 p.m. She said she would sometimes fill the oxygen tanks. She said the previous oxygen equipment was much easier to fill and use. CNA #7 was interviewed on 9/29/22 at 4:24 p.m. The CNA #7 said that the portable oxygen tanks freeze up. She said that they do not work properly. She said that the tanks can not be fully filled due to the freezing of the liquid oxygen. The nursing home administrator (NHA) and the (DON) director of nursing were interviewed on 9/30/22 at 1:40 p.m. The NHA said the facility has had the new oxygen company equipment since 7/28/22. She said the oxygen company trained some of the staff on equipment use on 7/28/22. The NHA said the staff who were trained by the oxygen company, trained the other staff. She said staff had told the NHA and the DON the portable tanks freeze up. She said they only complained of the freezing portables a couple of times when they first received the new oxygen tanks. She said the old tanks used to freeze as well. She said tanks could be more susceptible to freezing if there were changes in the air temperature or humidity. She said staff had to wait a few minutes after filling to turn the portable on so it would not freeze. The NHA said if it froze up, staff would just have to wait a few more minutes to thaw or fill another one while the resident would remain on the concentrator. The DON entered the oxygen storage room. In the storage room was a set of empty portable oxygen tanks and one partially filled tank. The DON placed an empty portable oxygen tank onto the fill tank. She said the first fill tank was not filling correctly and placed the portable tank onto a second fill tank. The fill tank slowly filled the portable oxygen tank. The DON said the tank was taking a while to fill. She said she was not aware that the tanks were taking so long to fill or it was common for them to freeze up. The DON said she would create a system to routinely fill the portable oxygen tanks, educate staff and monitor the tanks to ensure they are routinely filled. CNA #5 was interviewed on 9/30/22 at 4:30 p.m. CNA #5 said the portable tanks freeze up as they were being filled. He said, tanks and the liquid oxygen tanks do not seem to match. He said he had not received any training on the new tanks from the new company. He said all the CNAs had the same problem. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #9 was interviewed on 10/3/22 at 10:04 a.m. She said staff needed to make sure residents always felt comfortable. She said Resident #7 was one of the residents who needed extra attention. She said Resident #7 worried that staff do not pay enough attention to her. The CNA said she has had problems with the portable oxygen tanks freezing up sometimes if they were more than half way full or if they were overfilled. She said the tanks now take a little longer to fill either because the portable tanks were bigger than the old tanks or new oxygen equipment just filled slower. CNA #9 said she was trained how to use the oxygen equipment when the new tanks arrived. CNA #9 said she was working on 9/23/22 during the evacuation. She said she thought there was a potential fire inside the facility so she did not make the attempt to fill resident's portable oxygen tanks during the evacuation. The CNA said the portable oxygen tanks freeze up when they are filled. (Cross-reference F689 accident hazards.) E. Facility follow-up The oxygen education was provided by the facility on 10/4/22. The oxygen education was created after the facility was informed of oxygen concerns identified during the survey. The oxygen education reviewed the portable oxygen canisters (tanks.) The education reviewed when staff should fill and check the oxygen canisters; how to check portable canisters; and where to store portable canisters. According to the staff oxygen education staff should: -Fill the canisters during the night shift before resident arising in the morning; -Check the canisters before and after meals and fill if indicated; -Check the canisters before the resident goes to bed and fill if indicated; -The canisters as needed when requested by the resident; and, -Store the canisters in the residents' room. 47349 III. Resident #12 A. Resident status Resident #12, age 85, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure with hypoxia (low blood oxygen), dementia, and essential primary hypertension. The 7/8/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a score of two out of 15 on the brief interview for mental status (BIMS). The MDS assessment coded that the resident required extensive assistance with activities of daily living, and that she was receiving oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record Review The care plan, initiated 5/3/22 and revised 7/8/22, identified she was at risk for an alteration in cardiovascular status with an intervention that the resident required oxygen as ordered. The care plan also identified Resident #12 as having increased risk for potential of an ineffective respiratory pattern related to the need of oxygen therapy, thus requiring continuous oxygen at a setting 2 to 3 liters per minute (LPM). The September 2022 CPO failed to show a physician order for the use of the oxygen. The CPO documented, for concentrator use (no directions specified) and portable oxygen use (no directions specified). The orders started 5/3/22. C. Observations Resident #12 was lying in bed 9/27/22 at 8:43 a.m. with a nasal cannula in place, and the oxygen concentrator was set to 8 LPM. On 9/27/22 at 2:00 p.m. the resident's nasal cannula was not in place, it was lying across her chest with the oxygen concentrator set to 8 LPM. On 9/29/22 at 8:50 a.m. the resident was lying in bed, the nasal cannula was in place with the oxygen concentrator set to 7 LPM. On 9/30/22 at 8:43 a.m. the resident was lying in bed, the nasal cannula was in place with the oxygen concentrator set to 7 LPM. D. Staff Interview Registered nurse (RN) #2 was interviewed on 9/28/22 at 1:00 p.m. She reviewed the record and was unable to locate Resident #12's oxygen orders from the physician. She said that she would ask the director of nurses (DON) about the location. E. Facility follow-up On 9/29/22 Resident #12 received a physician order which read, oxygen at 3 LPM per nasal cannula. IV. Resident #26 A. Resident status Resident #26, age 73, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, other fracture of first lumbar vertebra (backbone), and repeated falls. The MDS assessment on 8/17/22, revealed that the resident was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment revealed the resident needed limited assistance to extensive assistance with activities of daily living. The resident was coded as using oxygen therapy. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The September 2022 current CPO included the following: oxygen use (canister) and portable oxygen use (both with no directions specified), started 8/10/22. The care plan, initiated 8/10/22, identified the resident was at risk for alteration in cardiovascular status and required oxygen use. Pertinent approaches were to wear the oxygen continuously via nasal cannula at 2 to 3 LPM. C. Observation On 9/26/22 at 9:23 a.m. the resident was lying in bed, with her nasal cannula in place. The oxygen concentrator was set at 4 LPM. The tubing was not labeled with the date as to when it was changed last. On 9/28/22 at 8:27 a.m., observed the resident lying in bed, with nasal cannula intact, the oxygen concentrator was set at 3 LPM. On 9/29/22 at 8:54 a.m., observed the resident lying in bed, with nasal cannula intact, the oxygen concentrator set at 3 LPM. D. Staff interview Registered nurse (RN) #2, was interviewed on 9/28/22 at 1:00 p.m. She reviewed the record and was unable to locate Resident #26's oxygen orders from the physician. She said that she would ask the director of nurses (DON) about the location. The DON was interviewed on 9/29/22 at 11:02 a.m. She said the procedure on obtaining orders for oxygen was the admission nurse ensured an order was obtained from the physician. If a resident was already part of the community, and required oxygen, then it was the responsibility of the resident's current nurse to obtain an order from the physician. She said the tubing should be changed out by the respiratory therapist, who comes to the facility every two weeks and dates when changed. E. Facility Follow up On 9/29/22 Resident #26 received a physician order which read, continuous oxygen at 3 LPM per nasal cannula.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 20287 Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide adequate nursing staff which considered the acuity and diagnoses of the facility's resident population in accordance with the facility assessment, resident census and daily care required by the residents. Cross-reference F689 accident hazards, F692 nutrition, and F744 dementia care. Findings include: I. Resident census and conditions According to the 9/26/22 Resident Census and Conditions of Residents report, the resident census was 36 and the following care needs were identified: -23 residents needed assistance of one or two staff with bathing and seven residents were dependent. Three residents were independent. -13 residents needed assistance of one or two staff members for toilet use and six residents were dependent; 15 residents were independent. -16 residents needed assistance of one or two staff members for dressing and four were dependent; 13 residents were independent. -15 residents needed assistance of one or two staff members and four were dependent for transfers; 15 residents was independent -Four residents needed assistance of one or two staff members with eating and 30 were independent. II. Staffing requirements for each station The director of nursing (DON) was interviewed on 10/4/22 at approximately 10:00 a.m. The DON provided the staffing requirements for each station. They were as follows: Hall A was to have one licensed nurse 12 hours for day shift and one certified nurse aide (CNA); Hall C and D were to have one licensed nurse 12 hour shifts from 6:00 a.m. to 6:00 p.m. and two CNAs for day shift and evening shift; and, The night shift has one licensed nurse 6:00 p.m. to 6:00 a.m. for the entire building and two CNAs for the entire building to cover all three halls. