STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065267	A. Building B. Wing	04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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** 38185 Based on observations and interviews, the facility failed to ensure one (#37) out of 33 sample residents had the right to a dignified existence. Specifically, the facility failed to ensure Resident #37 was treated with dignity and respect by answering her call light timely and speaking to her in a respectful manner. Findings include: I. Resident #37 status Resident #37, age 84, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included major depressive disorder. The 2/8/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility and personal hygiene and extensive assistance of two people with toileting and transfers. A. Observations and resident interview On 4/10/22 at 11:32 p.m. Resident #37's call light was activated. -At 11:40 p.m. Resident #37 was observed walking with her front wheel walker from the nursing station down the hallway. Resident #37 said she had been waiting for 40 minutes for her call light to be answered. She said her mouth was very dry and she just wanted some ice water. She said her mouth was so dry, it was hard to talk. She said two certified nurse aides (CNAs) had been in her room and promised to bring her some ice water, but they never came back. She said she was just at the nursing station and the nurse manager gave her an ice water and potato chips. She said she did not understand why the nurse would give her potato chips which were high in salt when her mouth felt dry. She said she felt the nursing staff dinked around and did not do their job. She said the nurse was rude to her and she felt the nurse was disrespectful. (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	Resident #37's lips were dry and cracked. The resident had white build up in the corners of her mouth and connected from her upper lip to her bottom lip. She was moving her tongue out of her mouth and back in. Her tongue had white residue on the top. Resident #37 walked back to the 200 unit nursing station. Registered nurse (RN) #4 was sitting at the nursing station. Resident #37 told RN #4 she felt the staff were not doing their job and she did not understand why she was given potato chips. RN #4 said, honey, that is all you get. Resident #37 became visibly upset and told RN #4 not to call her honey and said that was disrespectful. RN #4, in front of Resident #37, said the resident was confused. She said the resident had come to the nursing station asking for water and snacks. She said when she tried to give her the water, the resident refused and then pushed aside the potato chips. -However, Resident #37 was holding a large Styrofoam cup of water, which she had received from RN #4. Resident #37 responded saying she was not confused and she did not refuse the water because it was in her hand. She said RN #4 did not give her a straw like she had asked. RN #4 got up and gave the resident a straw. Resident #37 then walked to her room. A CNA assisted and calmed the resident down from being visibly upset. II. Staff interviews The nursing home administrator (NHA) was interviewed on 4/11/22 at 4:00 p.m. She said RN #4 had called her around midnight and told her about an incident with Resident #37. She said she had started an investigation, but had yet to interview the resident because she had asked her to return later that evening. She said all residents deserve to be treated with dignity and respect. She said staff should not use terms such as honey and that could be construed as disrespectful. She said she had suspended RN #4 while the investigation was being completed. She said she reported an allegation of neglect to the State Agency.

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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** 46022 Based on record review and interviews the facility failed to ensure residents had the right to formulate advance directives by not keeping advance directives updated and current for two (#27 and #44) of two residents reviewed for advance directives out of 33 sample residents. Specifically, the facility failed to ensure the medical orders for scope and treatment (MOST) forms matched Resident #27 and Resident #44's physician orders. Findings include: I. Facility policy and procedure The Social Services Guidelines policy and procedure, revised [DATE], was provided by the assistant nursing home administrator (ANHA) on [DATE] at 3:00 p.m. It revealed in pertinent part, Advance care planning is defined as-A process used to identify and update the resident's preferences regarding care and treatment at a future time, including a situation in which the resident subsequently lacks capacity to do so. This is a comprehensive definition that includes decisions established by advance directives and decisions established through physician orders. III. Resident #27 A. Resident status Resident #27, age 66, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included type two diabetes mellitus, bipolar disorder, diarrhea, hypothyroidism, depression, heart disease, morbid obesity, gastro-esophageal reflux disease, diverticulitis and dermatitis. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required supervision for all activities of daily living (ADLs). B. Resident interview Resident #27 was interviewed on [DATE] at 2:07 p.m. He said he had reviewed his MOST form with the facility staff in a care conference. He said he wished to be a do not resuscitate (DNR). C. Record review The MOST form, dated [DATE], documented Resident #27 wished to be a do not resuscitate (DNR). The [DATE] CPO documented the following physician order: (continued on next page)

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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	-Code status: full code-ordered [DATE] (indicating resuscitation an event of cardiac arrest) D. Staff interview Licensed practical nurse (LPN) #2 was interviewed on [DATE] at 2:09 p.m. She said if she found a resident unresponsive she would check the physician orders for the resident 's code status. She confirmed the physician 's orders for Resident #27 's code status and the MOST form did not match. The social services coordinator (SSC) was interviewed on [DATE] at 4:02 p.m. He confirmed the MOST form documented Resident #27 wanted to be DNR, while the CPO indicated the resident was a full code. He said a staff member must have updated the MOST form with the resident and did not update the physician orders to ensure they matched. The interim director of nursing (IDON) was interviewed on [DATE] at 5:20 p.m. She said the physical MOST form should match the CPOs. She said if a resident was to become unresponsive, nursing staff could look at the physical MOST form or the physician's other; therefore, they should match. IV. Resident #44 A. Resident status Resident #44, age 85, was initially admitted on [DATE] and readmitted on [DATE]. According to the [DATE] CPO, the diagnoses included hyponatremia, type two diabetes mellitus, dementia, hypertension, hearing loss and chronic kidney disease. The [DATE] MDS assessment revealed the resident had cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance with one person for dressing, toileting, personal hygiene, and locomotion. B. Record review The [DATE] MOST form documented Resident #44 wished to be a DNR, but wished for a defibrillator to be used in a circumstance of cardiac arrest and not chest compressions. The physician order read DNR. The [DATE] (during the survey) physician order read: full code defibrillator only, no cardiopulmonary resuscitation (CPR). C. Staff interviews LPN #2 was interviewed on [DATE] at 3:10 p.m. She said Resident #44 was a DNR, but the directions on the MOST form indicated the resident wanted to receive defibrillator treatment in the circumstance of a cardiac arrest. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #2 said if the resident was to receive defibrillator treatment she would be considered a full code. The IDON was interviewed on [DATE] at 5:10 p.m. She confirmed Resident #44 would be considered a full code if she wanted to receive a defibrillator treatment following cardiac arrest. She said the MOST form should have been reviewed with the power of attorney (POA) and the physician to clarify the order.

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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 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. 46022 Based on interviews and record review, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to provide resolutions to food concerns voiced by residents in the food committee, resident council and reported directly to a staff member. I. Facility policy and procedure The Patient Protection policy, revised October 2021, was provided by the assistant nursing home administrator (ANHA) on 4/18/22 at 2:30 p.m. It revealed in pertinent part, The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment, which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their long-term care (LTC) facility stay. The facility must make information on how to file a grievance or complaint available to the resident. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file fiances orally or in writing; the right to file grievances anonymously; the contact information for the grievance official with who a grievance can be filed, that is, his or her name, business address (mailing and email), and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, Status Survey Agency and State Long-Term Care ombudsman program or protection and advocacy system. Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusion regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. II. Resident council president interview The resident council president was interviewed on 4/18/22 at 10:32 a.m. He said grievances were often voiced to him from other residents at the facility or during resident council meetings. He said residents rarely received acknowledgement when a grievance was filed. He said there was never follow-up that the concern had been investigated or the resolution. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident interviews All residents were identified by the facility and assessment as interviewable Resident #64 was interviewed on 4/6/22 at 12:10 p.m. The resident said the food was good half of the time and half of the time it was not good. The vegetables were cooked to death and the food in general need more seasoning, butter and salt would help the food. Resident #59 was interviewed on 4/6/22 at 3:07 p.m. The resident said the food was not good. The meat was tough which made it hard to cut, and the vegetables were overcooked. She said she felt that the staff did not follow recipes. Resident #56 was interviewed on 4/6/22 at 3:40 p.m. The resident said the food had no taste. The meat was hard and was difficult to chew. Resident #20 was interviewed on 4/6/22 at 4:24 p.m. The resident said the food was not good. She said the eggs were not cooked right and they were super hard. She said the egg rolls which were served last night were not edible as they were hard. Resident #68 was interviewed on 4/7/22 at 9:49 a.m. The resident said the food looks good, however, it was too salty. Resident #51 was interviewed on 4/7/22 at 10:17 a.m. the resident that the food did not taste good. He said that the food needed to have more flavor. He said it was not always served hot. IV. Record review A. Resident council minutes The resident council minutes were provided by the activities director (AD) on 4/18/22 at 2:30 p.m. The minutes documented the following: -January 2022: the residents requested butter instead of margarine; -February 2022: the resident's reported their meals were being delivered late; and, -March 2022: the residents reported they did not like scrambled eggs or confetti eggs. B. Food committee minutes The AD provided the food committee minutes on 4/19/22 at 4:52 p.m. However, the minutes were individual progress notes from the medical records from three residents. The 3/22/22 progress notes documented the residents attending the food committee meeting, were able to review upcoming proposed menus and were able to ask questions, voice opines and make suggestions. Dietary provided residents with a copy of the menus and his name and contact information. -The committee minutes did not identify the concerns of the residents. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews The AD was interviewed on 4/18/22 at 2:50 p.m. She said about half of the residents voiced concerns about food. She said recently there were no concerns about the food in resident council meetings, except regarding the scrambled eggs. The AD said the food council had not met for a while. She said there had been a turnover in the food service director (FSD). She said that the menu cycle has been switched. She said when food complaints were received in the food committee or the resident council then they were presented to the FSD to follow up on. The AD was interviewed a second time on 4/18/22 at 4:52 p.m. The AD said after looking for the food committee minutes, it was identified that the food committee was not documented correctly for the grievance process. She said they would write a performance improvement plan (PIP). The FSD was interviewed on 4/19/22 at approximately 3:00 p.m. The FSD said he had heard some food complaints. He said he would talk to the resident if he knew someone was not happy with the meal. He said he had not received any grievance forms from either resident council or the food committee. The social services director (SSD) was interviewed on 4/19/22 at 10:38 a.m. He said the facility uses an electronic system for grievances. He said when residents reported grievances to a staff member, they were responsible for submitting the grievance into the electronic system. He said whoever entered the grievance was responsible for assigning it to the correct department. He said the nursing home administrator (NHA) was the only one that had the authority to resolve the grievance. He said he reported the amount of grievances and the areas of concern in the monthly quality assurance meeting. -A copy of the report was not provided before the survey exit on 4/19/22. 20287 Based on interviews and record review, the facility failed to ensure residents were provided prompt efforts by the facility to resolve grievances. Specifically, the facility failed to provide resolutions to food concerns voiced by residents in the food committee, resident council and reported directly to a staff member. I. Facility policy and procedure (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Patient Protection policy, revised October 2021, was provided by the assistant nursing home administrator (ANHA) on 4/18/22 at 2:30 p.m. It revealed in pertinent part, The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or repirsal. Such grievances include those with respect to care and treatment, which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their long-term care (LTC) facility stay. The facility must make information on how to file a grievance or complaint available to the resident. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents ' rights contained in this paragraph. Notifying resident individually or through postings in prominent locations throughout the facility of the right to file frivances orally or in writing; the right to file grievances anonymously; the contact information for the grievance official with who a grievance can be filed, that is, his or her name, business address (mailing and email), and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, Status Survey Agency and State Long-Term Care ombudsman program or protection and advocacy system. Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident ' s grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusion regarding the resident ' s concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. II. Resident council president interview The resident council president was interviewed on 4/18/22 at 10:32 a.m. He said grievances were often voiced to him from other residents at the facility or during resident council meetings. He said residents rarely received acknowledgement when a grievance was filed. He said there was never follow-up that the concern had been investigated or the resolution. III. Record review The resident council minutes were provided by the activities director (AD) on 4/18/22 at 2:30 p.m. The minutes documented the following: -January 2022: the residents requested butter instead of margarine; -February 2022: the resident ' s reported their meals were being delivered late; and, -March 2022: the residents reported they did not like scrambled eggs or confetti eggs. IV. Staff interviews (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The AD was interviewed on 4/18/22 at 2:50 p.m. She said about half of the residents voiced concerns about food. She said recently there were no concerns about the food in resident council meetings, except regarding the scrambled eggs. She said the dietary team held a food committee meeting. She said this meeting had not been held regularly because there were staffing changes in the kitchen. The social services director (SSD) was interviewed on 4/19/22 at 10:38 a.m. He said the facility uses an electronic system for grievances. He said when residents reported grievances to a staff member, they were responsible for submitting the grievance into the electronic system. He said whoever entered the grievance was responsible for assigning it to the correct department. He said the nursing home administrator (NHA) was the only one that had the authority to resolve the grievance. He said he reported the amount of grievances and the areas of concern in the monthly quality assurance meeting. A copy of the report was not provided during the survey process.