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Observations On 9/27/22 at 5:00 p.m., the C and D hallway had only two CNAs working, however, one was clocking out at 6:00 p.m. IV. Resident council minutes The review of the Resident Council minutes from June 2022 through August 2022 revealed resident concerns -Call lights being shut off and no staff returning; -CNAs not doing care when they should; and, -Need more than one CNA at night. V. Resident interviews Resident #20 was interviewed on 9/26/22 at 9:15 a.m. She said there was not enough staff. The resident said CNAs sometimes told her they were limited on help. She said the facility was short staffed at night. She said they had to pull CNAs from other hallways to help assist residents in her hall. Resident #9 was interviewed on 9/26/22 at 9:58 a.m. The resident said his call light did not get answered timely. He said it could take an hour during the evening shift. Resident #33 was interviewed on 9/26/22 at 10:39 a.m. The resident said staffing was short, that her call light was not answered timely and that it could take up to 30 minutes. Resident #26 was interviewed on 9/27/22 at 10:01 a.m. The resident said her call light was not answered timely. She said she has had to wait for a few hours. She said often times there was only one CNA for both C and D hallway. She said it was especially difficult to have call light answered right after dinner when others have to go to the bathroom. Resident #35 was interviewed with her family member on 9/28/22 at 10:40 a.m. The family member said Resident #35 has long waits for activity of daily living (ADL) assistance because staff have to spend so much time with the wandering residents (Cross-reference F744 dementia care). VI. Resident group interview The resident group interview was conducted on 9/28/22 at 1:35 p.m. The group consisted of six alert and oriented residents (#3, #20, #22, #31, and #33) selected by the facility. The residents stated the following: -Not enough nursing staff during the evening or night; -Call lights were not answered timely, and the staff shut the call light off and do not return; -Call lights can take up to 30 plus minutes to wait for call light to be answered; and, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Administration told the residents that the facility could not afford anymore staff, and that they were staffed accordingly. VII. Family interview The family member of Resident #35 was interviewed again on 10/3/22 at 1:10 p.m. The family member said he felt frustrated. The family member said Resident #35 had to wait over 45 minutes to have her brief because there was only one CNA on the floor. The family member said there was not enough staff when so many residents needed two person care person care. VIII. Schedule Random dates were provided to the business office manager and to the director of nurses for the licensed nurse and certified nurse aides for both the evening and night shifts. The following was found: 7/3/22 showed two CNAs for the entire shift on evening and one CNA who left at 6:08 p.m. The facility did not provide any time cards for the night shift. 8/9/22 showed one CNA on the night shift. The facility did not provide any time cards for the night shift. 8/15/22 had one CNA who worked on the night shift from 9:58 p.m. to 1:55 p.m. and one CNA who worked from 5:00 a.m. to 7:00 a.m Otherwise, only one CNA for the full night shift. 9/27/22 showed the evening shift had two CNAs and one that finished at 6:00 p.m. which left two CNAs for the evening shift. VIIII. Interviews Licensed practical nurse (LPN) #1 was interviewed on 9/28/22 at 7:45 p.m. She said two nurses worked the floor except on Wednesdays when one nurse had to be responsible for all the facility residents. The LPN said during the day shift there were two CNAs per unit equally for CNAs. She said at night two CNAs assisted with resident's ADLs for the facility. CNA #1 was interviewed on 9/26/22 at 7:30 p.m. The CNA said that she works hall A alone. She said because she worked alone, when she needed help with the mechanical lift, she would ask someone in administration to be the second person. The activity director (AD) was interviewed on 10/4/22 at approximately 10:00 a.m. The AD said that she was a CNA and that at times she was pulled away from her current job to work the floor as a CNA. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The director of nurses and the nursing home administrator were interviewed on 10/4/22 at approximately 11:00 a.m. The NHA said the staffing requirements were based on census and the acuity of the residents. She said when the CNA staff had a call off then she pulled from other departments who were also CNAs. She said she tried to replace it within an hour. The DON said that she staffed the halls with two CNAs on C and D halls and one CNA on A hall for both days and evenings. She said he licensed nurses worked 12 hour shifts and had two licensed from 6:00 a.m. to 6:00 p.m. She said then it dropped to one licensed nurse for the entire building from 6:00 p.m. to 6:00 a.m. The NHA said the facility staffed accordingly and believed it was fully staffed. A staff member who preferred to remain anonymous was interviewed on 10/4/22. They said the facility would not increase its staff numbers till the census was up even though staff continue to express that they need more assistance with residents. They said the facility had several residents with high acuity needs but they were not receiving all care needed because there was not enough staff to adequately provide the care. They said some nurses have to worked alone, which was not safe for the residents. They said sometimes one nurse for the entire facility for eight hours. The staff member reiterated that current staffing levels were not safe; residents were falling, wandering unsupervised, and receiving a slower response to cares. The director of nurses was interviewed a second time on 10/5/22 at approximately 9:00 a.m. The DON said she was going to look for more employee time cards, as she said she always ensured there were three CNAs on evenings and two on night shifts. She said the building had a total of 11 residents who need the mechanical lifts, three sit to stand lifts, six residents who wander throughout the facility. A certified nurse aide who wished to stay anonymous was interviewed on 10/5/22. The CNA said that the front hall was tough to get everything done, which included call lights, and residents ready for the day. The social service director (SSD) was interviewed on 10/5/22 at 9:49 a.m. The SSD who was also a CNA said she was pulled from her current job to work as a CNA. She said that when she was pulled, then her job in social services did not get completed. The SSD was interviewed again on 10/5/22 at 12:03 p.m. She said she had heard a CNA say it's lunch time, the resident would have to wait to be changed. The SSD said that should not happen.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on observations, record review and staff interviews, the facility failed to ensure three (#4, #30 and #34) of five out of 26 sample residents, received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being. Specifically, the facility failed to comprehensively assess and effectively identify person-centered approaches for dementia care for Resident #4, #30 and #34. Findings include: I. Facility policy and procedure The Dementia Care clinical protocol, revised November 2018, was provided by the director of nursing (DON) on 10/3/22 at 4:05 p.m. It documented in pertinent part, For the individual with confirmed dementia, the facility will identify a resident-centered care plan to maximize the remaining function and quality of life. Nursing assistants will receive initial training in the care of residents with dementia and related behaviors. In-services will be conducted at least annually thereafter. Direct care staff will support the resident in initiating and completing activities and tasks of daily living to include bathing, dressing, mealtimes, and therapeutic and recreational activities will be supervised and supported throughout the day as needed. II. Resident census and conditions The 9/26/22 Resident Census and Condition form documented 36 residents with 16 residents diagnosed with dementia and 16 residents with a psychiatric diagnosis. III. Resident #4 A. Resident status Resident #4, age 92, was admitted on [DATE]. According to the September computerized physicians orders (CPO), the diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, depression, and generalized anxiety disorder. The 6/20/22 minimum data set (MDS) assessment revealed, the resident had severe cognitive impairment with a brief mental status score (BIMS) of four out of 15. He had inattention and disorganized thinking. He required supervision with dressing and was independent with all other activities of daily living (ADL). He had no behaviors and did not reject care. He wandered daily which placed him at risk of getting into a potentially dangerous place. He received anti anxiety medication daily. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident altercations (cross-reference F600) The facility documentation from 6/28/22 revealed Resident #4 was in another resident's room. Residents #31 heard a resident scream and went to her room. He saw Resident #4 standing in the room so he took Resident #4 by hand to escort him out of the resident's room and into the hallway like the staff had done. Resident #4 said something that Resident#31 did not understand and he responded, We are going down here. Resident #4 swung his arm and Resident #31 blocked it with his left arm. Resident #4 ended up on the floor. Resident #31 had a bruise to his posterior forearm. The facility documentation from 6/30/22 revealed Resident #4 was standing in front of Resident #17's room entrance where he was sitting in his wheelchair. A nurse heard Resident #17 yelling and when she exited the nurses station she saw Resident #4 swing his arm to hit Resident #17. The nurse yelled to Resident #4 to stop. Resident #4 walked away, entered and exited an empty room, and exited down the hallway. The nurse went to escort Resident #4 from the area. Resident #4 shoved the nurse in her left shoulder with his right shoulder as she approached. Another staff member intervened and escorted Resident #4 off the east wing and back to the west wing where his room was located. Resident #17 stated Resident #4 had hit him. A red mark was noted to Resident #17's neck, which faded in a short time. Resident #4 was placed on one-on-one monitoring (during the investigation) and then every 15 minute checks thereafter. C. Behavior documentation The September 2022 behavior monitoring documented five episodes of grabbing, hitting or pushing others, expressing anger or agitation and three episodes of wandering. Progress notes The 6/9/22 health status note documented the resident was awake and wandering on the east and west wings and entering other resident rooms. He was redirected constantly but had poor short term memory. The 6/23/22 nursing progress note documented the nurse was summoned to help separate Resident #4 from another resident. When the Resident #4 was asked to leave the other residents room he became combative with the staff and the other resident. The other resident had a cane and Resident #4 swung at her but did not make contact. The staff member intercepted the swing and the resident hit the staff member. The 7/9/22 general progress note documented the resident had exited through an exit door to the outside and activated the alarm. After several minutes the resident was persuaded to return to the building by staff members. The 8/24/22 health status note documented the resident was moving furniture around in his room causing a skin tear to his right elbow. The resident was unable to state how the skin tear occurred due to his dementia. The 9/14/22 behavior note documented the resident wandered into a female resident's room and she was screaming and said she was scared. A certified nurses aide (CNA) removed the resident from the room and reminded Resident #4 not to go into other resident rooms. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 10/2/22 health status note documented the resident could not be redirected after several attempts. He continued to insist on grabbing items out of the medication cart during count and taking items off of the medication and treatment carts. It documented Ativan (anti-anxiety medication) was given with good results. Care Plan The mood care plan, revised 7/7/22, documented the resident had alterations in mood and behaviors as evidence by outburst. The goal was to have fewer episodes of outburst of anger. Pertinent interventions listed were to administer medications as ordered and monitor/document side effects and effectiveness, anticipate and meet the residents needs, minimize potential for the resident's disruptive behaviors by offering tasks which divert attention, provide a program of activities that is of interest and accommodates resident status, and provide positive reinforcement/praise of the resident's progress/improvements/control in behavior. The dementia care plan, revised 7/7/22, documented the resident may have days where he became physically and/or verbally towards staff and others due to poor impulse control. Pertinent interventions listed were to speak to him in a calm, quiet voice and activities. -The resident's care plan did not have personalized interventions to address his behaviors including wandering into others rooms. IV. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 9/29/22 at 3:52 p.m. He said Resident #4 wandered and tried to hug and kiss other residents and staff. He said Resident #4 had altercations in the past and wandered into other resident's rooms. He said the staff tried their best to keep him out of other resident rooms. CNA #5 said on one occasion Resident #4 swung at him as he attempted to escort him out of a resident's room. He said on one occasion Resident #4 walked into a female resident's room and she started screaming because she was fearful of him. So, he escorted Resident #4 out of her room. He said they were doing every 15 minute checks and some of the residents have a stop sign across their door. Licensed practical nurse (LPN) #1 was interviewed on 9/29/22 at 4:07 p.m. She said Resident #4 had dementia and if you argued with him he would get aggressive. She said the staff tried to redirect him by giving him something to read or write. She said she had only been at the facility for a month and had not seen him in any altercations. She said sometimes Resident #4 would wander into other resident rooms and the other residents would get angry and ask the staff to remove him from their room. She said Resident #4 was on every 15 minute monitoring. The activity director (AD) was interviewed on 10/4/22 at 4:11 p.m. She said Resident #4 liked to go outside and watch the birds. She said she had very little dementia training. She said she had experience from her previous job as an activity assistant. She said there were minimal activities for residents with dementia and there was no current dementia program. She said the activities were not person center, but were for all residents to attend. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The executive director (ED) was interviewed on 10/4/22. She said Resident #4 wandered into other resident rooms because he liked to visit. She said she was not sure why the other residents feared him. She said the staff was behind on their computer based dementia training. She said the computer based dementia training was not specific to activities. She said person centered activities would help with wandering. She said the facility would be opening a memory care unit, which would help residents have a sense of belonging and an activity program to give them a sense of well being. She said the unit would help with residents who wander and disrupt activities and meals. She said the facility should have activity supplies to engage the dementia residents. The ED was interviewed again on 10/5/22 at 4:24 p.m. She said dementia care was not discussed in the quality assurance/performance improvement (QAPI) meetings. 40467 V. Resident #30 A. Resident status Resident #30, age 86, was admitted to the facility on [DATE]. According to the October 2022 computerized physician orders (CPO), diagnoses included repeated falls, Parkinson's disease, neurocognitive disorder with Lewy bodies, cognitive communication deficit, difficulty in walking, muscle weakness, and a need for assistance with personal care. According to the 8/27/22 minimum data set (MDS) assessment, a brief interview for mental status (BIMS) was not conducted. According to the staff assessment for mental status, the resident had severe impairment for making decisions regarding tasks of daily life. Resident #30 had a short and long term memory problem. The assessment identified the resident displayed inattention and disorganized thinking. The MDS assessment indicated Resident #30 required limited assistance of one person for dressing, toileting and personal hygiene. He required supervision with set up for bed mobility transfers and eating. According to the MDS assessment the resident was independent in walking in his room and locomotion on and off the unit B. Observation Observations were conducted between 9/26/22 and 9/30/22, and again on 10/3/22 and 10/4/22. Observations identified long periods of the resident sitting or standing near the nursing station without an offer for an activity. The resident was observed sitting in his room without offers of an activity, including an offer to put western music on for him to listen to. Observation did identify staff holding his hand to walk down the halls, and in one instance away from a resident's room that was being mopped on 9/30/22 at 10:46 a.m. C. Record review The impaired cognitive function care plan, initiated on 2/3/22 read resident had impaired thought processes related to dementia. Interventions directed staff to: (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Communicate with the resident, the family and caregivers regarding residents capabilities and needs; and, -Present just one thought, idea, question or command at a time. The 2/3/22 CPO read Resident #30 was not capable of understanding his rights due to dementia. The psychosocial care plan, initiated on 2/14/22, identified Resident #30 was dependent on staff for meeting his emotional, intellectual, physical, spiritual and social needs related to his cognitive deficits and disease process. Interventions included: -All staff to converse with the resident while providing care; -Encourage ongoing family involvement; -Establish and record the resident's prior level of activity involvement and interests by talking with the resident, caregivers, and family; -Introduce the resident to residents with similar background, interests and encourage and facilitate interaction; -Invite the resident to scheduled activities; -Provide the resident with an activity calendar; -The review of resident activity needs with the family/representative; -The resident enjoys country music; -The resident enjoys socializing with friends, family and staff; -The resident enjoys westerns; -The resident needs assistance/escort to activity functions; -The resident prefers activities which do not involve overly demanding cognitive tasks; and, -Thank the resident for attendance at the activity function. The wandering care plan, initiated on 3/22/22, read Resident #30 known to wander in other residents' rooms. The care plan directed all staff to redirect the resident when he wandered into other resident rooms. The 5/4/22 elopement wanderer care plan directed staff to distract residents from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. sitting with other residents. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The alteration in cognitive status, initiated on 8/30/22, read resident #30 had delirium due to his Lewy body dementia. Interventions included: -Ensure the resident's toileting routine was enforced; -Resident #16 had an improved understanding when staff used short, simple sentences; According to the intervention, staff should speak slowly and clearly to the resident, they should not act rushed and identify self with their name at each contact; -Provide medications to alleviate agitation as ordered by the physician; and, -Repeat questions if needed, allowing adequate time for response. The 8/17/22 CPO identified the resident had an order for a wanderguard. The 8/12/22 CPO identified the resident had an order for a lorazepam for anxiety. The 8/29/22 health status note read attempted to enter another resident's room but was easily redirected. The September 2022 medication and treatment administration record MAR/TAR identified monitor behavior pacing, agitation, anxiety every shift for lorazepam. The 9/22/22 CPO read Resident #30 may participate in all activities and social functions. The 8/29/22 health status note read Resident #30 attempted to enter another resident's room but was easily redirected. D. Staff interview Certified nurse aide (CNA) #9 was interviewed on 10/3/22 at 10:11 a.m. She said Resident #30 usual routine was to sit in his reclining chair in his room and take a nap and his wife often visits. She said his increased behaviors such as wandering often worsen around dinner time. CNA #9 said staff tried to redirect Resident #30. She said staff encourage him to follow them or stay near staff. She said he had short attention and needed activities that were engaging but were short in duration. She said staff could benefit from dementia, specifically behavior interventions for wandering and learn what it was like to be in their shoes referring to the perspective of a resident with dementia. The CNA said Resident #30 took a lot of staff's time. She said staff could use more help redirecting Resident #30 or just keeping him busy. CNA #9 said other residents could become very frustrated with him because of the intrusion into their rooms. She said if Resident #30 was occupied instead of wandering, it would take a lot of stress off the staff and cognitively intact residents. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The social service director (SSD) was interviewed on 10/3/22 at 4:40 p.m. The SSD said Resident #30 would often wander into several residents ' rooms including Resident #7 and Resident #35. She said the nursing staff tried to redirect him. She said the facility has implemented stop signs. She said the stop signs had helped him from going into Resident #7's for as much. The SSD said he liked to rest in his room and listen to western music, sit by the nurses station and talk to staff and residents. She said Resident #30 had behavior tracking on the MAR/TAR for his psychotropic medication target for his anxiety. A staff member who requested to remain anonymous, was interviewed on 10/4/22. They said the staff need training on redirecting behaviors. They said they had seen staff try to redirect Resident #30 out of a resident room by holding his upper arm which would then escalate his behaviors. They said staff needed to just have Resident #30 hold their hand and would go where they wanted it to go. The activity director (AD) was interviewed on 10/04/22 at 9:01 a.m. The AD said activities helped residents calm down and helped with wandering, when they were lost, helped them to be with somebody. The AD said Resident #30 was fixated on looking for his wife. She said if he was brought to an activity or wandered in for a moment, she would mark on his participation record that he was present for the activity whether he engaged in the activity or not. The AD said Resident #30 liked to listen to music in his room. She said he also enjoyed sitting at the nursing station and talking to people. The AD said activities took him for walks and gardening. She said he was a farmer and liked to garden. She said activity she did not recall when the last time Resident #30 had gone out to garden and water the flowers. She said it had not been gardening recently. She said she did not know if watering was identified on the attendance records. The AD said he liked to play ball toss. She said she did not know when he last played ball toss. She said she tried to put in a note when Resident #30 did a specific activity. She said needed to improve the one to one program. She said a one to one program that was individualized for the resident and would consist of a ten minute visit, three times a week. The AD said Resident #30 was not on a one-to-one program but he could benefit from one. She said needed to improve the one-to-one program. She said she did not know why he was not on a one to one program. VI. Additional interviews from residents and family interview Resident #7 was interviewed on 9/28/22 at 12:26 p.m. She said she was very uncomfortable when wandering residents entered her room. She said some of the confused residents tried to kiss her or were aggressive. She said she said there was a female resident that liked to sit on her bed and would not leave and could become aggressive. She said Resident #30 walked in her room and could become aggressive if she told him to leave. She said he could be more aggressive with staff. He became upset with her. She said another male resident, Resident #4 often wanted to come up to her and kiss her. She said she had a past history with trauma related men being aggressive or attempting to advance themselves on her. She said it made her want to have a flight or flight response, and when she wanted to flight, she had nowhere to go so she would fight if she had to. She said staff put up the stop sign across her to help stop the wandering in her room. She said the wandering in her room was a little bit better. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #35 was interviewed with her husband on 9/28/22 at 10:40 a.m. The husband of Resident #35 said he had seen Resident #30 become aggressive with staff. She said staff had to remove him from rooms forcefully. He said it was forceful within reason. He said however when they place their hands under his upper arm and shoulder, it seems to upset him more and he gets more aggressive with staff. The husband said he had removed Resident #30 from his wife's room. Resident #35 said they were nice to him when he came into their room but she would prefer the wandering residents not come into her room because she never knows the confused residents would do. The husband said one time their son was visiting from out of town and they were having a special family dinner together. He said Resident #30 continued multiple times to entered Resident #35's room and disrupt their meal. He said his son finally had to take Resident #30 to the nurses stations and told the staff that families should not have to handle the problem of resident's wandering into rooms, it should be the staff's problem to handle it. Resident #35 said she just wanted more privacy and for the wandering residents not to come into her room. She said no staff would want people to continue to wander in their rooms. The husband said they used to have a stop sign across the door of the room but it was taken down when the inside of the facility was being painted. He said staff never hung the sign back up. He said the stop signs were still not enough however, to keep the other residents out of the room. He said staff had to watch the wanders all the time. The family member said Resident #35 has long waits for activity of daily living (ADL) assistance because staff have to spend so much time with the wandering residents (Cross-reference F725 staffing). VII. Resident group meeting The resident group interview was conducted on 9/28/22 at 1:35 p.m. The group consisted of six alert and oriented residents (#3, #20, #22, #31, and #33) selected by the facility. The residents stated the following: There were residents who would wander into their rooms without permission. The residents wander in during all times of the day or night, even when they were in the bathroom. VIII. Dementia training The staff online training program course description for communicating with dementia residents, challenging behaviors with dementia care, and managing aggressive behaviors, was provided by the facility on 10/5/22. The course description for communicating with dementia residents read the course would teach the staff how to: Understand the person with dementia by knowing them as an individual and recognizing common speech patterns; how persons with dementia use behaviors for communicating discomfort; and the communication strategies you can employ to ensure the person received your message. The course description for challenging behaviors with dementia care read: Individuals with Alzheimer's disease and Related Disorders often have challenging behaviors. It is important to know all of that behavior has meaning. Although there is no way to prevent all-in-one behaviors there are ways to decrease their occurrence. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The course description for managing aggressive behaviors the course would teach the staff how to: Use strategies and techniques to reduce a person's aggressive aggression. In this course you will learn ways to recognize, prevent, and manage aggressive behaviors to protect yourself and others. -However, not all staff received training on dementia care (Cross-Reference F943 abuse, neglect and exploitation training). IX. Lack of dementia care training A. Staff interview CNA #3 was interviewed on 9/28/22 at 9:50 a.m.The CNA said staff had annual training of dementia through a computer based training program. She said the online program offered tips on how to interact with residents with dementia. A staff member who requested to remain anonymous, was interviewed on 10/4/22. They said the facility had a lack of effective dementia training for all staff with behavior interventions. They said staff needed more specialized training to work with dementia residents. They said staff need to know how to interact with residents. They said they have seen staff stressed when trying to continue to manage the wandering residents' behaviors. They said they have seen staff throw up their hands and say I don ' t have time for this in response to dementia resident continuous needs. They said the wandering residents always needed to be busy unless they were medicated. They said the facility needed more activities for dementia residents. They said the activities that were offered were geared for highly functioning leveled residents and were not appropriate for dementia residents. The staff member said staff did not have the staffing needed to handle the acuity needs of the residents (cross-reference F725 staffing). They said there were times that there was only one nurse in the facility in the evenings, which was a critical time for residents with sundowning and wandering behaviors. They said many staff did not feel supported by management with staffing and training concerns. The SSD was interviewed on 10/5/22 at 9:31 a.m. The SSD said the facility was planning to open a memory care unit for dementia residents in the near future. The SSD said the memory care unit would be beneficial for residents like Resident #7, that did not want to be approached by wandering residents. The SSD said the unit would be more specialized to meet the needs of dementia residents including dementia appropriate activities. The SSD said the memory care unit would have an activity assistant full time to work with the dementia residents. The SSD said dementia appropriated activities should occur if a resident was in a memory care unit or not. She said staff should be able to accommodate each resident's individual needs. The activity director (AD) was interviewed on 10/4/22 at 9:01 a.m. The AD said she received her guidance on dementia care from the NHA, plus she was often pulled away from her AD role so work the floor as a CNA (Cross-reference F725 staffing.). (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA and the DON were interviewed on 10/4/22 at 2:21 p.m. The DON said staff should always be patient with residents, never raising their voice. She said staff's approach should be personalized to the individual resident. The DON said when staff needed to redirect a wandering resident, staff should ask the resident to hold their hand and come with them. She should never hold the upper arm of a resident. She said that approach could create a negative response. 47351 X. Resident #34 A. Resident status Resident #34, age 94, was admitted on [DATE]. According to the September 2022 CPO diagnosis included Alzheimer dementia. The 5/23/22 MDS assessment revealed, the resident had severe cognitive impairment with a brief mental status score (BIMS) of two out of 15. She had inattention and disorganized thinking. She required limited assistance with dressing and was independent with all other activities of daily living (ADL). She had no behaviors and did not reject care. She wandered daily which placed her at risk of getting into a potentially dangerous place. She received anti anxiety medication daily. B. Observations On 9/26/22 at 12:00 p.m., the resident was in the hallway and was asking where she was. The staff she asked did not offer redirection. On 9/27/22 at 10:00 a.m., the resident was sitting with registered nurse (RN) #2 at the nurses station. RN #2 did not interact with the resident while she did her computer work. On 9/28/22 at 8:00 a.m., the resident was wandering down the hallway throughout the morning. The staff had minimal to no contact with the resident. The staff ultimately redirected her back to her room. At 3:00 p.m., the resident was in her room awake, alone, and unattended sitting in a recliner. No meaningful activity. On 9/29/22 at 8:15 a.m., the resident was wandering the halls confused and disoriented. At 12:30 p.m., the resident was dressed in the same clothing as the day prior. The resident constantly asked for help. CNA #4 was within close proximity of the resident but did not offer resident assistance. The resident stood alone in the hallway and asked for help multiple times throughout the afternoon. At 2:00 p.m., the resident was listening to a performer sing and play piano in the activities room. On 9/30/22 at 8:40 a.m., the resident was asleep in the room. The resident awakened and escorted to dining room by CNA #5. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Record review The care plan last updated 6/2/22 identified the resident had impaired cognitive function, impaired thought process and had a diagnosis of Alzheimer's/dementia. Pertinent interventions were to ask yes no questions to determine her needs, and to encourage the resident to make decisions regarding tasks of daily living, and keep the most recent routine consistent and try to provide consistent care givers as much as possible to decrease confusion. There was no documentation to support residents' participation in meaningful activities to address the resident's routines, interests, preferences, and choices to enhance the resident's wellbeing. The physician's admission order dated 6/2/22 read, The resident is not capable of understanding her rights. -The care plan failed to include the resident's target behaviors and pertinent interventions specifically for the resident to address her behaviors. The activity participation for July, August, and September 2022 did not include evidence of attendance. The September 2022 treatment administration records identified target behaviors as: -Constant pacing, wandering, asking the same question over and over. Interventions included to redirect, one to one activities, return to room, activity, toilet, food, fluids, change position, adjust room temperature, backrub, and medication. -Teary eyed, interventions included to redirect, one to one activity, return to room, activity, toilet, food, fluids, change position, adjust room temperature, backrub, and medication. -Withdrawn, interventions included to redirect, one to one activity, return to room, activity, toilet, food, fluids, change position, adjust room temperature, backrub, and medication, -There was no documentation to support residents' participation in meaningful activities to address the resident's routines, interests, preferences, and choices to enhance the resident's wellbeing. D. Staff interviews The activities director (AD) was interviewed on 10/4/22 at 11:40 a.m. The AD said there were minimal activities geared toward residents with dementia. She said in the past, the resident had participated in kick ball and balloon toss. The activities director had no record of attendance or documentation about Resident #34 attendance in activities. The AD said it was a struggle to keep the resident's attention. The AD did offer one-on-one activities for Resident #34. The AD said her and the two assistants did not have dementia training.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on record review and staff interviews, the facility failed to act upon recommendations by the pharmacist in a timely manner, based on medication regimen review (MRR) for two (#28 and #34) of six reviewed for unnecessary medications out of 26 sample residents. Specifically, the facility failed to ensure response to pharmacist recommendations for: -Resident #28, a discontinue order for diazepam (anti anxiety medication) and an order for serum creatinine laboratory (lab) level was not drawn as requested; and, -Resident #34, failed to ensure the drug regimen review was acted upon in a timely manner. Findings include: I. Facility policy and procedure The Unnecessary Medications policy and procedure, last revised 4/9/07, was provided by the director of nursing (DON) on 9/29/22 at 4:05 p.m. It read in pertinent part: The facility must evaluate the resident, the resident's medication regimen and if necessary consult with the resident's physician: when an irregularity is identified in the pharmacist's monthly medication regimen review. II. Resident #28 A. Resident status Resident #28, age 78, was admitted to the facility on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included unspecified dementia, altered mental status, depression, repeated falls, and muscle weakness. The 5/22/22 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of two out of 15. She was rated as being independent to supervision only with her activities of daily living (ADLs). B. Record review Review of the resident's medication administration record (MAR) and treatment administration record (TAR) revealed the resident had orders to receive the following medication: -Diazepam, 5mg tablet, one tablet every eight hours as needed for anxiety. Failure to act upon pharmacist recommendations (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/7/22 pharmacist's consultation report requested for a serum creatinine lab to be performed to check the resident's renal function, as she had not had one within the past six months. This was a second request, the first request occurred on 5/10/22. The consultation report also requested the diazepam medication be discontinued. This was the second request, as the first time occurred on 5/10/22. C. Staff interview The pharmacist was interviewed on 10/4/22 at 5:45 p.m. The pharmacist said she reviewed the resident's record once a month. She said once she makes a recommendation, the physician has 30 days to respond to the recommendation. The pharmacist reviewed Resident #28's consultation report and confirmed she had provided the recommendations. She said that she had not received an answer as to whether the recommendations were accepted. She said when she completed the drug review of the resident's medications, she emailed the recommendations to the nursing home administrator (NHA) or DON, and that it was left up to the facility to contact the physician. She said when she reviewed the resident's record again the following month, she looked for the follow up to the previous month's recommendations. 47351 III. Resident #34 A . Resident status Resident #34, age 94, was admitted on [DATE]. According to the September 2022 CPO diagnosis included, Alzheimer's disease, anxiety and depression. The 6/5/22 MDS assessment revealed the resident had severe cognitive impairment with a score of two out of 15 on the brief interview for mental status. The resident was independent in walking and required limited assistance with all activities of daily living. The MDS assessment did not determine if the resident experienced falls prior to admission, therefore, no evidence the resident fell at home or in the community of prior to admission. The 9/5/22 MDS coded the resident has had two falls since last quarter. B. Record review Review of the resident's September 2022 medication administration record (MAR) and treatment administration record (TAR) revealed the resident had orders to receive the following medication: -Fluoxetine 20 mg by mouth one time a day with the associated diagnosis of depression. Start date of 6/23/22. Failure to act upon pharmacist recommendations The 8/6/22 pharmacist's consultation report requested for the resident's recent falls, showed the combination of a Benzodiazepine, Alprazolam and the Fluoxetine (antidepressant). The recommendation was to gradually reduce Fluoxetine HCL and then discontinue. The pharmacist suggested, 10 mg every day for 14 days, then 10 mg every other day for 14 days then discontinue. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The recommendation for the Fluoxetine had not been followed by the facility as staff continued to administer the Fluoxetine daily after 8/6/22. Nor was there any effort by the facility to outreach the primary care provider to sign off on the pharmacist's recommendations to start the weaning process as advised. C. Staff interview The pharmacist was interviewed on 10/4/22 at 5:45 p.m. The pharmacist reviewed the record and confirmed the recommendation of completing a gradual dose reduction on the Fluoxetine and then to discontinue. She said the resident continued to receive the 20 mg of Fluoxetine and the recommendation had not been resolved.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47349 Based on record review and interview, the facility failed to ensure the facility failed to ensure that residents were free of unnecessary psychotropic medications for three (#4, #28 and #34) of six residents reviewed for unnecessary medications out of 26 sample residents. Specifically, the facility failed to ensure: -As needed (PRN) psychoactive medications were discontinued after 14 days for Resident #28, Resident #34, and Resident #4 without a documented rationale; -Consent forms were signed for Resident #34; and, -Non-pharmacological interventions were utilized prior to the administration of the PRN psychoactive medications for Resident #34, #28 and #4. Findings include: I. Resident #28 A. Resident status Resident #28, age 78, was admitted to the facility on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included unspecified dementia, altered mental status, depression, repeated falls, mood disturbance and anxiety. The 5/22/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for a mental status score of two out of 15. She was rated as being independent to supervision only with her activities of daily living (ADLs). She was coded as having no behavior symptoms, she did not reject care and that she did not wander. She was on antianxiety and antidepressant medications. B. Record review The care plan initiated 5/9/22, and revised on 5/25/22, identified the resident with chronic anxiety, but did not identify if any anti-anxiety medications were being used. It also did not include any behavior monitoring for the target behaviors of feeling anxious, agitated, and irritable. -The care plan did not include person-centered individualized non-pharmacological interventions to attempt, prior to the use of the PRN medication. The September 2022 electronic medication administration record (eMAR) documented a diazepam 5 mg tablet every eight hours as needed for anxiety. The medication was started on 5/10/22. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review the September 2022 medication administration record (MAR) showed the resident received diazepam: at least one dose 23 out of 30 days. Two doses were given on nine out of 30 days. -There were not any non-pharmacological interventions for anxiety documented in the resident's progress notes. -Review of the progress notes revealed the physician failed to document a rationale for the continued use of the PRN diazepam after 14 days. C. Observations On 9/26/22 at 11:58 a.m., the resident was wandering the hallways with no meaningful activities. On 9/28/22 at 3:50 p.m. the resident was in the hallway crying while on her personal cell phone. She was near the nursing station on 9/30/22 at 12:25 p.m. crying, wanting extra blankets. D. Staff interviews The social services director was interviewed on 10/5/22 at 9:22 a.m. She stated that anxiety, crying, and hyperventilating were some target behaviors that the resident would exhibit for diazepam administration. She acknowledged that those behaviors and the non-pharmacological interventions should be on the resident's care plan. She reported that the psychotropic drug committee meets monthly with the pharmacist, physician, nursing home administrator (NHA) and the director of nursing (DON). 