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F 0603 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews, record review and observations, the facility failed to ensure the resident had the right to be free from involuntary seclusion not required to treat the resident's medical symptoms for one (#59) of three out of 33 sample residents. Specifically, the facility failed to ensure Resident #59 was kept free from involuntary seclusion which resulted in psychosocial harm. Resident #59, who had a documented history of anxiety, claustrophobia and was totally dependent upon staff, activated her call light on 3/19/22 to get staff assistance. The resident had a history of yelling out, after activating her call light, because of past experiences of staff not answering her call light timely. The facility staff closed the resident's door, against her wishes (which was documented in the resident's plan of care), because the resident was disturbing others, effectively secluding the resident against her will. The resident's wishes of keeping her door open while she was alone was well documented in the resident's medical record and staff interviews revealed the facility staff had been aware of the resident's wishes for over a year. The resident stated, in an interview with the psychologist four days after the incident, with the door shut, no one could hear her call for help. She felt the staff were punishing her, felt she was suffocating, her heart was racing and thought she might die. After the incident, an interview with the social services coordinator (SSC) documented Resident #59 replayed the event since it occurred, caused her emotional distress and had a continued negative psychological and emotional effect on the resident daily. Findings include: I. Facility policy and procedure The Patient Protection policy and procedure, dated October 2021, was provided by the nursing home administrator (NHA) on 4/6/22 at 2:00 p.m. It revealed, in pertinent part, The most critical step toward detecting and preventing abuse is acknowledging that no one should be subjected to violent, abusive, humiliating, exploitative or neglectful behavior. -Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. -Mental abuse includes, but is not limited to humiliation, threats of punishment or deprivation. -Involuntary seclusion is defined as separation of a patient from other patients or from his/her room or confinement to his/her room (with or without roommates) against the patient's will, or the will of the patient's legal representative. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	II. Failure to ensure the resident was kept free from psychological abuse A. Resident #59 status Resident #59, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included congestive heart failure (CHF), pressure ulcer, pressure induced deep tissue damage of unspecified site, type two diabetes, moderate persistent asthma, chronic obstructive pulmonary disease (COPD), chronic pain, trigeminal neuralgia, fibromyalgia and generalized anxiety disorder. The 3/4/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident did not exhibit physical or verbal behaviors during the assessment period. The resident rejected care for four to six days during the assessment period. B. Resident and frequent visitor interview Resident #59 was interviewed on 4/6/22 at 2:49 p.m. She said she did not like it when the staff shut the door to her room. She said she was claustrophobic and with her diagnosis of COPD, she felt like she could not breathe when the staff shut her door. She said she was totally dependent upon staff for all of her care and was unable to get out of bed without assistance. She said she was not able to walk. She said she had been at the facility for quite a few years and felt the staff did not like her very much. She said there was a history of the staff not answering her call light timely so she had gotten into the practice of yelling out for help when she pushed her call light. She said she felt the facility staff would not answer her call light unless she yelled out. She said the staff at night were particularly bad about answering her call light. She said Saturday night, on 3/19/22, she had activated her call light because she needed to be changed because of a bowel movement. She said the staff did not answer, so she began to yell out, answer my call light and I need help. She said one of the certified nurse aides (CNA) came to her room, stood in the doorway, told her to stop screaming, told her she was being disruptive to other residents, and then shut the door. She said she felt like she was being punished. She felt like she could not catch her breath and started to panic. She said she screamed as loud as she could for help. She said she did not know how much later, after she started screaming, a nurse entered her room to help her. The nurse sat with her until the CNAs came back to provide incontinence care. She said she told the social services coordinator (SSC) about what happened and he completed a form (trauma informed care evaluation, see under record review). She said she did not feel as though anything was done. She said she still gets blamed for calling out when she activates her call light. She said she would not call out if she trusted they would answer her call light. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	A frequent visitor with knowledge of the resident was interviewed on 4/11/22 at 12:18 p.m. She said it was a known fact at the facility that Resident #59 did not want her door to be closed. She said the facility had been aware of this for at least over a year, if not longer. She said Resident #59 was afraid the facility staff would not answer her call light if she had an emergency. She said it caused distress to the resident, which was why when she pushed her call light, she would also yell out for help. She said the facility had a history of long call light time periods and felt the resident was justified in her concern. She said, in the past year, the facility had been using a lot of agency staff. She said many residents had reported an overall attitude with the staff toward the residents, felt they were overworked and when they entered a resident's room, the staff were quick to get in and out and not really addressing the resident's needs. C. Observations On 4/11/22 at 11:31 a.m. Resident #59 activated the call light. CNA #4 was walking down the hallway and entered the resident's room. CNA #4 turned off the call light and walked back to the nursing station. Resident #59 reactivated the call light and began yelling out, where did my aide go,and come back and I need to be changed. CNA #4 was observed grabbing towels, sheets and walking slowly down the hallway toward the resident's room. CNA #4 arrived at the doorway of Resident #59's room at 11:42 a.m. She pulled down her N95 respirator mask, and yelled from the doorway, I told you I was going to get supplies. What do you want me to do, slip and fall? CNA #4 then entered the room and shut the door. Another CNA entered the room to assist a few minutes later. Both CNAs exited the resident's room at 11:53 a.m. after providing the resident incontinence care. -At 11:54 a.m. Resident #59 activated her call light. After two minutes, the resident yelled out, I need a nurse. CNA #4 told licensed practical nurse (LPN) #2 I have no idea what she needs. We just got out of there. Resident #59 began yelling out, I need Tylenol, and please answer my call light and please just answer my call light. LPN #2 opened the medication drawer, pulled out a medication and put it into a medication cup. She lifted her head toward the ceiling, let out a deep breath, locked the medication cart and entered the resident's room. -At 12:00 p.m. Resident #56 activated her call light. The CNAs were observed passing out meal trays for lunch and LPN #2 was standing at the medication cart in close proximity to the resident's room. Resident #59 yelled out, I need a blanket. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	LPN #2 shook her head, back and forth, looked up to the ceiling, let out a deep breath, locked the medication cart and entered the resident's room. LPN #2 turned off the call light and exited the room. She told CNA #4, Resident #59 needed a blanket and she had told her the CNAs were busy and she needed to wait. CNA #4 said she would get a blanket for the resident when she was finished passing meal trays. On 4/12/22 at 8:01 p.m. Resident #59's call light had been activated for an unknown amount of time. Resident #59 was not yelling out. Upon entering the 200 unit nursing station, LPN #3 and CNA #1 were observed sitting at the nursing station. CNA #1 was scrolling on her phone and LPN #3 was on the computer. The call light board was lit up and making an audible beeping noise with Resident #59's room highlighted. When CNA #1 looked up from her phone, she put her cell phone in her pocket, walked out of the nursing station and entered Resident #59's room. D. Documented history of the resident's claustrophobia, wish to not have the door closed and dependence upon staff The activities of daily living care plan, initiated on 11/21/17 and revised on 12/30/21, revealed the resident had a self-care deficit related to weakness, COPD, obesity, a contracture to the hand, foot drop to both feet and the resident's hospice status. It indicated the resident required two person assistance with a Hoyer lift for transfers and the resident required care in pairs. The claustrophobia care plan, initiated on 1/21/21, documented the resident had reported to the nurse and executive director that she was claustrophobic. The interventions included do not close the resident's door unless it is for short periods of time to provide privacy during care. The anxiety care plan, initiated on 2/25/21 and revised on 6/14/21, documented the resident was at risk for anxiety. The resident would call out for help despite using the call light. She would request for tissues to be picked up off the floor and to move her water. The interventions included: re-educating the resident that sometimes staff cannot be there right at the scheduled time to assist the resident with care due to having to assist other residents. The verbal agitation and aggression care plan, initiated on 3/4/21, documented the resident calling out for help from the nurses or CNAs after activating the call light. It indicated the resident would continue to yell after the staff told her someone would be in to help. The resident was very particular and rigid on what time she wanted care to be provided. If the staff was not in her room at the designated times, then the resident would yell out for help until someone comes to provide care. The Kardex (a staff directive for care), undated, documented to leave the resident's door open at all times, except for privacy during care. If the resident requested to have her door shut when in the room by herself, get a witness to clarify the resident's request. E. Incident on 3/19/22 (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	The 3/23/22 individual therapy notes documented the resident met with a psychologist. It indicated, in addition to being anxious the resident is claustrophobic. The Saturday night staff lost patience with her and shut her door. With the door shut, no one could hear her call for help. She felt the staff was punishing her. She felt she was suffocating, her heart was racing and thought she might die. Finally, the nurse came in and made sure she had the assistance she needed. The 3/23/22 nursing progress note documented the resident met with the psychologist. The resident reported that the staff shut her door on Saturday, 3/19/22. She said she felt this was done because the staff were punishing her. It indicated an investigation was started. The 3/23/22 abuse investigation revealed the resident reported to the director of nursing (DON) that her room door was closed on 3/19/22 by the facility staff. The resident said she was claustrophobic and did not want her door closed. The resident said she felt like the facility staff were punishing her. The resident statement documented, Saturday night was a nightmare for me. When I can ' t get anyone on the call light, I call out from my room and the staff does not like it so they closed the door which I think was to punish me. They say it's because my calling out disturbs other residents. But I ' m claustrophobic and I couldn ' t breathe. If I had my phone, I would have called 911 or the police because I panicked. Finally, a nurse came back approximately 30 minutes later but it felt like two hours. I don ' t report anyone unless I ' m fearful of them and I never want to see the staff member who closed the door on me ever again. The investigation documented the staff who worked on 3/19/22 were interviewed and said they had shut the door to the resident's room, but left it cracked because they were caring for another resident and Resident #59 was being disruptive and screaming out. It indicated all staff were educated to keep the resident's door open at all times unless they were providing care. The conclusion of the investigation documented neglect was unsubstantiated, the resident's care plan had been updated to keep the door open at all times unless providing care, a trauma assessment was completed and the resident would continue to have follow ups with social services. -However, based on the interviews with the staff documented in the investigation, the staff admitted to shutting the door to the resident's room and left it open a crack because she was disturbing other residents, which effectively secluded the resident against her will. The resident's wish of not having her door shut when she was by herself was well documented in the resident's medical record. F. Documentation of continued emotional distress from the incident on 3/19/22 The 3/24/22 social services progress note documented the SSC followed up with the resident who had reported a concern with her treatment by the facility staff. It indicated the resident frequently spoke of the incident on 3/19/22, appeared to still be distressed about what happened and appeared to still bother and affect the resident daily. The SSC indicated he ensured the resident's care plan indicated the resident's preference to never have her door shut, unless the staff were in the room providing care. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	The 3/24/22 trauma informed care evaluation revealed the incident on 3/19/22 was considered the worst event by the resident and the event that bothered her the most. It indicated the following: -The resident had quite a bit of episodes of disturbing and unwanted memories of the stressful experience; -The resident had episodes of suddenly feeling as though the stressful experience was happening again, as if she was reliving the incident; -Felt upset quite a bit when something reminded her of the incident; -Had quite a bit of strong physical reactions when something reminded her of the incident; -Avoided memories, thoughts, or feelings quite a bit related to the stressful experience and external reminders of the stressful experience; -Had quite a bit of negative beliefs about herself and negative feelings such as fear, horror, anger, guilt, or shame; and, - Felt super alert, watchful or on guard, jumpy or easily startled quite a bit. III. Staff interviews The SSC was interviewed on 4/11/22 at 4:47 p.m. He said he had worked at the facility since October 2021. He said he was the social worker for Resident #59. He said the resident was overall a very pleasant person. He said she would call out when she needed help after activating her call light. He said she had told him there was a history of the staff not answering her call light timely. He said she felt helpless because she was totally dependent upon staff, so if they did not answer her call light, she would not get what she needed. He said the resident did not like her door to be shut. He said she was claustrophobic and it had been documented in the resident's care plan. He said he had updated the resident's care plan after the incident, but the resident's wishes had been documented in the resident's care plan for over a year. He said he spoke with the resident about the incident that occurred on 3/19/22. He said the facility staff had closed her door when she was calling out for help. He said Resident #59 was claustrophobic and was shook up after the incident. He said the resident's impression was the staff were trying to punish her because she called out. He said he was not aware of the results of the investigation. Certified nurse aide (CNA) #3 was interviewed on 4/12/22 at 10:40 a.m. He said Resident #59 was totally dependent upon staff for assistance with all activities of daily living. He said she was not able to get out of the bed on her own without two person assistance and a mechanical lift. (continued on next page)

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F 0603 Level of Harm - Actual harm Residents Affected - Few	He said Resident #59 called out for assistance because she was afraid the call light would not be answered. He said she would call out for help even if the call light had only been activated for a minute. He said he thought this was because of a history of the staff not answering her call light timely. He said she did not like it when her door was closed unless someone was in the room with her. He said she was claustrophobic and had anxiety. He said Resident #59 wanting her door open was common knowledge and was not a new request by the resident. The NHA was interviewed on 4/12/22 at 4:44 p.m. She said Resident #59 had reported on 3/19/22 the night shift staff had shut her door because she was calling out for help. She said Resident #59 said she was claustrophobic and felt she was being punished by the facility staff for calling out for help. She said it was documented in the resident's chart for a long time that she did not want her door to be closed when someone else was not with her. She said the incident occurred on 3/19/22 and it was reported, by the resident, to the psychologist on 3/23/22. She said the facility conducted an investigation and reported the allegation of neglect to the State Agency. She said the SSA interviewed the resident and other nursing management interviewed the staff. She said she signed off on the final investigation. She said the investigation concluded the allegation of neglect was unsubstantiated because the staff did not have intent to harm the resident. She said she had not considered the potential of involuntary seclusion as a form of abuse from the incident. She confirmed in the interviews, the staff admitted to shutting the resident's door, but left it open a crack because she was disturbing other residents by calling out. She said she felt abuse was unsubstantiated because the staff did not intend to harm the resident. -However, the resident sustained psychosocial harm from the event on 3/19/22, when the facility staff, who were aware of the resident's claustrophobic tendencies and wishes to have her door kept open, closed her door because they felt she was disturbing other residents. The resident began to panic, screamed out for help and thought she was going to die.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review, and interviews, the facility failed to revise and review comprehensive care plans for four (#51, #23, #68, and #22) of 18 residents out of 33 sample residents. Specifically, the facility failed to: -Ensure Resident #51's care plan was reviewed and revised to reflect the resident's range of motion needs; -Ensure Resident #23 care plan was integrated with hospice services; and, -Ensure Resident #68 and Resident #22 were invited and participated in their plan of care conference and care plan updated accordingly. Cross0reference F688 for range of motion Findings include: I. Professional reference According to [NAME], P., & [NAME], A., & Stockert, P., & Hall, A. (2017) Fundamentals of Nursing (9th ed.), pp. 248-249, which read in pertinent part, A nursing care plan includes nursing diagnoses, goals, and/or expected outcomes, specific nursing interventions, and a section for evaluations so any nurse is able to quickly identify a patient's clinical needs and situation. Nurses revise a plan when a patient's status changes. The plan gives all nurses a central document that outlines a patient's diagnoses/problems, the plan of care for each diagnosis/problem, and the outcomes for monitoring and evaluating patient progress. A well-planned comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later for evaluation. The plan of care communicates nursing priorities to nurses and other healthcare providers. II. Resident #51 A. Resident status Resident #51, age 62, was admitted on [DATE]. According to the April 2022 computerized physician order (CPO) diagnoses included cerebral vascular accident (CVA), and hemiplegia and hemiparesis following cerebral infarction affecting right non- dominant side. The 2/22/22 MDS assessment coded the resident with a brief interview for mental status of 15 out of 15. The MDS showed the resident had impairment on one side for both upper and lower extremities. The resident required extensive assistance with personal hygiene. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident interview The resident was interviewed on 4/7/22 at 10:33 a.m. The resident said he did not receive range of motion on his right hand or his upper extremity or lower right extremity. C. Record review The care plan last updated on 2/1/22 identified the resident had self care deficit related to CVA to right hemiparesis and right hand contracture. Interventions included, to assist with grooming, bed mobility, transfers, toileting, dressing, and oral care, encourage and assist to reposition. Transfers two person mechanical lift. The care plan did not include interventions to provide the range of motion to his upper extremity, and lower extremity. -No orders were revealed for Resident #51. The kardex last updated dated 4/18/22 failed to show range of motion to his hand contracture and his lower extremities. III. Resident #23 A. Resident status Resident #23, age 84, was admitted on [DATE]. According to the April 2022 CPO diagnoses included, major depressive disorder, hypertension and post polio syndrome. The 1/26/22 MDS assessment showed the resident was severely cognitively impaired with a score of four out of 15 on the BIMS. The resident required extensive assistance with activities of daily living. The resident was receiving hospice services. B. Record review The April 2022 CPO showed the resident had a physician order for hospice services with the associated diagnosis of post polio syndrome. The care plan last updated on 11/3/21, failed to include an integrated care plan with the hospice services. The care plan identified the resident was receiving hospice services, however, it did not identify the specifics of what services were provided. The hospice agency had developed an individual care plan which was in the medical record. However, it was not integrated with the facility care plan. C. Interview (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The licensed practical nurse (LPN) #6 was interviewed on 4/7/22 at approximately 2:00 p.m. The LPN #6 said Resident #23 was currently on hospice. She said the hospice agency sent in a licensed nurse and also a certified nurse aide, however, she was not sure when they came into the facility. IV. Resident #68 A. Resident status Resident #68, age 75, was admitted [DATE]. According to the April 2022 computerized physician orders (CPO) diagnoses included hypertension, and major depressive disorder. The 3/17/22 MDS assessment coded the resident with moderate cognitive impairment with a score of 13 out of 15 on the brief interview for mental status. The resident required limited assistance with activities of daily living. B. Resident interview The resident was interviewed on 4/7/22 at 9:48 a.m. The resident said that she had not been invited to a care conference meeting. She said she wanted to be involved in her plan of care. C. Record review The care plan progress note dated 3/17/22 documented the resident was interviewed and the MDS assessment was completed by the MDS coordinator. The medical record from the resident's admitted to April 2022 failed to show a care conference was held for Resident #68. The director of rehabilitation (DOR) was interviewed on 4/18/22 at 12:03 p.m. The DOR said the range of motion and management of the contracture should be on the care plan and the kardex. V. Resident #22 A. Resident status Resident #22, age 68, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included adult failure to thrive, hypertension, type 2 diabetes mellitus, chronic respiratory failure, quadriplegia, post-traumatic stress disorder, chronic pain, and generalized muscle weakness. The 1/25/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance from two staff members for bed mobility, dressing, toileting, and personal hygiene. B. Resident interview (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was interviewed on 4/6/22 at 11:17 a.m. The resident said she did not receive passive range of motion exercises on her upper extremities. She said that she had been asking for physical therapy, but had not received any therapy. The resident did not recall having a care conference. C. Record review The care plan last dated 7/23/21 identified the resident had self care deficit as evidenced by impaired mobility related to physical limitations, quadriplegia, right hand contracture, obesity, chronic pain, and type 2 diabetes mellitus. Interventions included transfer with mechanical lift, assist to bathe/shower as needed, break activity of daily living (ADL) tasks into subtasks for easier patient performance, Extensive assist with bed mobility, transfers, toileting, daily hygiene, grooming, dressing, oral care and eating as needed and uses assistive/adaptive equipment (wheelchair). The care plan did not include interventions to provide the range of motion to her upper extremities. No orders were revealed. The kardex dated 4/12/22 failed to show range of motion to her bilateral hand contractures. No care conference was documented in the resident's medical records. The social services director (SSD) was unable to find any documentation of a completed care conference. VI. Interviews The director of rehabilitation (DOR) was interviewed on 4/18/22 at 12:03 p.m. The DOR said the range of motion and management of the contracture should be on the care plan and the kardex. The MDS coordinator (MDSC) was interviewed on 4/18/22 at 4:03 p.m. The MDS coordinator said the progress note was her note she wrote when she completed the MDS assessment. It was not a care conference note. The MDSC said social services set the schedule and provided the invitations to residents. She said the care plans were reviewed and revised during the care conferences. The social service director (SSD) was interviewed on 4/19/22 at 10:37 a.m. The SSD said the standard procedure was to review in a care conference on a quarterly, change of condition or if the resident or family wanted to meet for a meeting. He said that the interdisciplinary team which included, social services, activities, nursing, registered dietitian. The resident and or family were invited. He said during the meeting the resident's plan of care and goals were discussed. The SSD said he and the SSA were recently hired within the past six months. He said the facility had identified in January 2022 that care conferences were not completed. He said an audit was done and he had written a performance improvement plan. He said that they did not have an overall goal set, but thought they could be caught up by the end of the month. The SSD reviewed the medical record and confirmed although the resident had an MDS assessment completed in March 2022, the resident did not have a care conference meeting. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ANHA was interviewed on 4/19/22 at approximately 2:00 p.m. The ANHA said the range of motion should be on the care plan. The ANHA reviewed the care plan and confirmed the range of motion and management of the contracture was not on the care plan 45889

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on record review, observations and interviews, the facility failed to ensure services provided to three (#24, #32 and #13) of 33 sample residents met professional standards of practice. Specifically, the facility failed to ensure an assessment was completed and documented by a registered nurse (RN) following a fall sustained by Resident #24, Resident #32 and Resident #13. Findings include: I. Resident #24 A. Resident status Resident #24, age 85, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPOs), the diagnoses included dementia with behavioral disturbance, adult failure to thrive, macular degeneration, muscle weakness, obsessive compulsive behavior, and history of falling. The 1/27/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of one person with bed mobility, toileting and personal hygiene. She required limited assistance of one person with dressing, transfers, and walking in the resident's room. It indicated the resident had experienced falls since the prior assessment, one with a sustained injury. B. Observations On 4/11/22 at 4:52 p.m. Resident #24 was observed sitting on the floor. Licensed practical nurse (LPN) #2 was observed entering the resident's room. LPN #2 lifted the resident off the floor, by herself, prior to an assessment being conducted to determine if the resident sustained an injury. Certified nurse aide (CNA) #1 entered the room and asked if the resident was okay because Resident #24 was crying. CNA #1 told Resident #24 she fell because she did not have her socks on. LPN #2 got the vital signs machine and began obtaining the residents vital signs. LPN #2 did not call an RN to conduct an assessment of the resident to determine if the resident had sustained an injury. C. Record review The 1/26/22 nursing progress note documented Resident #24 sustained a fall at 8:20 a.m. LPN #1 documented the resident was walking around the bed with no shoes or socks on, when she plopped on the floor in the sitting position. LPN #1 documented she and the CNA lifted the resident up, checked the resident's bottom for injuries and placed the resident back in the wheelchair. LPN #1 educated the resident to wear non-skid socks and use the call light for assistance. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/26/22 fall investigation recounted the details of the fall documented in the nursing progress note. It indicated LPN #1 had assessed the resident and found no injury or bruising. It did not document LPN #1 contacted an RN to complete an assessment of the resident following the fall and prior to moving the resident off the ground. The 2/10/22 nursing progress note documented the resident had an unwitnessed fall at 4:00 p.m. The resident said she slid from the wheelchair. LPN #7 documented she assisted the resident off the floor and into the wheelchair. LPN #7 notified the resident's representative and the physician. It indicated the resident did not complain of pain. The 2/10/22 fall investigation documented a CNA found the resident on the floor after sliding off the wheelchair. It indicated no injuries were found. The fall investigation was completed by LPN #7. It did not indicate an RN had been contacted to complete an assessment of the resident following the fall and prior to being assisted off the ground by LPN #7. No RN assessment was found in the residents chart. The 4/2/22 nursing progress note documented Resident #24 was found sitting on the floor. The resident said she slipped off her chair and landed on the ground. LPN #1 documented she assessed the resident and found no injuries or wounds. LPN #1 indicated she assisted the resident up off the ground and into the wheelchair. The 4/2/22 fall investigation provided the same account of the fall as documented in the nursing progress notes. The fall investigation was completed by LPN #1. It did not indicate an RN had been contacted to complete an assessment for potential injury of the resident following the fall or prior to LPN #1 picking the resident up off the floor. The 4/11/22 nursing progress note documented the CNA reported to LPN #2 Resident #24 was on the ground in her room. The resident said she was getting up to go to bed and her wheelchair rolled backwards. LPN #2 and did call for an RN to assess the resident for an injury following the fall and prior to moving the resident off the ground (see observations above). No RN assessment was found in the residents chart. II. Resident #32 A.Resident status Resident #32, age 63, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 CPOs, the diagnoses included multiple sclerosis. The 3/22/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two people with bed mobility and transfers and extensive assistance of one person with dressing, toileting and personal hygiene. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It indicated the resident had not sustained any falls since the previous assessment period. B. Record review The fall risk care plan, initiated on 3/16/22, documented the resident had a history of falls. The interventions included to encourage the resident to transfer and change positions slowly, have commonly used articles within reach, provide assistance to transfer and ambulate as needed and reinforce to call for assistance. The 4/7/22 nursing progress note documented the CNA reported to LPN #2 that the resident was sitting on the floor with her back against the wheelchair. It indicated LPN #2 assessed before she got onto the bed after the fall. The resident said she fell asleep and slid out of the wheelchair. The 4/7/22 fall investigation provided the same recounting of the fall event as the nursing progress note. It indicated the resident did not sustain an injury. The fall investigation did not have any further information and was completed by LPN #2. It did not document an RN had completed an assessment of the resident following the fall to ensure the resident had not sustained an injury. The 4/17/22 nursing progress note documented at 6:20 a.m. the resident was found sitting on the floor in front of her wheelchair. The resident said she fell asleep and slid out of the wheelchair. LPN #1 documented she assessed the resident and with the help of a CNA, moved the resident back into her wheelchair. It did not document LPN #1 had called for an RN to complete an assessment following the fall and prior to moving the resident off the floor. No RN assessment was found in the residents chart. III. Resident #13 A.Resident status Resident #13, age 95, was admitted on [DATE]. According to the April 2022 CPO, the diagnoses included anxiety, heart disease, gastro-esophageal reflux disease, myalgia, and hypothyroidism. The 4/19/21 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of four out of 15. He required extensive assistance of one person for bed mobility, transfers, dressing, toileting, personal hygiene and one person limited assistance for locomotion. B. Record review The fall risk care plan, initiated on 4/14/21, revealed the resident had a history of falls. The interventions included: placing dycem (non-slide mat) to the recliner chair, encourage the resident to transfer slowly, put commonly used items within reach, and to reinforce need to call for assistance. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/21/22 fall incident report documented LPN #1 found Resident #13 laying on the floor in his room when she went to administer his medications at 5:00 p.m. The resident sustained a laceration to the top of his head and was bleeding. It indicated LPN #1 assessed the resident and then assisted the resident from the floor to the bed. The resident' medical record did not indicate the resident was assessed by an RN) following the fall and prior to the resident being moved off the ground. The 4/19/22 nursing progress note documented Resident #13 was found by LPN #1 on the floor next to his bed on his left lateral side. The resident sustained a half dollar sized skin tear to his head and a 4 cm (centimeter) x 3 cm skin tear to his left arm. LPN #1 documented she notified the resident' family, the physician and the hospice agency. -It did not document Resident #13 was assessed by an RN following the fall and prior to being moved off the ground. IV. Staff interviews CNA #6 was interviewed on 4/13/22 at 4:27 p.m. She said the nurse was responsible for assessing the resident for injuries following a fall. She said the CNAs assisted the nurse in moving the resident off the floor to the bed. LPN #2 was interviewed on 4/13/22 at 5:42 p.m. She said when a resident had a fall, she would immediately check the resident' vital signs. She said she would conduct an assessment of the resident including a skin check after she transferred the resident from the ground back to bed. She said after the assessment was completed, she would notify the resident' family and the physician. She said an incident report was completed after the resident was assessed and neurological checks were initiated for all unwitnessed falls and if the resident hit their head. LPN #1 was interviewed on 4/18/22 at 9:54 a.m. She said the assessment of a resident following a fall should occur immediately, prior to moving the resident off the floor, to determine if the resident sustained an injury. She said the nurse on duty should perform the assessment. She said it did not matter if the nurse was an LPN or an RN, both were able to conduct an assessment. LPN #2 was interviewed on 4/18/22 at 10:43 a.m. She said a resident should be assessed immediately following a fall to determine if the resident sustained an injury. She said the nurse on duty, if an LPN, should contact the RN in the facility to conduct the assessment. She said assessments were not within the LPNs scope of practice. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:10 p.m. She said a RN must complete an assessment of a resident post fall and prior to moving the resident off the ground. She said it is not within a LPN' scope of practice to complete assessments. The director of nursing (DON) was interviewed on 4/18/22 at 5:11 p.m. She said an RN assessment should be completed after each fall to determine if the resident sustained an injury. She said an LPN was not able to conduct an assessment because it was not within their scope of practice. She said the RN assessment should always be documented in the resident's medical record.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews, the facility failed to ensure three (#24, #46 and #44) of four residents reviewed out of 33 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to ensure three female residents (Residents #24, #46 and #44) received grooming services to remove long facial hair from their chin. Findings include: I. Facility policy and procedure The Activities of Daily Living policy and procedure, revised October 2019, was provided by the nursing home administrator (NHA) on 4/14/22 at 2:00 p.m. It revealed in pertinent part, Morning care should be individualized to each patient's preferred morning hygiene habits and routine. Apply deodorant and/or make-up, comb hair, and shave as applicable and as needed. II. Resident #24 A. Resident status Resident #24, age 85, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included dementia with behavioral disturbance, adult failure to thrive, macular degeneration, muscle weakness, obsessive compulsive behavior, and history of falling. The 1/27/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of one person with bed mobility, toileting and personal hygiene. She required limited assistance of one person with dressing, transfers and walking in the resident's room. B. Observations On 4/7/22 at 10:24 a.m. Resident #24 was observed sitting in her wheelchair. She was not wearing a facial covering. Multiple one and half to two inch long hairs were observed on the resident's chin. On 4/12/22 at 10:26 a.m. Resident #24 was observed with a surgical mask tucked below her chin. The resident still had multiple one and half to two inch long hairs on her chin. C. Record review (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated on 7/2/19 and revised on 1/27/22, revealed the resident had a self-care deficit related to dementia and weakness. The resident required extensive assistance for bed mobility, transfers, dressing, toileting and personal hygiene. The cognitive loss care plan, initiated on 2/3/2020, documented the resident had cognitive loss related to a diagnosis of dementia. D. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 4/18/22 at 10:45 a.m. She said each resident should be provided personal hygiene and grooming every morning. She said grooming consisted of washing the resident's face, brushing the resident's hair, putting on deodorant, washing the resident's hands and providing incontinence care. She said facial hair was usually taken care of during the resident's shower. She said facial hair was difficult at times to notice because of the use of facial coverings, however it should be recognized during the morning grooming and personal hygiene. She said facial hair should be shaved off on a woman, especially a resident with dementia. She said she had not provided bathing for Resident #24 for a while. She confirmed Resident #24 had multiple pieces of hair on the resident's chin that were approximately two inches long. Licensed practical nurse (LPN) #2 was interviewed on 4/18/22 at 10:43 a.m. She said, during grooming and the resident's showers, the CNAs should assist the female residents with long facial hair. She said each resident's facial hair should be monitored every day by the CNAs when providing assistance with ADLs. She said hair on a female resident should take extra monitoring to ensure it was taken care of. The director of nursing (DON) was interviewed on 4/18/22 at 5:11 p.m. She said each resident should be provided with grooming every day. She said that included facial hair for female residents. She said, whatever the facility staff do for themselves every day, they should do for the residents when providing grooming and personal hygiene. She said the chin should be groomed for all female residents to ensure a dignified existence. 46022 II. Resident #44 A. Resident status Resident #44, age 85, was initially admitted on [DATE] and readmitted on [DATE]. According to the April 2022 CPO, the diagnoses included hyponatremia, type two diabetes mellitus, dementia, hypertension, hearing loss, and chronic kidney disease. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/16/22 MDS assessment revealed the resident had cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance with two persons for bed mobility, transfer and extensive assistance with one person for dressing, toileting, personal hygiene, and locomotion. B. Observations On 4/7/22 at 9:20 a.m. Resident #44 was observed sitting in her wheelchair in her room. She had hair on her chin and upper lip that were approximately one inch long. On 4/12/22 at 10:35 a.m. Resident #44 was observed sitting in her wheelchair in her room. She had hair on her chin and upper lip that were approximately one inch long. C. Staff interviews CNA #1 was interviewed on 4/13/22 at 4:51 p.m. She said she assisted female residents with facial hair grooming when she noticed it needed to be attended to. She said Resident #44 was able to perform personal hygiene when cueing was provided. CNA #8 was interviewed on 4/18/22 at 10:45 a.m. She said assisting females with grooming facial hair was a part of their ADLs. 45889 III. Resident #46 A. Resident status Resident #46, age 77, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included generalized muscle weakness, dementia, anxiety disorder and need for assistance with personal care. The 2/21/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. She required extensive assistance of one or two persons with bed mobility, dressing toileting and personal hygiene. She required limited assistance of two persons for transfers, walking and supervision of one person for eating. B. Resident observation On 4/7/22 at 10:45 a.m. Resident #46 was observed coming out of her room in her wheelchair. The resident was wearing a denim nightshirt and no pants. The resident's hair had not been brushed and numerous approximately half an inch long gray curly hairs were observed on her chin. Certified nurse aide (CNA) #4 reminded the resident to wear a mask while out of her room, and helped her place a surgical mask over her nose and mouth, covering the long hairs on her chin. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review The comprehensive care plan for activities of daily living (ADLs), initiated on 2/15/22 revealed the resident required assistance with ADLs due to a history of falls with left shoulder injury, weakness, degenerative disc disease, history of thoracic spine fracture and urinary tract infection. Interventions included one person assist with walker, assist to bathe/shower as needed, assist with bed mobility, transfers, toileting, daily hygiene, grooming, dressing, oral care and eating as needed, break ADL tasks into subtasks for easier patient performance, and care in pairs. The April 2022 point of care charting for personal hygiene documented that the resident was provided one person physical assistance for personal hygiene including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face and hands. Assistance for these tasks was provided as follows: -4/6/22 at 5:53 a.m., 11:49 a.m. and 7:04 p.m. -However, based on observation (see above) on 4/7/22 the resident's hair was not groomed and she had hairs on her chin.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on observations, record review, and interviews, the facility failed to provide necessary care and services for residents who were unable to carry out activities of daily living for two (#40 and #51) of six residents reviewed for activities of daily living of 33 sample residents. Specifically, the facility failed to: -Provide showers and personal care such as washing face and brushing teeth for Residents #40; and, -Offer and encourage oral care for Resident #51, who required assistance with personal hygiene. Findings include: I. Facility policy and procedure The A.M. Care policy was provided by the nursing home administrator on 4/14/22 at 2:00 p.m., read in pertinent part, Assist with face and hand washing and oral hygiene. The H.S. (hour of sleep) Care P.M. read in pertinent part, Assist with mouth care. II. Resident 40 A. Resident status Resident #40, age 75, was admitted to the facility 2/9/21. According to the April 2022 computerized physician orders (CPO), diagnoses included contracture of the left shoulder, left wrist, neuromuscular disjunction of the bladder, epilepsy, hemiplegia hemiparesis of the left dominant side. The 2/9/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He had no behavioral problems, psychosis, or rejection of care. He required extensive assistance of two people with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. B. Resident interview and observation Resident #40 was interviewed on 4/6/22 at 2:43 p.m. He said he was in the facility long term for care because he was not able to move his left arm and his left leg. He said he did not recall when his last shower was. He said his preference was to receive shower, but it rarely occurred. He said aides were very busy and probably did not have time to transfer him to a chair for showers. He said he was able to brush his teeth with one hand, but he needed someone to bring him supplies or take him to the bathroom. He said he was not assisted with brushing his teeth. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's appearance was disheveled. He had below the chin long oily hair loosely hanging down with dandruff and skin flakes in his hair, forehead, neck and shoulders. His glasses were foggy with fingerprints on the glass. Yellow food debris was in his beard. The space between his teeth was packed with white debris. Bread crumbs with leftovers of food observed on juice stained gown on his chest. His nails were long and packed with brown substance under them. The resident had a strong body odor. The resident was observed on 4/7, 4/11, 4/12, 4/13 and 4/14/22. His appearance regarding his hair, glasses, teeth and nails did not change from the initial observation (see above). C. Record review The care plan for activities of daily living (ADLs) and self care deficit, was initiated on 2/9/21 and revised on 2/9/22, revealed the resident had self care deficit related to left sided weakness, left hand, wrist and elbow contracture, and left foot drop. Interventions included one person assistance with grooming, and dressing. Assistance with meals as needed. One person assistance with bathing and toileting. Extensive assistance with daily hygiene, grooming, bed mobility, transfers, toileting, dressing, and oral care. The care plan for behavior was initiated on 2/15/21. The resident was refusing bed baths, showers, and shaving. He preferred to keep facial hair and his hair long. Interventions included to educate the resident on the importance of bathing, offer to assist with bed baths, offer to schedule bathing times to his preferences. -The care plan was not revised since it was initiated in 2021. There were no interventions to address the resident's refusals and maintain his hygiene. The care plan did not document the residents' bathing preference. The resident's Kardex (a staff directive) documented he required the following care: One person extensive assistance for grooming, upper and lower body dressing, extensive one person assistance for bathing, and toileting. Extensive assistance with daily hygiene, grooming, bed mobility, transfers, toileting, dressing, oral care and eating as needed. Bathing preference was documented as Fridays and Tuesdays days (with no specification for shower, bath or bed bath). The resident required assistance from two people with mechanical lift for transfers. -The care plan did not include documentation for the residents' bathing preference and assistance. The shower log was reviewed for March 2022, the resident received three bed baths for the entire month (3/15, 3/22, and 3/29/22) out of 10 opportunities for month. -The resident's progress notes were reviewed for March 2022 and revealed no notes regarding resident's refusals, re-approaches or any alternatives that were offered to the resident. D. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/14/22 at 12:30 p.m. She said she did not know where preferences were documented. She said probably CNAs provided showers when residents asked and documented it on the computer. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #15 was interviewed on 4/14/22 at 12:50 p.m. She said she did not recall giving the resident shower and did not know what his preferences were. CNA #16 was interviewed on 4/14/22 at 1:29 p.m. She said she did not recall giving the resident a shower because it was not scheduled on her days. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:15 p.m. She said shower preferences should be documented on the resident's Kardex and care plan. The CNAs were able to see the residents ' Kardex and provide showers or baths per their preference. When showers or baths were refused, it was the CNAs responsibility to reproach the resident and try to accommodate preference. She said CNAs must document refusal on the computer and report it to the nurse. She said Resident #40 should have been assessed for his preferences to see why he was refusing and if CNAs were able to provide showers per his preferences. She said regarding brushing teeth and personal hygiene, she said all residents must be offered to brush teeth at least twice a day, wash their face and other basic needs. 20287 III. Resident #51 A. Resident status Resident #51, under age 65, was admitted on [DATE]. According to the April 2022 computerized physician order (CPO) diagnoses included cerebral vascular accident (CVA), and hemiplegia and hemiparesis following cerebral infarction affecting the right non-dominant side. The 2/22/22 MDS assessment coded the resident with a brief interview for mental status of 15 out of 15. The MDS showed the resident had impairment on one side for both upper and lower extremities. The resident required extensive assistance with personal hygiene. B. Resident interview The resident was interviewed on 4/7/22 at 10:32 a.m. The resident said he was unable to brush his teeth independently, and that he required assistance. He said that the staff did not offer him to brush his teeth but maybe once a week. The resident did have white substance on his front lower teeth. The resident was interviewed again on 4/12/21 at 10:00 a.m. The resident said he received a bed bath and they shaved him but the staff did not offer to brush his teeth. The white substance on the bottom of his teeth remained. The resident was interviewed on 4/13/22 at 3:00 p.m. The resident said he was not offered to have his teeth brushed with his morning care. The white substance remained on his bottom teeth. C. Record review (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan, last updated on 2/22/22, identified the resident was dependent on staff for oral care related to the CVA. Pertinent approaches included to assist with daily hygiene, grooming, shaving, dressing and oral care. The Kardex (a staff directive) dated 4/18/22 showed the resident required assistance with oral care. D. Staff interview Registered nurse (RN) #3 was interviewed on 4/14/22 at 2:55 p.m. RN #3 said the resident was cooperative in care and that he was dependent on staff for all personal care. She said his teeth should be brushed in the morning during the a.m. (morning) care. She said that the certified nurse aides should offer and assist him with the brushing of his teeth. The interim director of nurses (IDON) was interviewed on 4/18/22 at 5:39 p.m. The IDON said the resident's teeth should be brushed twice a day. Once in the morning and then again at bedtime. She said the staff should offer and assist when the resident was unable to perform the task.