40960 II. Resident #4 A. Resident status Resident #4, age 92, was admitted on [DATE]. According to the September computerized physicians orders (CPO), the diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, depression, and generalized anxiety disorder. The 6/20/22 minimum data set (MDS) assessment revealed, the resident had cognitive impairment with a brief mental status score (BIMS) of four out of 15. He had inattention and disorganized thinking. He required supervision with dressing and was independent with all other activities of daily living (ADL). He had no behaviors and did not reject care. He wandered daily which placed him at risk of getting into a potentially dangerous place. He received anti anxiety medication daily. B. Record review The anti-anxiety medication care plan, revised 6/20/22, documented the resident used the medication for adjustment issues, anxiety, and periods of agitation. Pertinent interventions listed were to administer medications as ordered by the physician, monitor side effects and effectiveness, and attempt non drug approaches to assist in redirecting behavior. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The mood care plan, revised 7/7/22, documented the resident had alterations in mood and behaviors as evidence by outburst. Pertinent interventions listed were to administer medications as ordered and monitor/document side effects and effectiveness, anticipate and meet the residents needs, minimize potential for the resident's disruptive behaviors by offering tasks which divert attention, provide a program of activities that is of interest and accommodates resident status, and provide positive reinforcement/praise of the resident's progress/improvements/control in behavior. The September 2022 CPO documented, Lorazepam (anti-anxiety medication) give 0.5 mg (milligrams) by mouth every 4 (four) hours as needed (PRN) for anxiety times 90 days. The medication was started on 9/18/22 for 90 days. Review of the medication administration record (MAR) from 9/18/22 to 10/4/22 revealed the resident was administered the Lorazepam (brand name Ativan) PRN on 9/18/22 x two doses, 9/19/22 x two doses, 9/20/22 x two doses, 9/21/22, 9/22/22 x two doses, 9/23/22 x two doses, 9/24/22 x two doses, 9/25/22, 9/26/22 x two doses, 9/27/22, 9/28/22, 9/29/22, 10/1/22 x two doses, 10/2/22, and 10/4/22. -There were not any non-pharmacological interventions documented in the resident's progress notes. -Review of the progress notes revealed the physician failed to document a rationale for the continued use of the PRN Lorazepam after 14 days. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 9/29/22 at 4:07 p.m. She said Resident #4 would get aggressive and wander into other resident's rooms. She said if he could not be redirected, he would be given the PRN Lorazepam. She said PRN Lorazepam should be given until the ordered stop date. The pharmacist was interviewed on 10/4/22 at 4:48 p.m. She said she visited monthly and sat in the quality assurance/performance improvement (QAPI) and the psychotropic meetings. She said Resident #4 had been on Lorazepam since June 2022 and the PRN Lorazepam was started on 9/18/22. She said she did not advise a stop date after 14 days because he was already taking it routinely. 47351 III. Resident #34 A . Resident status Resident #34 was admitted on [DATE]. According to the September 2022 CPO diagnosis included Alzheimer's disease, anxiety, and depression. The 9/5/22 MDS assessment showed the resident had severe cognitive impairment with a score of two out of 15 on the brief interview for mental status (BIMS). The resident required limited assistance with activities of daily living. She had no behaviors and did not reject care. She wandered less than which placed her at risk of getting into a potentially dangerous place. She received anti anxiety, and an antidepressant medication daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review The 6/7/22 care plan identified the resident had an alteration in mood and behavior related to depression and anxiety. Pertinent interventions listed were to administer medications as ordered by the physician, monitor side effects and effectiveness, and assist the resident in developing/provide the resident with a program of activities that was meaningful and of interest and group exercise. Encourage and provide opportunities for exercise, physical activity. -The care plan failed to document the target behaviors and what non-pharmaceutical approaches were to be used. The September 2022 CPO documented the following: -Fluoxetine HCL capsule 20 mg by mouth once time a day for depression with a start date of 6/23/22; -Alprazolam 0.5 mg by mouth every two hours as needed for anxiety. Start date of 8/19/22. Review of the medication administration record (MAR) from 8/19/22 to 10/4/22 revealed the resident was administered the Alprazolam (brand name Xanax) PRN nearly every day at least one time a day and 18 times she received it twice and four times received it three times a day. Although there were target behaviors documented in the plan of care on 6/7/22 such as constant pacing, wandering and asking the same question over and over, there were not any non-pharmacological interventions documented in the resident's progress notes. The original order for the Alprazolam was received on 6/2/22 at 0.25 mg but was increased on 8/19/22 to 0. 5mg. The June 2022 MAR showed the mediation was administered daily and on 13 days it was given twice and once three times. -Review of the progress notes revealed the physician failed to document a rationale for the continued use of the PRN Alprazolam after 14 days. -The medical record did not have signed consents for either the Fluoxetine or the Alprazolam. C. Staff interview The social service director (SSD) was interviewed on 10/4/22 at 9:49 a.m. The SSD reviewed the record and confirmed the signed consents were not completed. She said the resident was admitted to the facility on the Alprazolam. She said that it helped calm her down. She said that the resident was severely cognitively impaired. She said she wandered and she asked the same question over and over. She said that the resident needed to be redirected. She said anytime the as needed medication was administered then a non-pharmaceutical should be attempted. The anti-depressant was added, as the resident was showing signs of sadness, which she no longer was showing. D. Facility follow-up The informed consent for the use of the Fluoxetine or the Alprazolam were signed by the power of attorney on 10/4/22.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 20287 Based on record review, and staff interviews, the facility failed to conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Specifically, the facility failed to develop a facility assessment which included all resources, staff education, staff competencies, and facility based risk assessments. Findings include: I. Record review The facility assessment was last reviewed on 4/8/22 by the nursing home administrator (NHA), director of nurses, and the interdisciplinary team. The facility assessment failed to include the following: -Include staff competencies that were necessary to provide the level and types of care needed for the resident population or include the staff training program to ensure any training needs are met for all new and existing staff; -Include staff trainings/education necessary to provide the level and types of support and care needed for the resident population; -Identify facility resources needed to provide competent resident support during day to day operations and emergencies; and, -Include the facility-based and community-based risk assessment, utilizing an all-hazards approach. II. Staff interviews The nursing home administrator (NHA) was interviewed on 10/5/22 at 6:40 p.m. The NHA said that she and the interdisciplinary team developed the facility assessment. The NHA reviewed the facility assessment and confirmed that although the assessment had some staff training, specified, however, dementia care and emergency preparedness were not included. The NHA said the facility-based risk hazards for their facility were fire, chemical spill and high winds. The NHA confirmed the risk hazards were not part of the facility assessment. The NHA said not all of the resources which the facility utilized were on the facility assessment or direction where the contracts were maintained. Although some staff competencies were on the facility assessment, abuse, change of condition, oxygen, mechanical lift, and nutritional services were some not on the assessment.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 40467 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and implement an effective system to identify facility concerns or address need for quality improvement in their QAPI program. Findings include: I. Facility policy The Quality Assurance Performance Improvement (QAPI) policy, updated February 2020, was provided by the nursing home administrator (NHA) on 9/26/22. The policy documented in pertinent part, This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven qapi program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are to: -Provide a means to measure current and potential indicators for outcomes of care and quality of life; -Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators; -Reinforce and build upon effective systems and processes related to the delivery of the quality care and services; and, -Established system through which to monitor and evaluate corrective actions. The QAPI Committee oversees implementation of our QAPI plan, which is the written component describing the specifics of the QAPI program, how the facility will conduct the QAPI functions, and the activities of the QAPI committee. The QAPI Plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: -Tracking and measuring performance; -Establishing goals and thresholds of performance measurement; -Identifying and prioritizing quality deficiencies; (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Systematically analyzing underlying causes of systemic quality deficiencies; -Developing and implementing corrective actions or performance improvement activities; and, -Monitoring or evaluating the effectiveness of corrective actions/performance improvement activities and revising as needed. The committee meets monthly to review reports, evaluate data, and monitor QAPI-related activities and make adjustments to the plan. II. Cross-referenced citations affecting quality of care identified during the facility's recertification on 10/5/22. A. F689, accident hazards The facility failed to ensure the resident environment remained as free of accident hazards as possible. This deficiency was cited at an K scope, immediate jeopardy at a pattern, for failure to ensure staff were prepared for a potential threat of fire due to lack of fire training and supplement oxygen management. Additional accident/hazards failures were identified related to fall prevention. B. F692, nutrition services cited at a G scope of severity, actual harm, isolated. C. F690, failures related to catheter care cried at a G scope, actual harm, isolated. D. F585, failure to respond to grievances of the resident council and individual residents, cited at E scope, potential for more than minimal harm, pattern. E. F600, failure to prevent abuse, cited at D scope, potential for more than minimal harm, isolated. F. F641, failure to have an accurate minimum data set (MDS) assessment, cited at an E scope, potential for more than minimal harm, pattern. G. F695, failures relating to respiratory services, cited at an E scope, potential for more than minimal harm, pattern. H. F725, failure to have adequate nursing staffing, cited at E scope, potential for more than minimal harm, pattern. I. F758, failures with unnecessary medications, cited at E scope, potential for more than minimal harm, pattern. J. F880, infection control failures, cited at E scope, potential for more than minimal harm, pattern. K. F882, failure to have a qualified infection preventionist, cited at F scope, potential for more than minimal harm, facility wide. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	L. F943, failure to have abuse and neglect training, cited at E scope, potential for more than minimal harm, pattern. M. F947, failure to have required inservice training, cited at an E scope, potential for more than minimal harm, pattern. III. The facility failed to self identify effective systems or need for quality improvement in their QAPI program. The NHA was interviewed on 10/5/22 at 4:23 p.m. She said the QAPI committee met monthly to continuously improve processes, meet standards and make sure not to miss anything. The NHA said all managers, the medical director, therapy service, the pharmacist, and the registered dietitian, participated in the monthly QAPI meeting. The NHA said during the meeting, the committee reviewed fire drills, facility plant concerns, safety meetings and resident council minutes, and any newly identified workmens' compensations concerns. She said the QAPI committee reviewed old business concerns, and status of new hired and terminated staff. The NHA said the committee discussed dietary and resident care conference concerns. She said the committee looked at medication utilization and new pharmacist processes interventions. The NHA said the QAPI committee also reviewed any breakdowns in departments such as turnover and infection control concerns. The NHA said the QAPI committee used various sources of data to identify problems for improvement including past surveys, the [NAME] quality indicator report, staff schedules, and clinical reports. She said data was collected weeking and graphed for review. The NHA said the committee then reviewed the generated findings and outcomes. She said the QAPI committee reviews additional input from family and resident satisfaction surveys. The NHA said when a concern was identified, the committee attempted to find the root cause using the Five whys method to find the breakdown. She said the committee used audits and education to sustain systematic changes. The NHA said the QAPI committee did not identify concerns with fire drills or training, even though the drills were reviewed during QAPI. The NHA said the management and delivery of oxygen was not identified as a concern or was reviewed in QAPI. The NHA said the oxygen management process would improve. The NHA said the facility would implement a system to monitor through rounding and audits. She said the committee would review the findings to identify the system breakdown and discuss ways to improve the process. The NHA said falls were reviewed in QAPI. She said the committee reviewed any identified fall trends, the type of the fall occurrences, residents with multiple falls, locations of the falls, and any interventions incorporated. The NHA said the committee also reviewed the root cause of the falls. The NHA said weight loss concerns were discussed in QAPI in prior months and their plan was to implement audits related to nutrition documentation and processes, however the audits were incomplete. She said the director of nursing (DON) was to complete the records but she has had to work as a floor nurse too often to do the audits. The NHA said staffing patterns, turn-over and open positions were reviewed in QAPI. She said hiring additional staff was determined based on the census. She said the facility could hire more staff as they increased the census. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The NHA said staff training has not been reviewed in QAPI. She said staff competencies were reviewed in March 2022. The NHA said the process for grievances was not reviewed in QAPI, only the actual identified concerns. The NHA said infection control was reviewed in QAPI. She said the committee reviewed trends of infections, illness related to the season, county and community levels, and identified transmission-based infections. The NHA said abuse was reviewed in QAPI. She said the committee reviewed any abuse allegations and investigations. She said the committee discussed interventions to prevent abuse. She said most of the QAPI review on abuse had been related to wandering residents with dementia. She said the facility incorporated activity sorting buckets and stop signs of resident room doors. The NHA said the committee identified a need for a new MDS coordinator to improve MDS accuracy. The NHA said psychiatric medications have been discussed with the pharmacist. The NHA said the pharmacist informed the committee that all prn meds needed to have a stop date. She said there had been a lack of response by the physicians so the committee would initiate the stop dates if the physicians would not. The NHA said additional identified the above (cited) concerns had not been reviewed in the QAPI committee in recent months. The NHA said the facility needed to implement changes in their QAPI process. She said the QAPI committee needed to work on how the committee identified concerns. She said the QAPI structure needed to change. The NHA said the committee needed to focus on how they identify concerns; how they implement the changes; how the facility documented identified issues, and how the committee evaluates and reevaluates the identified changes and processes. The NHA said QAPI needed to tighten its systems.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus (COVID-19) and infection for one out of two units. Specifically, the facility failed to: -Ensure housekeeping staff cleaned high-touch surfaces in resident rooms and follow manufacturer surface contact time during routine daily cleaning; -Ensure housekeeping staff followed the appropriate procedure when cleaning resident rooms and bathrooms; and, -Implement appropriate hand hygiene with glove changes. Findings include: I. Professional standards The Centers for Disease Control and Prevention (2020) Preparing for COVID-19 in Nursing Homes, updated 11/15/21, retrieved on 10/11/22 from: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html/, revealed in part: For environmental cleaning and disinfection: develop a schedule for regular cleaning and disinfection of shared equipment, frequently touch surfaces in resident rooms and common areas. Clean high-touch surfaces at least once a day or as often as determined is necessary. Examples of high-touch surfaces include: pens, counters, shopping carts, tables, doorknobs, light switches, handles, stair rails, elevator buttons, desks, keyboards, phones, toilets, faucets, and sinks. II. Product information The Disinfectant surface contact time, retreived on 10/11/22 from: https://www.spartanchemical.com//globalassets/sharepoint/product-literature--documentation---epidocuments/efficacy-bulletins/x-effect-efficacy-bulletin.pdf, revealed the surface must remain wet for 10 minutes. III. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/29/22 at 9:40 a.m., housekeeper (HK) #1 was observed preparing to enter room [ROOM NUMBER]. She used alcohol based rub (ABHR) and donned gloves. She removed a white rag and a red rag from the tub of disinfectant on top of the HK cart with a surface contact time of 10 minutes. She removed the toilet brush and the toilet bowl cleaner. She entered the bathroom, lifted the toilet seat and poured the toilet bowl cleaner into the toilet. She used the wet white rag to clean the top of the sink, the inside, the sides and bottom. She used the toilet brush to clean the toilet bowl and then placed it back into its holder. She used the wet red rag to clean the rim of the toilet, the side, the base, the seat, the lid, and the toilet tank. She used the same red rag to wipe down the over the toilet seat from top to bottom. She emptied the trash and placed the trash, the two rags, the toilet brush, and toilet cleaner back on the cart. She removed her gloves but did not use ABHR. She donned clean gloves. At 9:44 a.m. the sink and toilet were already dry. She emptied the room's trash and placed it on the cart. She removed a purple rag from the disinfectant tub. At 9:48 a.m. she used the purple rag to wipe down the over bed table from top to bottom. She placed the soiled rag into the hanging trash bag on the side of the cart. She removed a mop pad from the disinfectant in the mop bucket and the mop handle. At 9:50 a.m. she dropped the mop pad onto the floor and placed the mop handle on top of it. She mopped the room and pushed the debris to the room entrance and used a dustpan with a hand held brush to pick it up. She used a clean mop pad to mop the bathroom. At 9:54 a.m. the room's floor was dry. She placed the soiled mop pad from the bathroom onto the cart as well as the mop handle. She removed her gloves and placed a wet floor sign in the doorway. She did not use ABHR before pushing her cart to room [ROOM NUMBER]. -HK #1 failed to clean and disinfect highly touched areas such as door knobs, light switches, closet handles, night stand, call light, television remote, and the bed controller. She failed to perform hand hygiene after removing her gloves. She failed to follow the manufacturer's instructions of a 10 minute kill time. She failed to clean the toilet from top to bottom and clean to dirty. HK #1 was observed on 9/29/22 at 9:58 a.m. preparing to enter room [ROOM NUMBER]. She donned gloves and removed a wet rag from the disinfectant and a dry rag. She unlocked the cart and removed the toilet brush and the toilet bowl cleaner. She entered the bathroom, lifted the toilet seat and poured the toilet bowl cleaner into the toilet. She used the wet rag to clean the inside of the sink, the top of the sink, and the sides. She used the dry rag to immediately dry the sink. She used the toilet brush to clean the toilet bowl. She used the same wet rag to clean the toilet rim, sides of the toilet, under the seat, the seat, the lid, and then the toilet tank. She emptied the trash and placed the trash, the soiled rag, the dry rag, the toilet brush, and toilet cleaner back on the cart. She did not remove her gloves and removed a dry rag from the cart. She used the dry rag to dust the bedside table, the head board, the front of the bedside table, the top of the dresser, the bottom of the desk chair and the recliner. She placed the dry rag on the cart and doffed her gloves. She used ABHR and donned clean gloves. She removed the mop pad and mop handle from the cart. At 10:04 a.m. she dropped the mop pad onto the bedroom floor and placed the mop handle on it and began to mop the room. (continued on next page)