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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** 46022 Based on observations, record review and interviews, the facility failed to ensure activities designed to support residents physical, mental and psychosocial well-being were provided for three (#44, #74 and #282) of four residents reviewed for activities out of 33 sample residents. Specifically, the facility failed to ensure Resident #44, #74, and #282 were provided activities and developed a comprehensive care plan which addressed each resident's socialization and activity needs. Findings include: I. Facility policy and procedure The Program Types policy and procedure, dated July 2019, was provided by the activities director (AD) on 4/19/22 at 2:43 p.m. It revealed in pertinent part, Group programs involve a number of people in physical, mental and social interactions. By providing group programs, the center maximizes resources, encourages cohesiveness and promotes socialization. A one-to-one program is provided for patients unable or unwilling to participate in large group settings, meeting some or all of the following criteria: health and or disease status limits participation in group activities; isolation status, medically related or self-imposed isolation limits exposure to other patients; behavioral symptoms that limit tolerance and participation in group settings; patient chooses not to participate in group activities offered or seldom initiates own activities. The one-to-one program format is based upon the comprehensive assessment, interests and the physical, mental and psychosocial needs of the patient. Care plans reflect frequency and types of services provided. Visiting time frames vary according to individual patient needs. The activity/recreation director is responsible for scheduling specific days and providers for patients requiring a one-to-one visit. Programs presented in a group setting can be adapted or modified for a one-to-one activity. A one-to-one cart containing the appropriate supplies based on patient likes and interests can be utilized on the unit during scheduled visits. II. Resident #44 A. Resident status Resident #44, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 computerized physician orders (CPO) diagnoses included hyponatremia, type two diabetes mellitus, dementia, hypertension, hearing loss and chronic kidney disease. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2/16/22 minimum data set (MSDS) assessment revealed the resident had cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance with two people with bed mobility and transfers and extensive assistance of one person with dressing, toileting, personal hygiene, and locomotion. The 1/18/21 MDS assessment indicated it was important to the resident to be around animals, keep up on the news, do things with groups of people, do her favorite activities, and get fresh air. B. Observations During a continuous observation on 4/6/22 beginning at 9:58 a.m. and ended at 12:19 p.m The following was observed: -Resident #44 was in bed with the breakfast tray on her bedside table in front of her. -At 11:25 a.m. Resident #44 was observed still in bed. No staff members had entered the resident' room. -At 11:40 a.m. certified nurse aide (CNA) #3 entered the resident' room to verify the resident had oxygen. -At 12:19 p.m. CNA #3 entered the resident' room to deliver the lunch meal tray. The resident was not encouraged to go to the dining room to socialize with other residents. CNA #3 assisted the resident to sit up in bed. Resident #44 consumed her meal in bed. -During this observation, the facility staff did not enter the resident' room to invite her to the group activities. On 4/7/22 at 9:22 a.m. Resident #44 was sitting in her wheelchair in her room, conversing with herself. -At 10:06 a.m. Resident #44 sitting in her room in a wheelchair. The resident did not have any meaningful activities in her room. -At 3:04 p.m. Resident #44 was still sitting in her room in a wheelchair with no meaningful activities. On 4/11/22 at 10:36 a.m., Resident #44 was observed sitting in her wheelchair, in her room with no meaningful activities within reach. -At 11:01 a.m. she fell asleep while sitting in her wheelchair, with her head hanging downward. During a continuous observation on 4/11/22 beginning at 2:11 p.m. Resident #44 was sitting in her wheelchair, in her room, reading the daily chronicle. She continued to read the same page until 3:16 p.m. On 4/12/22 at 9:06 a.m. Resident #44 was sitting in her wheelchair in her room. The lights were off and the resident was twiddling her thumbs staring at the wall. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:22 a.m. an unidentified activity staff member entered Resident #44' room and handed the resident a copy of the newspaper and the daily chronicle. The activity staff member spent 30 seconds in the resident' room. She did not offer the resident the daily activities schedule. The blinds in the resident' room were shut. After the staff member left the room, the resident began singing to herself. -At 10:31 a.m. Resident #44 was still sitting in her wheelchair in her room with the lights off. -At 10:35 a.m. Resident #44 was laying in bed with no lights on or a meaningful activity. -At 11:49 a.m. Resident #44 remained in bed with the television on. C. Record review The activity care plan, initiated on 3/15/19 and revised on 11/19/21, revealed the resident enjoyes animals, music, spending time with family, reading the daily chronicle, watching movies, going outside and resting in her room. It documented that the resident needed to anticipate some of her needs and she is on the one-to-one program. The interventions included: one-to-one program for extra socialization; stimulation and sensory needs (initiated 1/22/21); encourage activity participation; assist the resident with calling her daughter; provide brief visits (as able), deliver the daily activity schedule and check on leisure materials, The cognitive loss care plan, initiated on 3/8/19 and revised on 8/11/19, revealed the resident exhibited cognitive impairment related to dementia. The interventions included: allowing the resident adequate time to respond, explaining care procedure prior to beginning, give the resident two choices when presenting options, provide access to a clock and calendar, and to provide cueing and prompting for activities. The 11/19/21 recreation/activity evaluation documented the resident liked to keep busy, spend time relaxing, enjoyed and participated in independent leisure activities, and enjoyed participating in outdoor leisure activities. It indicated she was not involved in group leisure activities. It documented that the resident enjoyed dogs, her family, music, facility parties, and the newspaper and daily chronicle. D. Staff interviews The activities director (AD) was interviewed on 4/18/22 at 2:50 p.m. She said Resident #44 loved to play the personal piano in her room and had a baby doll that she treated as her own baby. -However, during the observations the baby doll was never within reach of the resident. She said the resident occasionally attended group activities, but required additional assistance because she was disruptive. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said the resident' family visited frequently. She said the activities staff had previously assisted in calling her two sons who lived outside the state. She said the activity department was no longer in control of video calls with resident families. She said she was not sure how frequently the resident received calls from her family. She said the activities staff entered the resident' room daily to provide her with the daily chronicle and the newspaper. She said the activity staff often did not provide the resident with the daily activities calendar as the resident was unable to recall the times. She said one-to-one activities included the resident attending group activities, talking to other residents in the dining room, and the activities staff members dropping off the newspaper daily. She said they attempted to conduct one-to-one activities with the resident two or three times per week, but were not always able to complete that amount of visits due to staffing shortages. III. Resident #74 A. Resident status Resident #74, age 69, was admitted on [DATE]. According to the April 2022 CPO, the diagnosis included bacterial pneumonia, dysphagia, dementia, hypokalemia, obesity, and heart disease. The 3/22/22 MDS assessment revealed the resident had cognitive impairment with a brief interview for mental status score of two out of 15. She required extensive assistance with one person for all activities of daily living (ADL). It indicated it was important for the resident to listen to music, be around animals, enjoy her favorite activities, get fresh air, do things with groups of people, and keep up on the news. B. Observations On 4/6/22 at 10:16 a.m. an unidentified therapy staff member assisted Resident #74 to her room. The therapist assisted the resident next to her bed, in her wheelchair. The television was on a cartoon channel. -At 10:22 a.m. the resident began falling asleep, leaning forward in her wheelchair. She caught herself from falling out of her wheelchair on several occasions. CNA #2 check on the resident from the hallway, but did not enter the resident' room. -At 11:05 a.m. Resident #74 remained asleep in her wheelchair. -At 11:14 a.m. CNA #2 entered the resident' room and asked the resident if she was sleeping. The resident responded, yes. CNA #2 then asked what she wanted to eat for lunch and left the room. She did not offer to lay the resident down in bed. -At 11:26 a.m. occupational therapist (OT) #1 entered the resident' room and began therapy. On 4/7/22 at 9:22 a.m. Resident #74 was sitting in her wheelchair in her room. The television was on with cartoons playing. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/11/22 at 2:11 p.m. Resident #74 sitting in her wheelchair, in her room, with the television on. The volume was set very low. The resident was playing with the call light. -At 3:16 p.m. Resident #74 remained in her wheelchair looking out into the hallway. -At 4:44 p.m. the resident, still sitting in her wheelchair, was looking out into the hallway. She did not have any meaningful activities within reach. On 4/12/22 at 9:20 a.m. an unidentified activities staff member entered Resident #74' room. She handed the resident the daily activities schedule and the daily chronicle. She was in the room for 30 seconds. -At 10:30 a.m. Resident #74 was sitting in her wheelchair in her room with the lights off, curtains closed, and no meaningful activities in front of her. At 4:21 p.m. Resident #74 was sitting in the same position, with the lights off and no meaningful activities within reach. On 4/13/22 at 10:13 a.m. Resident #74 was laying in bed with no lights on or meaningful activity. -At 11:49 a.m. the resident remained in bed with no lights on. -At 4:25 p.m. the resident was still in bed with no meaningful activity. The resident kept looking into the hallway. C. Record review The activity care plan, initiated on 3/24/22, revealed the resident needed assistance with some independent activities. The interventions included: to allow time for the resident to respond, to encourage the resident to plan own activities, the family to provide items to make room home-like, to provide supplies for leisure activities as needed and to redirect as needed. The cognitive loss care plan, initiated on 3/17/22, revealed the resident had cognitive loss related to dementia. The interventions included: to allow adequate time for the resident to respond, to explain activities and care procedures prior to beginning, to give two choices when presenting options, to repeat as needed, and to use brief/simple words when speaking with the resident. The 3/24/22 recreation/activity evaluation revealed the resident enjoyed spending time relaxing, participating in independent and group leisure activities, and enjoyed the outdoors. The one-to-one activity/recreation program documentation for Resident #44 was provided by the activities director (AD) on 4/18/22 at 3:15 p.m. It documented she liked dogs, her grandkids, watching television, and listening to music. -The documentation did not indicate the resident had received any one-on- one activities from the facility activity staff. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Staff interviews The AD was interviewed on 4/18/22 at 2:50 p.m. She said Resident #74 was not interviewable at the time of her admission to the facility. She said she conducted the activity's preference form with the resident' son. She said Resident #74 enjoyed music and attending group activities. The AD said cartoons were not age appropriate for the resident to watch. She said she would place a paper near the resident's television that provided age-appropriate channels. She said Resident #74 could have used more involvement from the activities department, especially when she was on isolation due to a COVID-19 positive test result. She said the activity department had not provided Resident #74 with any one-on-one activities or interactions. 45889 IV. Resident #282 A. Resident #282 Resident #282, age 77, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included generalized muscle weakness, and unspecified dementia The 3/4/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with an unscored brief interview for mental status. She had no behavioral problems, psychosis, or rejection of care. She required extensive assistance from one person with bed mobility, transfers, dressing, toileting and personal hygiene. The 3/24/22 MDS activity assessment was unanswered by the resident and indicated that a family member or significant other would be interviewed. No record of additional interviews were documented. B. Observations The resident was observed participating in an activity one time during the survey. Observations are as follows: On 4/6/22 at 3:15 p.m., Resident #282 was in isolation after testing positive for COVID-19. She was in a private room, laying in the bed dressed in a hospital gown. The television was on and the resident was watching it. On 4/7/22 at 3:27 p.m., Resident #282 had returned to her room. She was laying awake in her bed on her back. There was no music playing and her television was not on. On 4/11/22 at 10:55 a.m., Resident #282 was sitting in her wheelchair in her room facing the television. The television was not on and there was no music playing in her room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 2:45 p.m. the resident was in the same position sleeping in her wheelchair with no music playing and the television was not on. On 4/12/22 at 8:44 a.m. the resident was lying in her bed awake. Her breakfast was sitting on her tray table next to her bed. -At 10:56 a.m., the resident had returned to her room after being given a shower. The resident was left in her wheelchair next to her bed looking toward the television. Her glasses were on the tray table. The television was not on and there was no music playing. -At 11:09 a.m., certified nurse aide (CNA) #10 and licensed practical nurse (LPN) #1 provided wound care. After the wound observation was completed, the resident was returned to the same position in her wheelchair next to her bed facing the blank television. No activity was offered to the resident prior to staff leaving her room. -At 2:30 p.m.the resident was in the same position and the television was off and there was no music playing. On 4/14/22 at 8:47 a.m., Resident #282 was sitting up in bed in a hospital gown. The television was not on and there was no music playing. -At 11:34 a.m. the resident was still in bed in her hospital gown. There was no music and the television was not on. On 4/18/22 at 11:50 a.m., Resident #282 was sitting in her wheelchair next to her bed. The television was not on and there was no music playing. -At 2:22 p.m. the resident's door was closed, but voices could be heard from the room. -At 2:25 p.ml, the door opened and two staff members exited her room. The resident was in her wheelchair facing the doorway, looking out into the hallway. On 4/18/22 at 3:55 p.m., Resident #282 was observed sitting in her wheelchair under the television facing the doorway. The television was plugged into an outlet approximately two feet below the ceiling. The cord was dangling down. The activity director (AD) said that the resident unplugs her television. At 4:00 p.m. the director of maintenance (DOM) secured the television cord and the television was on, although the resident was sitting under the television facing the doorway. She was unable to see the television screen. 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 activity care plan, dated 7/9/21 and revised 3/24/22, documented that the resident engaged in independent activities with assistance needed and typically did not attend group activities. Interventions included assist in planning and/or encourage activity participation, assist in transport to and from activities of interest, encouraging participation in group activities of interest including music and socials, offer redirection and diversion as needed, and provide a CD player and CDs for resident to borrow. The activity care plan also documented that the resident tested positive for COVID-19 on 3/24/22 and was placed on isolation. A recreation/activity evaluation was conducted on 7/9/21 and revealed that the resident liked to spend time relaxing, enjoyed independent leisure activities, group leisure activities and outdoor activities. The resident' interests included animals, music, arts/crafts, cards/games, children, current events/news, movies, parties/socials, reading/writing, talking/conversing, travel, and television/radio. The resident pursued recreation and leisure activities with assistance. Daily recreation/activity participation logs for January 2022 through April 2022 document activity as follows: January 2022 Movies 1/6/22 and 1/22/22; Music 1/1/22 and 1/13/22; Socializing everyday except 1/6/22, 1/9/22, 1/15/22, 1/16/22, 1/30/22 and 1/31/22; Television was marked as independent participation; and, Mail 1/3/22 and 1/20/22. February 2022 Movies 2/17/22; Music 2/1/22; Sensory stimulation 2/6/22, 2/12/22 and 2/16/22; Socializing everyday except 2/7/22, 2/14/22 and 2/27/22; Television was marked as independent participation; and, Mail 2/6/22, 2/11/22 and 2/15/22. March 2022 Movies 3/24/22; Music 3/8/22 and 3/22/22; (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Socializing everyday except 3/26/22, 3/27/22, 3/29/22, 3/30/22, 3/31/22; and, Television was marked as independent participation. April 2022 Music 4/14/22; Socializing 4/8/22, 4/13/22, 4/14/22, 4/15/22, 4/16/22 and 4/17/22; and, Television as independent participation. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/18/22 at 2:25 p.m. She said that the resident was unable to communicate to staff what she would like to do but had been seen pulling herself along the wall in her wheelchair. She said she liked to watch television and often talked to herself. An unidentified certified nurse aide (CNA) was interviewed on 4/18/22 at 2:30 p.m. after disposing of trash removed from the resident's room. The CNA said that she did not know the resident or what the resident liked to do. The AD was interviewed on 4/18/22 at 3:00 p.m. She said that socializing with residents occured when staff talked to or had any interaction with residents, including delivering daily chronicles, meals, and activities with other residents. She said that it was difficult to include Resident #282 in group activities because the resident was disruptive and talked too much. She said that the resident enjoyed music programs but if she talked too much, then she had to be returned to her room. She said that the resident liked to watch television but often pulled the plug out of the wall. She said the resident could turn the television on and off, but could not change the channel. Immediately after the interview, the AD went to the resident's room at 4:05 p.m. and was unable to find the resident's television remote. The television was on and the resident was sitting under the television facing the doorway. She said that the resident probably threw the remote away. She acknowledged that the resident did not turn the television on, nor could the resident see the television from where she was sitting.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and staff interviews, the facility failed to ensure six (#6, #25, #27, #44, #59 and #282) residents reviewed of 10 residents received treatment and care in accordance with professional standards of practice out of 33 sample residents. Specifically, the facility failed to assess Resident #6 for change of condition. Resident developed severe edema on his left lower leg and was sent to the emergency room for evaluation. In addition, Resident #6's skin assessments were not consistently and accurately documented to reflect the development of several wounds on his legs that led to infection and cellulitis. Resident #25-Failure to perform treatments as ordered by the physician, failure to notify the physician of newly developed skin concerns; Resident #27-Failure to ensure medications were administered according to physician orders and notify the physician was a medication was not administered; Resident #44-Failure to regularly monitor the resident's skin; Resident #59-Failure to perform treatments as ordered by the physician; and, Resident #282-Failure to provide dressing changes per physician and conduct weekly skin assessments. Findings include: I. Resident #6 A. Resident status Resident #6, age 67, was admitted to the facility 11/22/2017. According to the April 2022 computerized physician orders (CPO), diagnoses included Parkinson's disease, venous insufficiency, diabetes type 2, and acquired absence of right foot. The 12/23/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He had no behavioral problems, psychosis, or rejection of care. He required extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. He was at risk of developing pressure injuries and had skin tears at the time of the assessment on 12/23/21. B. Failure to assess Resident #6 after a change of condition on 3/10/22 and 3/29/22 and accurately document his skin conditions (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/10/22, the resident attended a physical therapy session with an outside provider. The resident was not able to participate in therapy and said he did not feel great today. He shared with the therapist that nurses at the facility were not attending the areas on his feet. The PT inspected the left leg and observed left heel open area with bloody drainage on the sock and heel. The PT documented, the open area approximately near the area that the orthotic insert may be rubbing with the heel lift that was put in the boot on 3/8/22. PT notified the wound clinic and replaced his orthopedic boot with a large walking boot. -Facility records review revealed no assessment after change of condition for resident on 3/10/22. No changes were implemented to the resident's care plan. The use of orthopedic boots were not mentioned under physician orders, residents care plan or treatment administration orders. On 3/21/22, the resident attended a scheduled wound care clinic visit, new ulcerations on the left foot were noted. The exam revealed Obvious edema occurring in the left extremity that was not noticed at last visit. -Wound #1 Plantar (on the sole) posterior (back) aspect of the left calcaneus (heel) shows an unstageable pressure injury. Devitalized tissue around the site with large eschar formation in the center. Measurements of the wound were not included in the notes. -Wound #2 was very large unstageable pressure injury to the left heel caused by the boot. The wound was measuring 7.5 cm by 11 cm., with poorly defined wound edges and macerated moist peeling skin around it. Treatment consisted of sharp debridement, the area was cleaned and new dressing was applied. The wrap was applied to the left leg as well to control edema. Facility was contacted over the phone and treatment orders for the resident were discussed with the nurse on duty. The facility was notified to watch for signs and symptoms of potential infection and plan to re-evaluate the resident in two weeks. -Facility records review revealed no assessment after change of condition for resident on 3/21/22. No changes were implemented to the resident's care plan to monitor his legs for edema and potential infection. On 3/29/21, the resident attended a regular PT session outside the facility. The nurse was called to the room to assess the wounds. Full removal of the dressings note worsening wounds, profoundly macerated and peeling skin on 90% of foot, severe redness over top of foot, that was taught and shiny. Also, increased swelling up to below knee with rubby skin and several new areas of concern that are open, with eshar areas to great toe, second toe and fourth toe. Resident reported that his dressings were changed but once since his appointment at the wound clinic over a week ago. The PCP was contacted and the order was received to send the resident to the emergency department for evaluation. According to the hospital admission records dated 3/29/22, the resident was seen in the emergency department on 3/29/22 for redness on his foot that got more red over the last two weeks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident was admitted to the hospital with a diagnosis of left lower extremity cellulitis with unstageable chronic wounds. Resident with cellulitis and multiple wounds on left foot. Left foot and lower leg are three times larger than the right leg. The resident was started on intravenous (IV) antibiotics and wound treatments with antimicrobial gel. Several open areas were located on residents legs, such as unstageable pressure injury to the left heel, measuring 9 cm by 9 cm; left foot plantar wound with unknown and potentially traumatic origin due to large amount of edema, measuring 9 cm by 13 cm., wounds on 1st, and 2nd toes measuring 1 cm each; two venomous ulcers on right leg measuring 3 cm by 3 cm and 9 cm by 9 cm. Resident was seen by a wound care specialist daily. He underwent sharp debridement and wound care treatments. Skin notes reviewed from January 2022 to March 2022 revealed multiple inconsistencies between wound care notes documented by the wound care clinic and the facility records (Cross reference to F686). C. Staff interviews Nurse practitioner (NP) #1 was interviewed on 4/12/22 at 10:55 a.m. She said she was a primary care NP who worked with the resident. She said she was not notified about the resident's deteriorating wounds and worsening edema in March 2022. She said it was absolutely important to her to know the changes in the resident's condition as it was determining the treatment. She said hospitalization for Resident #6 could have been avoided if changes in his condition were monitored and timely reported to the physician's office. Cross-reference F686 Licensed practical nurse (LPN) #1 was interviewed on 4/13/22 at 11:41 a.m. She said changes of condition should be documented in the progress notes and reported to the physician. She said it was important to notify the physician that he can direct the care. Wound care physician (WCP) #2 was interviewed over the phone on 4/13/22 at 4:45 p.m. He said Resident #6 was diabetic and he was at high risk of developing wounds. He said he had already lost his right foot due to the infections from wounds in the past. He said worsening wounds and edema in leg were significant changes of condition for this resident. He said if a resident's deteriorating wound and edema were caught at the early stage, the infection of the wounds and hospitalization could have been avoided. The interim director of nursing (IDON) was interviewed on 4/14/22 at 5:00 p.m. She said a change of condition would be any changes in resident's physical or emotional status that were not his/her baseline. She said deteriorating wounds and increased edema indicated a change of condition for Resident #6. She said the resident's edema and wounds should have been monitored closely after 3/21/22 as it was recommended by the wound care physician. All changes should have been documented in progress notes and reported to the physician. 46022 II. Resident #44 A. Resident status (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #44, age 85, was initially admitted on [DATE] and readmitted on [DATE]. According to the April 2022 CPOs, the diagnoses included hyponatremia, type two diabetes mellitus, dementia, hypertension, and chronic kidney disease. The 2/16/22 MDS assessment revealed the resident had cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of two people for bed mobility, transfers and extensive assistance of one person for dressing, toileting, personal hygiene, and locomotion. It indicated the resident was at risk for pressure injuries, but did not have any current skin issues. B. Record review The skin integrity care plan, initiated on 3/7/19 and revised on 2/16/22 revealed the resident was at risk for skin alteration related to frequent falls, impaired mobility, and incontinence. The interventions included: applying barrier cream to peri area and buttocks as needed, elevating the resident's heals as able, encourage fluids, encourage repositioning as needed, observe the resident's skin conditions with activities of daily living (ADL) care, and to provide preventative skin care routinely and as needed. The 2/16/22 Braden scale for predicting pressure ulcer risk documented Resident #44 was at risk for developing pressure injuries. A review of the resident's electronic medical record on 4/13/22 at 1:30 p.m. revealed the resident did not have a documented skin check in the last 90 days. C. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 4/13/22 at 10:15 a.m. She said certified nurse aides (CNA) were responsible for completing skin checks upon incontinence care and during showers. She said the skin check should be documented in the medical record, even if the skin was intact. She said licensed nurses did not complete skin checks. Registered nurse (RN) #1 was interviewed on 4/13/22 at 10:18 a.m. She said CNAs completed skin checks when providing incontinence care and during showers. She said she would look at the resident when a CNA reported a skin issue to her. She said skin issues were documented in a progress note as well as an incident report. She said she did not complete head to toe skin checks on a regular basis. RN #3 was interviewed on 4/13/22 at 10:24 a.m. She said she was responsible to complete body audits, which included head to toe skin assessments, on every resident. She said if a resident had a current skin issue, such as a pressure ulcer, she would complete daily skin assessments. She said if there were no current skin issues, skin assessments were completed weekly. RN #3 said if a new skin issue was found an incident report was completed, which included notifying the physician, resident, and resident representative, obtaining treatment orders and updating the resident's care plan (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The regional nurse manager (RNM) was interviewed on 4/13/22 at 2:23 p.m. She said each resident at the facility had a physician's order for the licensed nurse to complete a body audit, which included a head to toe skin assessment, every week. She said most residents had body audits completed weekly and residents with current pressure injuries had body audits completed daily. She said the body audits were signed off on the treatment authorization request (TAR). She said if a newly identified skin concern was identified during the body audit, the nurse should document a progress note, notify the physician and obtain treatment orders. She said all residents with newly identified skin concerns should be referred to the wound physician, who rounded at the facility every week. The RNM said if a CNA noticed a new skin issue during incontinence care of a shower, they were responsible for reporting it to the licensed nurse on duty. The licensed nurse was then responsible to assess the area, notify the physician, obtain treatment orders, and document in the resident's medical record. III. Failure to ensure Resident #27 were administered medications as ordered by the physician A. Resident status Resident #27, age 66, was admitted on [DATE]. According to the April 2022 CPOs, the diagnoses included bipolar disorder with depression. The 1/28/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required supervision for all ADLs. B. Record review The March 2022 CPOs documented the following physician orders: -Quetiapine Fumarate (Seroquel) 500 MG (milligram)-give two tablets by mouth at bedtime for Bipolar disorder-ordered on 10/23/21; -Metoprolol Succinate extended release 50 MG-give one tablet by mouth at bedtime for hypertension-ordered on 1/16/22; -Divalproex Sodium (Depakote) 500 MG-give two capsules by mouth in the morning for Bipolar disorder-ordered on 3/31/22; and -Divalproex Sodium (Depakote) 500 MG-give four capsules by mouth at bedtime for Bipolar disorder-ordered on 3/5/22. The March 2022 medication administration record (MAR) revealed the blanks, documenting the resident was not administered the Quetiapine on 3/5/22, the Divalproex Sodium four capsules at bedtime on 3/24/22 and 3/30/22, the Divalproex Sodium two capsules in the morning on 3/19/22 and the Metoprolol on 3/5/22 and 3/18/22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The April 2022 MAR revealed the blank, documenting the resident was not administered the Quetiapine on 4/8/22. A review of the resident's medical record did not reveal documentation of why the resident was not administered the medications as ordered by the physician. The resident's medical record did not document if the physician was notified of the missing medication doses. C. Resident interview Resident #27 was interviewed on 4/7/22 at 9:10 a.m. He said he had been told several times in the last two months his medications were on order from the pharmacy. He said he had missed doses of his medications. He said he had reported this to the director of nursing. At 4:48 p.m. Resident #27 said the nurses frequently brought him the wrong dose of his medications and he had to corrected them. He said he was supposed to receive two tablets of Depakote in the morning and four tablets at night. He said he had to correct the nurse that morning as she only brought him one. D. Staff interviews LPN #2 was interviewed on 4/13/22 at 5:42 p.m. She said nurses were responsible for filling medications via PointClickCare. She said when residents are down to two or three days of a medication, then the medication should be reordered. She said there was a machine at the 100 unit nursing station that had back up medications in it if needed. The interim director of nursing (IDON) was interviewed on 4/18/22 at 4:48 p.m. She said medications were automatically refilled, so she was unsure why medications were missed for Resident #27. She said if a resident missed a dose of a medication the licensed nurse should check the Pixis (medication machine backup) for the medication. If the Pixis contained the medication, the licensed nurse should contact the pharmacy to receive an authorization to dispense the medication and administer to the resident. She said if the Pixis did not contain the medication the licensed nurse should notify the physician and then contact the pharmacy. She said it could be extremely detrimental for a resident to miss a medication, especially a psychotropic medication. The medical director (MD) was interviewed on 4/19/22 at 2:07 p.m. He said the licensed nurse was responsible for notifying the primary physician if a medication dose was missed. He said if a dose of depakote or metoprolol were missed, negative side effects could occur. 38185 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #59 A. Resident status Resident #59, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 CPOs, the diagnoses included congestive heart failure (CHF), pressure ulcer, pressure induced deep tissue damage of unspecified site, type two diabetes, moderate persistent asthma, chronic obstructive pulmonary disease (COPD), chronic pain, trigeminal neuralgia, fibromyalgia and generalized anxiety disorder. The 3/4/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident was at risk for developing pressure injuries and had a stage three pressure injury and an unstageable pressure injury. The resident had a pressure reducing device for the bed and was not on a turning or repositioning program. B. Observations On 4/11/22 at 3:07 p.m. LPN #2 was observed providing wound care for Resident #59. The observations were as follows: -After providing privacy for the resident, Resident #59 was repositioned to lay flat on her bed and turned to her left side. The resident said that this position was uncomfortable for her. The resident was not offered any pain medication. Resident #59 said the wound physician was unable to look at her wounds last week because she had a bowel movement and needed incontinence care. She said the wound physician did not come back to look at her wounds. -Two 5 cm diameter purple discolorations on each side of the resident's coccyx were observed. LPN #2 applied a white cream to these areas and had an unidentified CNA reapply the resident's briefs. No open areas were observed. LPN #2 did not clean the area, apply medihoney or cover the area with optifoam to the right side, or clean the right area with normal saline, pat dry or apply betadine which was indicated on the physician's treatment orders (see the CPOs below). LPN #2 did not perform the correct treatment at any other time that day. -The CNA then raised the resident's right leg so the wound on her right outer foot could be observed. The resident said this caused a great deal of pain to her knee and hip. No pain medication was offered. -A circular scab was observed on the right side of the resident's foot. After observing the wound, LPN #2 covered the resident with her sheet. LPN #2 did not perform a treatment, which should have been completed by the nurse on her shift. On 4/12/22 at 2:19 p.m. the wound care physician (WCP) was observed providing wound care to Resident #59 by the registered nurse (RN) surveyor. Observations were as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observations On 4/7/22 at 10:14 a.m. a hospice certified nurse aide (CNA) was observed gathering supplies and entered Resident #25's room to provide the resident a bed bath and change the sheets to the bed. She exited the resident's room and went to the nurse at the 200 nursing station. She told the nurse the resident had redness to the coccyx and the bilateral heels. On 4/12/22 at 8:50 a.m. an observation of Resident #25's skin was completed with LPN #1 and certified nurse aide (CNA) #3. -On the resident's right ankle, a bandage was observed, dated 4/6/22. LPN #1 removed the bandage revealed a 7.5 cm L x 0.5 cm W open wound, that was pink and was healing; -The resident had multiple skin discolorations to the bilateral shins; -To the right calf, a dime size dark red and blackish wound was observed with scarring around the perimeter; -On the right forearm a 5 cm laceration with a scab was observed. No redness was observed around the scab. LPN #1 said it was an old skin tear; -Redness was observed, by the RN surveyor, to the coccyx and bilateral heels. LPN #1 said the wound physician was doing wound rounds that day, 4/12/22 and would put treatments in place, however she did not administer the physician ordered treatment to the right heel, as indicated in the CPOs. According to the resident's medical record, LPN#1 did not refer the resident to the wound physician. B. Record review The skin integrity care plan, initiated 12/30/19 and revised 2/1/22, documented the resident was at risk for skin breakdown due to impaired mobility and incontinence. The interventions included administering the treatment as ordered by the physician, applying barrier cream to the peri-area and buttocks as needed, elevate the heels as able and observe the resident's skin condition with ADL care daily and report any abnormalities. The April CPOs documented the following treatment orders: -Redness to the right heel: apply Marathon at bedtime every three days and as needed-ordered 1/3/22; -Body audit every week by the licensed nurse, write a progress note, update the skin sheets and care plan every Thursday for skin observation-ordered 4/9/2020. The 12/16/21 skin progress notes documented the resident had no open wounds. It indicated the resident had bruising to the right and left upper extremities from previous falls that were beginning to fade along with ecchymotic (common bruise) areas to the lower extremities. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She said treatment orders should always be followed as ordered and documented in the resident's medical record. LPN #1 said she felt the facility did not have an established system in place for skin and wounds. She said she doesn't know what direction to go when a new open area is observed. She said it was challenging to work at the facility. The nursing home administrator (NHA) and regional nurse manager (RNM) were interviewed on 4/13/22 at 2:22 p.m. The NHA said the facility had a system, it might not be perfect but it is a system. She said the nursing staff should sign off on the medication administration record (MAR) that a skin check was completed weekly. She said a corresponding progress note should be documented if the resident's skin was clear or any skin issues observed. She said if there was a new skin concern observed, the physician should be contacted, a treatment order obtained and a description should be documented in the progress notes of the resident's medical record. She said the skin check should be conducted weekly and should be on a different day than the resident's shower. She said only a licensed nurse or registered nurse could perform a skin check. The RNM said all treatments should be provided according to the physician's order in the medical record. She said it was never okay for the nurse to deviate from the physician's order. She said if the wound was resolved, then the nurse should continue to do the treatment as ordered and notify the physician to determine if the treatment orders should be changed. She said a nurse cannot change the treatment orders without direction from the physician. 