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	065249	A. Building B. Wing	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Tree Care Center	2050 S Main St Delta, CO 81416

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 10:07 a.m. the floor was beginning to dry. She used a clean mop pad to mop the bathroom. She removed the soiled mop pad from the handle and placed both of them on the cart. She placed a wet floor sign in the doorway. She removed a hydrogen peroxide wipe from the cart and cleaned the door knob and the light switch. She removed her gloves but did not perform hand hygiene. -HK #1 failed to clean and disinfect highly touched areas such as closet handles, night stand, call light, television remote, and the bed controller. She failed to remove her gloves and perform hand hygiene after cleaning the bathroom. She failed to follow the manufacturer's instructions of a 10 minute surface contact time. She failed to clean the toilet from top to bottom and clean to dirty. IV. Staff interviews HK #1 was interviewed on 9/29/22 at 10:09 a.m. She said she had only been working as a HK for two months. She said prior to that she was the facility hairdresser. She said she did not know what the surface contact l time was for the disinfectant. She said she had not received any training on how to clean and disinfect a room and had not yet taken the computer based training. She said she had not received any hand hygiene training and did not know what high touch areas were. The housekeeping supervisor (HKS) was interviewed on 9/29/22 at 10:15 a.m. She said she did not know the disinfectant surface contact time was 10 minutes. She said that was too long to keep the surface wet. She said since the contact time was 10 minutes, HK #1 should not have used a dry rag to dry the surfaces. She said she did not provide one-on-one training with the housekeeping staff. She said the computer based training was recently restarted and staff were trying to catch up on their required training. She said she did room checks but did not watch the housekeepers clean a room. She said she did not know the toilet should be cleaned from top to bottom and from clean to dirty. She said she had not received any training when she took over the HKS position. She said if the rooms were not cleaned properly, the facility could have an outbreak of any communicable diseases. She said she received training on cleaning high touch areas but did not pass the training to her staff because she figured it was common sense. She said she would immediately change disinfectants to a one minute surface contact and train her staff on proper cleaning techniques and proper hand hygiene. The executive director (ED) was interviewed on 10/4/22 at 9:52 a.m. She said the facility should not have been using a disinfectant with a 10 minute surface contact time because it would be difficult to keep the surface wet for that long. She said they would change the disinfectant to a one minute surface contact time solution. She said all housekeepers should be cleaning from top to bottom and clean to dirty. She said all high touch areas should be cleaned at least daily with the room cleaning and twice daily in the common areas or more frequently in an outbreak.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40960 Based on interviews and record review, the facility failed to employ an infection control preventionist (ICP) who had completed specialized training in infection prevention and control which had the potential to affect all 36 residents, including four who were currently on antibiotic therapy currently residing in the facility at the time of the survey. Specifically, the facility failed to have a qualified ICP involved with the facility's infection prevention and control program. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC), Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 9/23/22; retrieved on 10/6/22, from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control- recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2 F2019-ncov%2Fhcp%2Flong-term-care.html; read in pertinent part; This guidance is applicable to all U.S. settings where healthcare is delivered (including nursing homes). Nursing homes: Assign one or more individuals with training in ICP to provide on-site management of the IPC Program. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment. The CDC, Nursing Homes (long-term care facilities) Infection Preventionist (IP) Training, last reviewed 6/10/2020; retrieved on 10/6/22 form: https://www.cdc.gov/longtermcare/training.html; read in pertinent part: The nursing home infection preventionist training course is designed for individuals responsible for infection prevention and control (IPC) programs in nursing homes. The course covers core activities of effective IPC programs; and recommended IPC practices to reduce: pathogen transmission, healthcare-associated infections, and antibiotic resistance. II. Record review According to the Resident Census and Conditions form provided by the executive director (ED) on 9/26/22 at 11:00 a.m., the facility census at the time of the survey was 36 residents. The form documented there were four residents who were currently receiving antibiotics. The facility's last COVID-19 outbreak was 9/16/22. (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	III. Staff interviews The director of nursing (DON) and the executive director (ED) were interviewed together on 10/4/22 at 9:01 a.m. The ED said the DON was the acting ICP since the assistant director of nursing (ADON) position had not been filled. The DON said she had just recently taken over the position of ICP and had not yet started the Centers for Disease Infection Preventionist training, but was planning to start in the near future. The facility had no qualified ICP at the time of the survey.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews, the facility failed to implement policies and procedures related to pneumococcal immunizations for one (#9) of five residents reviewed for immunizations out of 26 sample residents. Specifically, the facility failed to provide the pneumococcal 23-valent polysaccharide vaccine (PPSV23) to Resident #9. Findings include: I. Professional standard According to the Centers for Disease Control and Prevention (CDC) Recommended Immunization Schedule for Adults Aged [AGE] years or Older, United States, 2020, retrieved from https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf (10/6/2022), the routine pneumococcal vaccination for adults aged [AGE] years or older and were immunocompetent, one dose of PPSV23 should be administered. II. Record review A. Resident #9 Resident #9, age 78, was admitted on [DATE]. According to the September 2022 computerized physician orders (CPO), the diagnoses included chronic respiratory failure with hypoxia (lack of blood oxygen). The 7/6/22 minimum data set (MDS) assessment revealed the resident was unable to complete the brief interview for mental status (BIMS). He had no behaviors and did not reject care. The resident's pneumococcal vaccination was not up to date and it was offered but declined. Resident #9's immunization record revealed the consent for the pneumococcal vaccination was signed by the resident on 6/29/22 giving permission to receive the vaccination. Review of the medication administration record (MAR) revealed the resident never received the vaccination. III. Staff interviews The admission nurse (AN) was interviewed on 10/3/22 at 10:27 a.m. She said when a resident was admitted they were offered the COVID 19 vaccination, the influenza vaccination and the pneumococcal vaccination. She said the resident signed a consent form for the vaccination and it was given to the assistant director of nursing (ADON) who was the infection preventionist (IP). She said the facility did not have an ADON for the past few months and she was not sure who the IP was at the facility (cross-reference F882). (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) and acting IP was interviewed on 10/4/22 at 2:01 p.m. After reviewing the residents immunization record, she said she was not sure why Resident #9 was not given the pneumococcal vaccination. She said she would immediately get a physician's order and order the vaccination from the pharmacy.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 20287 Based on record review and interviews, the facility failed to ensure all staff had current abuse and dementia care training. Specifically, the facility failed to ensure five out of five licensed nurses and CNAs reviewed within the previous year received dementia management training and abuse prevention training. Findings include: I. Record review Staff annual training for the selected nursing staff (CNAs and licensed nurses) were requested from the director of nursing on 10/3/22 at approximately 2:30 p.m. The facility was unable to provide the annual training which included, abuse, neglect and exploitation training and dementia care training. II. Staff interview The director of nurses was interviewed on 10/5/22 at 9:00 a.m. She said she did not have the training records and competency checklists. She said the assistant director of nursing (ADON) was no longer employed and she could not find the employee training logs and competency checklists. The DON said the abuse training and dementia training was completed on a computerized program, however, no logs could be found for completion for the selected staff. She said she would start to put a plan in place to ensure staff were completing the training. The corporate nurse was interviewed on 10/5/22 at 6:29 p.m. The corporate nurse said dementia and abuse training were required courses on the computerized training system. She said the names which were provided, they were unable to locate the records which showed they received the training.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 20287 Based on interviews and record review, the facility failed to ensure nurse aides received the required number of annual in-service training hours to ensure continued competence for four of four staff reviewed. Specifically, the facility failed to ensure certified nurse aides (CNA) #1, #5, #8 and #9 received 12 hours of continuing education annually. Findings include: I. Record review Staff annual 12 hour training for the selected nursing staff CNA #1, #5, #8 and #9 were requested from the director of nursing on 10/3/22 at approximately 2:30 p.m. The facility was unable to provide the annual training which included abuse, neglect and exploitation training and dementia care training, nutrition, accident hazards, emergency preparedness and dignity. II. Interviews The director of nurses was interviewed on 10/4/22 at 4:00 p.m. She said she did not have the training records and competency checklists. She said the assistant director of nursing (ADON) was no longer employed and she could not find the employee training logs and competency checklists. She said that she was actively alerting staff to start the training on the computerized system.