45889 VII. Resident #282-Failure to provide dressing changes per physician and conduct weekly skin assessments. A. Resident #282 status Resident #282, age 77, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included generalized muscle weakness, unspecified dementia, long term use of anticoagulant medication, pressure-induced deep tissue damage of the left heel and stage three pressure ulcer of sacral region. The 1/3/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment, a brief interview for mental status (BIMS) was not conducted. She had no behavioral problems, psychosis, or rejection of care. She required extensive assistance from one person with bed mobility, transfers, dressing, toileting and personal hygiene. B. Wound care observation and interview (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wound care observations were conducted on 4/12/22 at 11:09 a.m. CNA #10 had just completed showering the resident and said that there were no bandages present on Resident #282 prior to her shower. The resident was transported into her bathroom by LPN #1 and CNA #10 where she could use the grab bar to stand. The resident had a 2.5 centimeter (cm) long by 1 cm wide reddened skin tear on her right buttock. There was no dressing on the wound and the LPN did not provide any wound care or apply a dressing during this observation. The pressure ulcer on her coccyx was not visible while the resident was standing during observation. There was no dressing on the resident's coccyx and the LPN did not provide any wound care or apply a dressing during this observation. The resident was dressed and returned to her wheelchair. -The observation did not witness the LPN assessing or providing wound care to the resident's left calf or heel. The resident's clothing covered these wounds and the LPN did not remove clothing from the left calf or right heel. -The orders for the residents' wounds are written for as needed as well, see orders below. LPN #1 was immediately interviewed. She had CNA #10 assisted her to undress the resident from the waist down so that the wounds on the resident's buttocks could be observed. She said that she was not certain of the treatment for the pressure ulcer or skin tear. She said the treatments were usually completed on the night shift. The LPN asked the CNA to redress the resident and return her to her wheelchair. The LPN did not look at or attempt to provide treatments to the wounds on the resident's left lower leg or left heel. On 4/12/22 at 2:30 p.m. the wound care physician (WCP) #1 was observed performing wound care for Resident #282 accompanied by the MDS coordinator and RN #5. WCP #1 applied betadine solution to a triangular shaped wound on the resident's left calf measuring 2.5 cm by 2.5cm. WCP #1 then had the nurses position the resident to treat wounds on the coccyx and buttock area. He treated a 1 cm by 0.5 cm stage three pressure ulcer on the resident's coccyx with calcium alginate covered with an optifoam dressing. The skin tear to the right buttock was left open to air. The physician then had the nurses raise the resident's left leg to apply betadine to her left heel. The resident grimaced when WCP #1 attempted to remove hardened skin from the area. A quarter size deep tissue pressure injury was observed on the resident's left heel. The pressure ulcer was left open to air and a prevalon boot was placed on the resident's foot. C. Record review The care plan for skin integrity initiated on 7/5/21 revealed the resident was at risk for alteration in skin integrity related to impaired mobility, and incontinence. Interventions included barrier cream to peri area/buttocks as needed, elevate heels as able, observe skin condition daily, and pressure redistributing device on bed. On 3/10/22 the care plan was updated with the following interventions for deep tissue injury (DTI) to left heel: to administer treatment per physician orders, prevalon boot to left foot while in bed and report evidence of infectio[TRUNCATED]

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review, and interviews the facility failed to assist one (#20) of two residents out of 33 sample residents with obtaining vision services. Specifically, the facility failed to ensure Resident #20 received her prescribed eye glasses timely. Findings include: I. Resident #20 A. Resident status Resident #20, age 71, was admitted on [DATE]. According to the April 2022 computerized physician orders diagnoses included chronic pain, anxiety disorder, personality disorder and heart failure. The 1/21/22 minimum data assessment (MDS) assessment showed the resident did not have any cognitive impairment with a brief interview for mental status score of 15 out of 15. The MDS showed the resident required limited assistance for activities of daily living. The resident had adequate vision and did not wear corrective lenses. B. Resident interview Resident #20 was interviewed on 4/6/22 at 4:44 p.m. The resident said that she had an eye exam, however she has not received her glasses. She said that she was a member of program of all-inclusive care for the elderly (PACE), and that the facility social worker was blaming the PACE program for not getting glasses. She said she was tired of asking for her glasses. C. Observations On 4/11/22 at approximately 11:00 a.m., licensed practical nurse #6 was observed telling the social service assistant that Resident #20 was asking why she had not received her glasses. D. Record review The 1/18/22 social service note documented the resident was seen by the eye doctor. The note documented the resident was seen on 1/10/22. The note indicated the PETI (post eligibility treatment of income) packet was completed. Nearly two months after the resident was seen by the eye doctor, a social service note dated 3/3/22 documented, the social service department contacted the PACE program to see who would submit the glasses request to PETI. The social worker from PACE said the PETI program did not need to be used. The PACE social worker requested the bill. The note documented the facility social service department was under the impression that PACE would order the glasses. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An additional social service note was written on 3/3/22 which indicated the social worker from PACE contacted the eyeglass distributor and said to send bills to the PACE. The social service department documented that nothing further was needed by the facility social service department. The next note was nearly 30 days later which documented on 3/30/22 the social service assistant (SSA) contacted the eyeglass distributor to inquire about the whereabouts of the glasses. A voicemail left. The 4/4/22 social service note documented the social service department received a call back from the eyeglass distributor and said they had not received payment for the glasses, but would start fulfilling the order anticipating the payment. E. Interview The social service director (SSD) was interviewed on 4/12/22 at 10:08 a.m. The SSD said the social service assistance (SSA) handled all of the ancillary services. The SSA was interviewed on 4/12/22 at 11:00 a.m. The SSA said he did handle the ancillary items. He kept track of requests in a binder along with the consent forms. He said the nurses and residents would request to see the eye doctor to either himself or the SSD. The SSA said he sent the PETI application to the business office, and then he contacted the PACE social worker and found out that the PACE program paid for the glasses. The PACE social worker said the glasses would be paid for this week. The SSA said after reviewing the medical record, the resident was seen by the eye doctor on 1/10/22. The business office manager (BOM) was interviewed on 4/19/22 at 4:15 p.m. The BOM said Colorado could be slow to pay with the PETI program. She said the facility could pay for the ancillary items such as glasses and then reimburse from the PETI program. The BOM said she was not notified of Resident #20 was waiting for glasses.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37166 Based on observations, record review and interviews, the facility failed to implement interventions and provide appropriate treatments to prevent the development and worsening of pressure injuries for three (#6, #40 and #282) of six residents reviewed for pressure injuries out of 33 sample residents. Resident #6 had resided in the facility since 2017 for long term care. The resident had Parkinson's disease, venous insufficiency, and diabetes type 2. He wore custom modified orthopedic boots on both legs due to the acquired absence of his right foot. Record review revealed the facility did not ensure the resident's feet were monitored daily before and after a boot modification for tissue damage or signs of pressure or rubbing to prevent skin breakdown. -On 3/10/22, Resident #6 attended a scheduled physical therapy session with an outside provider when two wounds on his left leg were discovered. During his therapy session, the resident's left boot was removed and upon the removal of the sock, a long piece of skin came with. The sock was covered in serosanguinous, foul smelling drainage. The wound bed was red, and took up the entirety of the heel. Resident was sent back to the facility with dressing change orders. However, the dressing changes were not completed as ordered and the resident's wounds deteriorated. -On 3/29/22, Resident #6 attended another scheduled physical therapy session with an outside provider. Upon removal of the wound dressings, profound macerated and peeling skin was noted on 90% of the left foot, severe redness over top of the foot, increased swelling up to below the knee and several new open areas. The resident's primary care provider (PCP) was contacted and instructed that the resident be sent to the emergency department (ED) for evaluation. Resident #6 was evaluated and admitted to the hospital with a diagnosis of cellulitis secondary to wound infection. He received antibiotic treatments and debridement of the wound. Furthermore, after the resident developed tissue injury from his orthotpedic boot, the facility did not develop or complete a performance improvement plan or implement prevention measures to prevent this from happening again to other residents. There was no evidence staff had been educated on the use and placement of orthopedic devices. Cross-reference F867. The facility's failure to assess and monitor Resident #6 for pressure injuries due to his orthopedic devices created an immediate jeopardy situation for serious injury to reoccur if immediate corrective action was not taken. In addition to Resident #6, the facility failed to put interventions in place to prevent the development of stage 3 pressure injuries for Resident #40 and #282. Resident #40 had a left sided weakness on upper and lower extremities and required assistance with turning and repositioning. The resident was not consistently assisted with repositioning, his heels were not elevated and he developed a stage 3 pressure injury on his left heel. Resident #282 was admitted to the facility with no pressure injuries and developed two stage 3 pressure injuries during her stay. Findings include: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	I. Immediate Jeopardy A. Findings of immediate jeopardy Resident #6, diagnosed with Parkinson's disease, venous insufficiency, and diabetes type 2, wore custom modified orthopedic boots. He developed a pressure injury to his left heel on 3/10/22, which progressed to an unstageable 7 centimeters (cm) by 11 cm wound, and by 3/29/22, had become infected. The resident required hospitalization and evaluation by a wound care specialist. He was diagnosed with cellulitis due to wound infection. The resident underwent wound debridement and antibiotic treatments. The facility did not ensure the daily skin checks were completed before a boot modification to monitor for tissue damage. The facility further failed to complete skin assessments after boot modifications to ensure the resident's skin was consistently monitored for signs of pressure, rubbing or breakdown. Furthermore, after the resident developed tissue injury, the facility did not develop or complete a performance improvement plan or implement measures to prevent this from happening again to other residents. Cross-reference F867. The facility's failure to assess, monitor and treat Resident #6 for pressure injuries created an immediate jeopardy situation for serious injury to reoccur if immediate corrective action was not taken. On 4/13/22 at 2:20 p.m., the nursing home administrator (NHA) was notified that the findings regarding Resident #6 created a situation of immediate jeopardy for serious harm. B. Plan to remove immediate jeopardy On 4/14/22 at 1:35 p.m., the facility submitted the following plan to remove the immediate jeopardy situation: 1. Immediate actions -On 4/13/22, a skin assessment was completed by Director of Nursing and nursing team for every resident in the facility. All new findings and worsening of wounds were documented in the resident's medical record, the physician was notified and new treatment orders were obtained. -On 4/14/22, all current treatment orders were observed to ensure accuracy and frequency of treatments were being completed according to physician orders. All negative observations were immediately corrected and on the spot education was provided to the nursing staff. -On 4/13/22, a sweep was completed by Director of Nursing to identify each resident with an orthopedic device. A review of each resident's medical record with an identified orthotic will be completed to ensure a physician order is in place to include the scheduled application of the orthotic device, daily monitoring of the resident's skin to which the orthotic device was applied, and the care plan updated. The review will be completed by 4/14/22. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-All orthotic devices, including Prevalon boots that are used to offload heels, will be scheduled to be disinfected/cleaned daily by Director of Nursing or designee, and will be checked for proper functioning prior to application, -All residents who were identified with a diagnosis of diabetes or high risk for skin breakdown, skin checks will be completed by the licensed nurse every day. The skin checks will be documented in the resident's medical record. -The director of nursing and/or designee will complete daily audits of the treatment administration record to ensure wound care was completed according to physician orders. -The director of nursing and/or designee will complete treatment observations to ensure physician orders are being followed and appropriate infection control practice for all nurses. The director of nursing and/or designee will track the observations to ensure compliance. -The Nurse Practitioner or designee will be assigned as the wound nurse and will conduct weekly wound rounds, document the progress and any new findings of the wound, and track all wounds in the facility. -Each resident will have a skin assessment completed weekly and documented in the resident's medical record on the skin assessment form by a licensed nurse. The skin assessment will include any new, current, on-going and resolved skin concerns. It will indicate if the resident has no skin concerns. The physician will be notified of any new or worsening skin conditions and documented in the resident's medical record. The wound nurse will be notified of any new skin concerns via phone call or in person. -Residents with newly identified skin conditions will be assessed for a change of conditions and monitored for 72 hours on Alert Charting Log. -All wound care notes from all wound care providers will be scanned and kept in the resident's medical record. 2. Systemic Changes The director of nursing or designee will provide education to all licensed nurses on 4/14/22. The education will include: each nurse will conduct a skin assessment of the resident when a new skin condition is reported by other disciplines (CNAs during the shower, PT/OT, etc), the notification of the physician when new or worsening skin conditions/pressure injuries are observed, all new or worsening wounds should have treatment orders documented in the treatment administration record, ensuring all orthotic devices are removed and the skin is inspected daily and documented in the resident's medical record, and physician orders should be follow. The education will be monitored by the director of nursing and/or designee to ensure compliance. Any licensed nurse not educated on 4/14/22 will receive training prior to their next scheduled shift. 3. Monitoring (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interdisciplinary team, to include the medical director, will conduct a root cause analysis to determine the progress of the corrective plan and will provide a report to the quality assurance performance improvement committee to discuss recommendations and additional corrective actions. C. Removal of immediate jeopardy On 4/14/22 at 1:35 p.m., the NHA was informed that the facility's plan to remove the immediate jeopardy was accepted, based on the review of the facility's plan to address systemic issues in pressure injury management. However, deficient practice remained at H level, actual harm at a pattern. II. Facility policy and procedure The Skin Management Guidelines policy and procedure, dated March 2022, was provided by the director of nursing (DON) on 4/18/22 at 3:25 p.m. In pertinent part, it read: -Skin alterations and pressure injuries are evaluated and documented by the licensed nurse. -Body audits are completed by the licensed nurse daily for patients with pressure injuries and documented on the TAR (treatment administration record); new findings are documented in the progress notes. -The Pressure Ulcer Scale for Healing (PUSH Tool) is used to document the healing status of pressure injuries. It is initiated upon identification of a pressure injury and is updated weekly by the wound team during wound rounds until wound heals. -Wound rounds are completed weekly on pressure injuries and complex wounds. IV. Resident #6-Multiple failures in assessment, monitoring and care, contributing to the development of pressure injuries that worsened. A. Resident #6 status Resident #6, age 67, was admitted to the facility 11/22/2017. According to the April 2022 computerized physician orders (CPO), diagnoses included Parkinson's disease, venous insufficiency, diabetes type 2, and acquired absence of right foot. The 12/23/21 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He had no behavioral problems, psychosis, or rejection of care. He required extensive assistance of one person with bed mobility, transfers, dressing, toilet use and personal hygiene. He was at risk of developing pressure injuries and had no pressure injuries at the time of admission. He had pressure reducing devices for his bed. He was marked as not having any functional limitations in his arms or legs. Record review revealed that due to the absence of his right foot, the resident wore orthopedic boots for mobility and had done so since admission. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Braden scale assessment on 12/23/21 revealed a score of 18, indicating mild risk for pressure injuries. B. Resident interview and observations Resident #6 was interviewed on on 4/12/22 at 12:10 p.m. Resident #6 was lying in bed on his back. He was displaying constant involuntary movement of his arms and legs. The resident had Prevalon boots on both of his legs. The stump of the right leg was partially sticking out of the Prevalon boot due to continuous involuntary movements. A large (about 7 cm by 2 cm) scab on the upper shin was rubbing against the strings of the boot. The Prevalon boot on the resident's left leg had visible curlex covering most of the ankle. Four toes with multiple black scabs on top of each toe were sticking out of the boot. Space between the toes was packed with red to black debris, possibly skin. There was no visible space between the toes. Resident #6 said his right foot was amputated a while ago and since then, he had been wearing custom made boots on both legs for ambulation. A few weeks ago, his left boot got modified and it was at about this time he started to develop wounds on his left foot. He said his wounds were discovered during a physical therapy session with an outside provider. He said the wound started as a small area and later deteriorated to a large wound. He said his wound dressings were not changed routinely and day and evening nurses would say the dressings were scheduled to be done during the night shift. However, the night shift nurses would not change the dressings either. He said he was seen by an outside physician for wound care at least once a week and that was almost the only time his dressings were changed. He said the lack of wound care in the facility contributed to the deterioration of his wounds and he was hospitalized a few weeks ago with cellulitis. He said since he returned from the hospital, the wound care in the facility had not improved and nurses continued to skip dressing changes. C. Wound care observation Wound care observations were conducted on 4/13/22 at 11:41 a.m. in the presence of licensed practical nurse (LPN) #1 and the unit manager (UM). -Left leg: LPN #1 removed the velcro strip on the left Prevalon boot and opened it up. Upon opening, a large wound on the lateral side of the shin was observed. The wound was stuck to the inside of the Prevalon boot and saturated with red bloody drainage.The wound was about 3 cm by 6 cm with clear to bright red fluid seeping through its entire surface. The ankle was completely wrapped in curlex. The curlex on the heel area had a large black to red stain extending through the entire heel. It was partially dry and partially wet. The wet section of the curlex saturated the Prevalon boot and stained it with red to black drainage. Removal of the curlex revealed several foam dressings on the side and the top on the ankle. The foam dressings were saturated in dark red drainage and no longer were sticking to the tissue. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The foam dressing on the heel was dated 4/12/22. [NAME] xeroform dressings were removed together with foam dressings, and revealed multiple open areas covering the entire ankle with the largest open area covering the entire bridge of the foot. All open areas were seeping clear to pink drainage. The entire area on the heel presented with unstageable black wet eschar. The tissue between the wounds was cleaned with skin prep solution. Xeroform dressing was applied to open areas. Treatment for the heel was conducted per physician orders. The rest of the ankle and open areas were covered by ABD pads (absorbent multi-layer pads) and curlex. E. Record review-Record review revealed multiple failures in assessment, monitoring, care planning and treatment, contributing to the development of pressure injuries that worsened, became infected, and required hospitalization . 1. Failure to properly assess and care plan Resident #6's risk for pressure injuries prior to orthopedic boot modification. a. Record review revealed the resident experienced trauma, the potential for pressure injuries and wounds in January 2022 and February. There was insufficient documentation that the resident's injuries and potential for injuries were assessed, monitored, and treated. According to a skin progress note 11/30/21, wound care physician (WCP) #1 rounded on patient on left skin tear and per his observations, resident did not have any skin tears or wounds. There were no additional skin/progress notes until 1/18/22. However, on 1/18/22, a skin/progress note documented resident acquired traumatic skin tear to left shin (2 cm by 1.6 cm). No redness or irritation of surrounding skin. Care plan in place to promote healing and to prevent additional ulceration and infections. Treatment orders were to clean with normal saline, and to apply foam dressing daily. The treatment administration record (TAR) for January 2022 revealed the resident had an order in place to apply skin prep to bilateral heels and left plantar (bottom foot) for prophylaxis every third day. The order was discontinued on 4/8/22 (during survey). The resident also had an order in place to use a leg elevating device for the left leg while in bed, to make sure the left heel was floating. The order read to cover the device with absorbent pad due to wound drainage. The order was consistently signed by nurses three times a day, and was discontinued on 4/11/22 (during survey). Yet, the care plan for skin integrity, initiated on 11/22/17 and revised 1/4/22, while noting the resident's risks associated with immobility and incontinence, did not address skin tears or his use of orthopedic devices on his feet. Further, there was no mention of a wound on the left heel on the TAR, in progress/skin notes or care plan in January 2022. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Record review revealed the resident received new orthopedic boots in February 2022. Although skin breakdown was documented thereafter, record review revealed no planned interventions to monitor the resident's lower extremities to prevent his skin breakdown from worsening. On 2/11/22, the resident was seen by a physical therapist (PT), outside of the facility, who documented in her notes that the resident received his new boots and has been wearing them for the last two months. He had no problems on the right leg. On the left leg he had several areas that have broken down skin with some wounds. Resident said the wounds were discovered at the wound care clinic that he went to and dressing was put on at that time. He had two areas on his shin that were open and appeared to be shear type areas from the front of the boot, and several other areas. On 2/15/22, a wound clinic note mentioned the resident had multiple open wounds to left leg. A total of four open areas were documented, two on the ankle and two on the shin. All open areas were measured less than 1 cm, with granulation tissue and small serosanguinous drainage. Recommendations included to maintain wound care appointments and notify the clinic of any changes to wounds. On 2/17/22, the wound clinic note documented a total of two wounds on the left lower leg. Wound #1 was on the left plantar side and wound #2 was on the left upper ankle. Both wounds measured less than 1 cm. Recommendations included to clean both wounds with wound cleanser, apply skin prep to peri wound, and apply optifoam. In addition, off-loading and taking shoes off during the day. On 2/24/22 wound clinic note documented wound #1 had thick serosanguinous drainage with foul odor. The wound was beefy red with well defined edges, measured 1 cm by 0.5 cm, and appeared to be pressure related. TAR review for February 2022 revealed the resident received: - two treatments to right shin skin tear on 2/1 and 2/2. The order was discontinued after 2/2/22; -skin prep to bilateral heels at bedtime every third day; -leg elevating device for left heel since last month. Notwithstanding documentation of the resident's wounds, review of the resident's care plan for skin integrity revealed no update to ensure daily monitoring of the resident's feet and no documentation in the progress notes that showed staff was assessing the resident's skin under the orthopedic boots. Further, there were no additional orders to address the wounds that were documented in the wound clinic notes. 3. Record review revealed the facility failed to consistently assess and monitor the resident's feet, as well as consistently treat the resident's skin breakdown, contributing to new wounds, infection, hospitalization , loss of mobility and left leg cellulitis. On 3/1/22, the resident attended a physical therapy session with an outside provider, who documented the following findings: old left shin wound is healed, however new wounds are on left dorsum of the foot near ankle. (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/1/22, the wound clinic noted the resident had a wound on his right foot, measuring less than 1 cm, beefy red, pressure point related to boot. The wound notes did not mention the left leg. On 3/3/22 the wound clinic note documented the resident had wound #1 on his left foot, the wound measured less than 1 cm and was a skin breakdown in type. Treatment included to clean the wound and apply foam dressing. On 3/7/22, the wound clinic note read: we did not see much of anything on his left leg, except for an abrasion on his left upper leg from the boot that he had on. On 3/10/22, the resident attended a physical therapy session with an outside provider. The resident was not able to participate in therapy and said he did not feel great today. He shared with the therapist that nurses at the facility were not attending the areas on his feet. The PT inspected the left leg and observed left heel open area with bloody drainage on the sock and heel. The PT documented, the open area approximately near the area that the orthotic insert may be rubbing with the heel lift that was put in the boot on 3/8/22. PT notified the wound clinic and replaced his orthopedic boot with a large walking boot. On 3/10/22, a progress note by the facility nurse documented that she received a call from the wound clinic that the resident had pressure ulcers on his legs. She received an order for wound care treatments and completed an incident report. On 3/11/22, a progress/skin note by the facility nurse revealed the resident had two wounds. Wound #1 was on the left heel measuring 1.5 cm by 1.6 cm by 0.1 cm., Wound #2 located on the left shin and measuring 2 cm by 2 cm by 0.1 cm with serosanguinous drainage present. Report was received from the wound clinic indicating the pressure ulcer was a result of adjustment made to the boot. Two care plans were initiated 3/11/22. One documented the resident had an open wound on front of left lower leg related to orthopedic boots. The goal was to provide treatment for healing and keep it free from infection. Interventions include administering treatments per physician order, and applying Prevalon boot at night while in bed. The other care plan documented the resident had an unstageable pressure ulcer on the left heel related to orthopedic boot. Interventions included to administer treatment per physician orders and complete daily body audit. However, the walking boot that the resident now was using on his left leg after it was provided by therapy 3/10/22 was not mentioned in progress notes, TAR or the resident's care plan. There was no evidence that proper placement and care was completed. On 3/13/22, a progress/skin note by the facility nurse documented the same wound observations and measurements as above. Even though wound care treatment orders were initiated by the facility on 3/11/22 (after the wounds were discovered during the PT session on 3/10/22), notes from therapy sessions indicated skin assessments, monitoring and the treatments were not consistently completed by facility staff. Specifically: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/15/22, the resident attended the next scheduled therapy session. During the session, the nurse in the clinic was asked to assess his left heel. When (the nurse) took off the sock, a long piece of skin came with it. Patient's sock was covered in serosanguinous foul smelling drainage. The wound bed was red, and took up the entirety of the heel. The shin wound started to open up. A new wound was discovered on the back of the left calf. Resident #6 was sent to the PCP's clinic and seen by the nurse practitioner at that time due to a rapid change of condition. Blood tests and urine work were completed. On 3/17/22 during a physical therapy session, resident was not able to participate in ambulatory (walking) exercise due to a wound on the left heel. On 3/17/22, the resident was assessed in a wound care clinic; two wounds were observed. -Wound #1 located on the left heel: dressing was rolled up and it was saturated with serous drainage. Unstageable black eschar [was] covering most of the wound bed. Full thickness tissue loss in which the base of the ulcer is covered by slough and eschar in the wound bed. Treatments included to cleanse the left heel with wound cleanser or normal saline. Pat dry, and apply mepilex dressing. Change daily and off-load. -Wound #2 located on the left lower extremity below the knee and was caused by velcro from the walking boot. The wound was healing. Treatment order included to clean with wound cleanser and apply foam dressing. -The measurements for both wounds were not recorded on the notes. On 3/21/22, the resident attended a scheduled wound care clinic visit, new ulcerations on the left foot were noted. The exam revealed [O]bvious edema occurring in the left extremity that was not noticed at last visit. -Wound #1 Plantar (on the sole) posterior (back) aspect of the left calcaneus (heel) shows an unstageable pressure injury. Devitalized tissue around the site with large eschar formation in the center. Measurements of the wound were not included in the notes. -Wound #2 was very large unstageable pressure injury to the left heel caused by the boot. The wound was measuring 7.5 cm by 11 cm., with poorly defined wound edges and macerated moist peeling skin around it. Treatment consisted of sharp debridement, the area was cleaned and new dressing was applied. The wrap was applied to the left leg as well to control edema. Facility was contacted over the phone and treatment orders for the resident were discussed with the nurse on duty. The facility was notified to watch for signs and symptoms of potential infection and plan to re-evaluate the resident in two weeks. The facility failed to take steps to prevent further decline in the resident's condition, as ordered. -Progress notes and TAR review demonstrated that above recommendations for edema management and monitoring for infection were not added to the resident's medical record. There was no evidence in the resident's progress notes that the resident was monitored for edema and potential infection on his left leg. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No additional progress/skin notes were located in the resident's medical record regarding the further deterioration of his wounds. -The medication administration record (MAR) for March 2022 revealed staff failed to conduct all ordered treatments. Specifically: -The Prevalon boot was applied at bedtime to relieve the pressure on the heel (did not specify right or left). The order was initiated on 3/11/22, it was not signed as complete on 3/26/22. -Weekly body audits were signed as completed on 3/3, and 3/10/22, and on 3/15/22, body audits were switched to weekly despite the resident's decline. The audits were signed as completed every day except for 3/16 and 3/22/22. -Dressing changes for pressure ulcer on left front lower leg were initiated on 3/11 and discontinued on 3/23/22. The order was not signed/completed on 3/16, 3/21, 3/22, and 3/23/22. Additional orders for the same wound were initiated on 3/23/22 and read that dressing changes were scheduled to be done on Mondays, Wednesdays, and Fridays by the wound care clinic. The order was not complete/signed on 3/25/22. -Dressing changes for the pressure ulcer on the left heel were initiated on 3/11/22. The treatment order changed on 3/19/22 and was changed again on 3/25/22 to be completed on Mondays, Wednesdays, and Fridays by the wound care clinic. The order was not signed/completed on 3/16, 3/21, 3/22, 3/23 and 3/25/22. - Despite documentation of skin breakdown on the resident's heels, skin prep to bilateral heels at bedtime every third day was consistently signed as completed during the entire month of March. -Off loading left heel at all times was initiated on 3/23/22 and was not signed/completed on 3/25, 3/26, and 3/27/22. -Leg elevating device for left leg (initiated in January 2022) was not signed/completed on 3/2, 3/25, 3/26 and 3/27/22. See above; the wound care treatment orders were conflicting with one order calling for skin prep to the left heel and another one for dressing changes. In addition, some wounds and abrasions that the resident had on both legs early in March (see notes above 3/1 and 3/3/22) were not treated or documented in progress notes or TAR. On 3/29/21, the resident attended a regular PT session outside the facility. The nurse was called to the room to assess the wounds. Full removal of the dressings note worsening wounds, profoundly macerated and peeling skin on 90% of foot, severe redness over top of foot, that was taught and shiny. Also, increased swelling up to below knee with rubby skin and several new areas of concern that are open, with eschar areas to great toe, second toe and fourth toe. Resident reported that his dressings were changed but once since his appointment at the wound clinic over a week ago. The PCP was contacted and an order was received to send the resident to the emergency department for evaluation. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. hospitalization -documentation of decline According to the hospital admission records dated 3/29/22, the resident was seen in the emergency department on 3/29/22 for redness on his foot that got more red over the last two weeks. The resident was admitted to the hospital with a diagnosis of left lower extremity cellulitis with unstageable chronic wounds. Resident with cellulitis and multiple wounds on left foot. Left foot and lower leg are three times larger than the right leg. The resident was started on intravenous (IV) antibiotics and wound treatments with antimicrobial gel. Several open areas were located on resident's legs, such as unstageable pressure injury to the left heel, measuring 9 cm by 9 cm; left foot plantar wound with unknown and potentially traumatic origin due to large amount of edema, measuring 9 cm by 13 cm., wounds on 1st, and 2nd toes measuring 1 cm each; two venomous ulcers on right leg measuring 3 cm by 3 cm and 9 cm by 9 cm. Resident #6 was seen by a wound care specialist daily. He underwent sharp debridement and wound care treatments. The resident was discharged back to the facility six days later on 4/4/22. He continued to receive oral antibiotics for cellulitis for the next 10 days, until 4/14/22. Recommendations included to continue antibiotics therapy, off load pressure injuries and provide daily dressing changes. The Braden Scale Observation/Assessment (for predicting pressure sore risk), dated 4/4/22, revealed a score of 16, which indicated the resident was at moderate risk for the development of pressure injuries. The section 7 on the form contained a question whether to proceed to the preventative care plan and to the wound/skin care plan; the answer to which was marked as no. F. Staff interviews-Confirmation of facility failures in assessment, monitoring and treatment of the resident's skin condition and that these failures contributed to the resident's decline. Nurse Practitioner (NP) #1 was interviewed on 4/12/22 at 10:55 a.m. She said she was a primary care NP who worked with the resident in conjunction with the PCP. She said she was very familiar with the resident and had seen him frequently. -She said the resident was attending a therapy session in her building on 3/29/22 when the swelling of his left leg and wounds was brought to her attention. She said the swelling of his leg was so significant that she was surprised how that went unnoticed by the facility staff when they helped the resident get dressed for the appointment. She said the cellulitis infection was very clear, and she sent the resident directly to the emergency department as she felt he needed immediate interventions. She said his wounds appeared neglected and not tended to for several days. -She said she observed the resident previously in the facility on several occasions and he reported to her that nurses were not changing his dressings. Specifically, on one of her assessment days, she observed a

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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** 37166 Based on observations, record review, and interviews, the facility failed to ensure a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility for four (#22, #40, #51 and #59) of five residents reviewed for activities of daily living of 33 sample residents. Specifically, the facility failed to: -Provide restorative care services to Resident #40 on a regular basis, and consistently apply wrist splint as recommended by an occupational therapist (OT), -Provide range of motion (ROM) exercises for Resident #22, and, -Ensure Resident #51 and #59 received range of motion services for impaired mobility. In addition, the facility failed to assign a licensed nurse responsible for the audit and maintenance of the restorative nursing program, and failed to provide education to certified nurses aides (CNAs) who were assigned to provide the restorative care. Findings include: I. Facility policy and procedure The Restorative Nursing Guideline policy and procedure, dated 2019 with no revision date, was provided by the director of nursing (DON) on 4/18/22. In pertinent part, it read: Restorative nursing care includes nursing interventions that help to maintain the patient's highest level of function and prevent unnecessary decline in function. Restorative nursing programs are individualized to specific patient needs and have many tangible positive effects. -The patient's plan of care is updated or a plan of care is developed to include patient -centered interventions supporting the patient's restorative nursing program. The care plan must include measurable objectives or goals and interventions. Objectives are measurable when a form of measurement is attached to it, such as a distance. Amount, percentage, or time frame. -Interventions are provided by nursing staff who have completed the appropriate competency evaluation. Both types of interventions are supervised by the licensed nurse and are specifically defined in the patient's plan of care. -The initial review for restorative nursing is completed by the licensed nurse. The licensed nurse determines the specific goals and interventions required to develop the patient specific restorative care plan. -The licensed nurse is responsible for evaluating the patients response to the restorative plan according to individual state requirements. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The restorative nursing process is routinely audited through the utilization of QAPI process tools to identify potential or actual system issues. II. Resident #40 A. Resident status Resident #40, age 75, was admitted to the facility 2/9/2021. According to the April 2022 computerized physician orders (CPO), diagnoses included contracture of the left shoulder, left wrist, neuromuscular disjunction of the bladder, epilepsy, hemiplegia hemiparesis of the left dominant side. The 2/9/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He had no behavioral problems, psychosis, or rejection of care. He required extensive assistance of two people with bed mobility, transfers, dressing, toilet use and personal hygiene. B. Resident interview Resident #40 was interviewed on 4/6/22 at 12:43 p.m. He said he was in the facility long term for care because he was not able to move his left arm and his left leg. He said he was supposed to receive therapy for his left leg and left arm, but no one was providing such services. He said he voiced his concerns to the nurses on several occasions but it did not help. He said he was wearing a splint on his left hand to prevent the contracture. He pointed to the left hand that had spleen on and was positioned on a blue cushion. He said the splint was supposed to be on during the night hours, but nurses would forget to remove it and he was in it all day long. C. Observations On 4/6/22 Resident #40 was continuously observed between 3:00 p.m. and 5:00 p.m. Resident's left hand with a splint was on top of a small blue cushion under the blanket. The splint was not removed. On 4/7/22 resident was observed at 9:10 a.m. the resident was in bed, his left hand had a splint on. On 4/11/22 resident was observed at 11:09 a.m. CNA #13 provided incontinence care to the resident. Resident was wearing a splint on his left hand. -The facility staff failed to ensure the split was placed and removed according to the physician orders D. Record review The most recent occupational therapy discharge summary dated 12/10/21 recommended the splint during the night only. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for activities of daily living (ADLs) and self care deficit was initiated on 2/9/21 and revised on 2/9/22 revealed resident had self care deficit related to left sided weakness, left hand, wrist and elbow contracture, and left foot drop. Interventions included one person assistance with grooming, and dressing. Assistance with meals as needed. One person assistance with bathing and toileting. Extensive assistance with daily hygiene, grooming, bed mobility, transfers, toileting, dressing, and oral care. Transfers two person mechanical lift. WC for mobility. The care plan for loss of range of motion related to physical limitations was initiated on 3/10/21. Interventions included applying a splint/device for the left upper extremity during the night and taking it off during the day. -The resident did not have a care plan for the restorative program. According to the CPOs resident to wear a splint on his left wrist during the night. Review of the medication administration records (MARs) and treatment administration records (TARs) for March and April 18, 2022 revealed that the splint should have been applied only at night and should have been taken off during the day. Nurses consistently signed that the order was implemented. The most recent physical therapy discharge summary dated 3/12/21 recommended daily restorative range of motion and a splint for the left wrist. The restorative program logs were requested for the last six months. The most recent log was for January 2022. The January restorative log showed that an active range of motion was provided to the resident on 16 out of 30 occasions. The passive range of motion appeared to be documented twice per day with random duration. Occasional refusals were documented on the log. However no supporting progress notes were located regarding what was done and why the resident refused. -No logs were provided for February, March and April of 2022. D. Staff interviews The director of rehabilitation (DOR) services was interviewed on 4/12/22 at 9:43 am. He said Resident #40 was discharged from OT/PT therapy last year (2021). He said recommendations from both therapies included daily range of motion when a resident is getting out of bed and should be provided daily by CNAs. He said at the moment he can not name a person who is responsible for the restorative program in nursing due to frequent rotation of staff. Occupational therapist (OT) was interviewed on 4/12/22 at 12:08 p.m. She said Resident #40 had a recommendation to wear a wrist splint during the night. She said it was changed from the day because he felt too uncomfortable and after discussing it with a resident the decision was made to wear it only at night. Licensed practical nurse (LPN) #2 was interviewed on 4/14/22 at 12:30 p.m. She said she did not know what a restorative program was and who was in charge of it. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #15 was interviewed on 4/14/22 at 12:50 p.m. She said she assisted Resident #40 with cares, but he rarely got dressed, he always wore a gown. She said she moved his arms and legs when she provided the care but was careful with the left arm because it was painful for Resident #40 to move. She said she did not recall when was the last time she received training on range of motion. CNA #8 was interviewed on 4/14/22 at 1:20 p.m. She said she moved the Resident #40's legs and arms when she was assisting a resident with incontinence care. She did not recall when was the last time she received training on the range of motion. She did not know where to look for how many minutes arms and legs should be moved. CNA #16 was interviewed on 4/14/22 at 1:29 p.m. She said she moved the Resident #40's legs and arms when she was assisting a resident with incontinence care. She did not recall when was the last time she received training on the range of motion. She did not know where to look for how many minutes Resident #40's arms and legs should be moved. 45889 III. Resident #22 A. Resident status Resident #22, age 68, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included adult failure to thrive, type 2 diabetes mellitus, osteoarthritis, quadriplegia, post-traumatic stress disorder, chronic pain, and generalized muscle weakness. The 1/25/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance from two staff members for bed mobility, dressing, toileting, and personal hygiene. The resident had functional limitations in range of motion on both sides of her upper extremities. -Therapy and restorative minutes were not coded on the MDS assessment. B. Resident interview and observations Resident #22 was interviewed on 4/6/22 at 11:17 a.m. The resident was positioned on her back in her bed. Her torso was slightly elevated and the tray table was in front of her. She had contractures to both hands and the left wrist was in a brace. The resident said she doesn't wear a brace on the right wrist because it is too painful. She said her range of motion (ROM) is limited because of her spinal cord injury and that she has asked for physical therapy since arriving at the facility, but said that she had not received any physical therapy. She said that she does not receive any passive ROM exercises either. Resident #22 was interviewed again on 4/13/22 at 11:33 a.m. The resident said that the certified nurse aides (CNAs) and nurses do not perform ROM exercises for her at any time. She repeated that she was not receiving any kind of therapy and believed that it would be beneficial for her. C. Record review (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The care plan for activity for daily living (ADLs), initiated on 7/23/21 and revised on 12/30/21, revealed the resident had self care deficit as evidenced by impaired mobility related to physical limitations related to quadriplegia, right hand contracture, obesity, chronic pain and type 2 diabetes mellitus. Interventions included transfer with mechanical lift, assist to bathe/shower, break ADL tasks into subtasks for easier patient performance, extensive assistance with bed mobility, transfers, toileting, daily hygiene, grooming, dressing, oral care, and eating as needed, prefers to have her bed in high position and uses assistive/adaptive equipment (wheelchair). -The care plan did not mention passive ROM or details on when passive ROM should be provided and for how long. -The resident did not have a care plan for the restorative program. Review of the medication administration records (MARs) and treatment administration records (TARs) for March 2022 and April 2022 revealed no records that passive ROM was documented by nurses. -There was no restorative program log. The discharge summary from occupational therapy dated 8/4/21 revealed recommendations were assistance with independent ADLs, assistive devices for safe functional mobility, environmental modifications, grab bars, remove environmental barriers, shower chair with back, and 24 hour care. The prognosis indicated that the resident would maintain current level of function with good and consistent staff follow-through. -There was no order documented in CPOs D. Staff interviews Occupational Therapist (OT) #1 was interviewed on 4/12/22 at 11:55 a.m. She said that physical therapy and occupational therapy worked with Resident #22 for a while and then ran into insurance issues therefore the resident had to be discharged from therapy. OT #1 said that when the resident was discharged from therapy, a communication summary was presented to staff directing them to perform ROM to the resident during clothing changes and personal care. She said the completed form should be filed in the hard chart at the nurse's station. OT #1 said that discharge communication does have lapses because of travel staff so ROM exercises are not being performed as directed. She said that passive ROM is important for hygiene of the hand and to help prevent pain. She said that the restorative program in charge of passive ROM for residents was overseen by the charge nurse although she is not sure who is in charge of the restorative program now. CNA #14 was interviewed on 4/12/22 at 1:45 p.m. The CNA said that she provides care for Resident #22 that includes checking the resident every two hours and providing personal care as needed. She said that during personal care, the resident uses her right arm to grab staff while changing and repositioning her which counts as passive ROM. (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #15 was interviewed on 4/12/22 at 1:51 p.m. The CNA said that she rarely worked with Resident #22, although she knows her hands are very contracted and she moves her arms as much as the resident can tolerate. LPN #6 was interviewed on 4/18/22 at 11:35 a.m. She said that no one is specifically in charge of the restorative program. LPN #6 said that if a resident had contractures, that should be documented in the kardex for the CNA to perform. She said that she had restorative training in the past but wasn ' t sure who was offering training currently. She said that staff should be trained on passive ROM. LPN #2 was interviewed on 4/18/22 at 11:45 a.m. She said that she has not heard of a restorative program at this facility. LPN #1 was interviewed on 4/18/22 at 11:51 a.m. She said that the DOR provided oversight for the physical therapy program for residents but she was not aware of who provided oversight for the restorative nursing program. She said passive ROM should be performed by CNAs. The director of rehabilitation (DOR) was interviewed again on 4/18/22 at 12:00 p.m. He said he performs a thorough assessment after receiving an order from the physician. He said the discharge communication form relays basic recommendations for transfers, assistance needed, activity participation, ROM and activities of daily (ADL). He said that everyone gets a recommendation but everyone has the right to refuse to participate in the restorative program. - The DOR reviewed the recommendations for Resident #22 which consisted of being up in a chair and general ROM. He said that no contractures were noted in the records. The DOR said that long term consequences of a resident not receiving passive ROM include pain and loss of function. He said that contractures are never good but cannot always be prevented, although the process of loss of ROM can be slowed. The DOR completed a physical evaluation of Resident #22 on 4/18/22 at 12:40 p.m. and reported the following: -He said that he cannot fix problems that he doesn't know about. He said he feared that staff were being hired without proper training. His evaluation included that Resident #22 had incomplete quadriplegia and had use of her right hand sufficient for eating and using the television remote. He said she should be getting passive ROM in the morning and should be up in her chair. He said the resident was still in her nightgown and laying in bed so most likely has not received any passive ROM. The DOR concluded that it does not appear that Resident #22 is receiving restorative nursing services and that her ROM had declined. The interim director of nursing (IDON) was interviewed again on 4/18/22 at 5:10 p.m. She said that contracted hands should be opened and assessed by nurses, not CNAs. She said that restorative nursing services should be performed because the resident already had an issue and that passive ROM exercises help maintain current level of function and might prevent further loss of function. The IDON said that the CNAs should follow recommendations but that all staff should be offering restorative services, not just CNAs. The IDON said that it would be helpful if the facility had someone in charge of the restorative program and a team dedicated primarily to perform restorative services. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20287 IV. Resident #51 A. Resident status Resident #51, under age 65, was admitted on [DATE]. According to the April 2022 computerized physician order (CPO) diagnoses included cerebral vascular accident (CVA), and hemiplegia and hemiparesis following cerebral infarction affecting the right non-dominant side. The 2/22/22 MDS assessment coded the resident with a brief interview for mental status of 15 out of 15. The MDS showed the resident had impairment on one side for both upper and lower extremities. The resident required extensive assistance with personal hygiene. B. Observation and interview On 4/7/22 at 10:33 a.m., the resident's right hand was in a closed position. The resident said he was unable to open it any further. The resident said he had a CVA and it was affected by the stroke. He said he did not receive any range of motion on his right hand to help with the contracture or on his upper extremities or lower extremities. He said he did not get out of bed. C. Record review The occupational therapy (OT) evaluation dated 8/27/21 revealed the reason for the referral was for the change in self feeding abilities, to address decreased coordination, strength, range of motion and necessity of the residents right hand an upper extremity contracture. The evaluation also documented, the resident's right upper extremity, of range of motion, revealed that the shoulder, forearm, elbow, wrist and hand thumb index finger, middle finger, ring finger and little finger were all impaired. The facility had no follow-up to the OT evaluation on 8/27/21 which would develop a program for range of motion to include the areas identified that needed to be addressed. The care plan last updated on 2/1/22 identified the resident had a self care deficit related to CVA to right hemiparesis and right hand contracture. Interventions included, to assist with grooming, bed mobility, transfers, toileting, dressing, and oral care, encourage and assist in repositioning. Transfers two person mechanical lift. -The resident did not have a care plan for the restorative program, or range of motion to his right hand contracture or his lower extremities. The kardex last updated date of 4/18/22 failed to show range of motion to his right hand contracture and his lower extremities. -The medical record failed to show the resident had a restorative program where the passive range of motion could be done. -No refusals were documented. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No orders were revealed for range of motion to indicate it was ordered. D. Interview The director of rehabilitation (DOR) was interviewed on 4/18/22 at 12:03 p.m. The DOR said the resident was not on a restorative program and one was not recommended from the evaluation on 8/21/21. He said when the resident was first admitted to the facility in 2017, a lot of physical therapy was provided, however, the resident did not want to do much on his own and therefore the therapy was discontinued. He said the range of motion should be completed by the CNA. He said it consisted of moving both his upper and lower extremities in passive repetition for eight to to repetitions. He said during the time staff helped the resident with dressing, it was a good time to do the passive range of motion. He reviewed the medical record and said the contracture was at 50 degrees and that since the resident had a hand contracture, the range of motion would not help improve, but could help with the prevention of worsening. CNA #2 was interviewed on 4/18/22 at 2:00 p.m. The CNA said she did not perform passive range of motion for the Resident #51. She said Resident #51 did not get dressed on a regular basis. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:17 p.m. The DON said although she did not know Resident #51 that a hand contracture continued to need range of motion and a program to ensure that it did not worsen and that his upper and lower extremities also needed to have range of motion, especially because the resident did not get out of bed. 38185 V. Resident #59 A. Resident status Resident #59, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included congestive heart failure (CHF), pressure ulcer, pressure induced deep tissue damage of unspecified site, type two diabetes, moderate persistent asthma, chronic obstructive pulmonary disease (COPD), chronic pain, trigeminal neuralgia, fibromyalgia and generalized anxiety disorder. The 3/4/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident was at risk for developing pressure injuries and had a stage three pressure injury and an unstageable pressure injury. The resident had a pressure reducing device for the bed and was not on a turning or repositioning program. B. Resident interview (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #59 was interviewed on 4/6/22 at 3:03 p.m. She said her left hand was completely contracted. She said the facility staff did not provide anything to prevent her nails from digging into the palm of her hand. She said she would fit some tissues into her hand on her own in an attempt to prevent her nails from digging into her palm. C. Record review The activities of daily living care plan, initiated on 11/21/17 and revised on 12/30/21, revealed the resident had a self-care deficiency related to weakness, COPD, obesity, a contracture to the hand, foot drop to both feet and the resident's hospice status. It indicated the resident required two person assistance with a Hoyer lift for transfers and the resident required care in pairs. It did not address any preventative measures for the contracture to the resident's left hand. D. Staff interviews Certified nurse aide (CNA) #3 was interviewed on 4/12/22 at 10:40 a.m. He said he had worked at the facility for a month. He said since he had worked at the facility, Resident #59 had not been able to move her left hand. He said her hand was fully contracted to where her fingers touched the palm of her hand. He said he was not aware of a brace or device to assist the resident in preventing skin breakdown. He said he had not provided the resident with any assistive devices since he had worked at the facility. The director of rehabilitation (DOR) was interviewed on 4/18/22 at 12:00 p.m. He said Resident #59 had a long time contracture to the left hand. He said he did not know the progress of the resident's contracture, but he thought her fingers touched the palm of her hand. He said the therapy department had not been consulted to put preventative skin breakdown measures in place for Resident #59's left hand contracture. He said the nursing staff should have contacted the therapy department to get an order for an intervention to ensure the resident's skin does not breakdown. He said rolled gauze was a good intervention to prevent skin breakdown. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:11 p.m. She said nursing should be observing Resident #59's skin on the left hand contracture every day. She said an intervention should be in place to prevent skin breakdown. She confirmed the resident's comprehensive care plan and physician orders did not address the resident's left hand contracture to provide interventions to prevent skin breakdown. She said it appeared as though there was no monitoring of the resident's skin related to her contracture. E. Additional information The April 2022 CPOs documented the physician ordered: rolled gauze to the left hand. Remove the gauze every shift, check the skin integrity of the resident's left hand, and document the findings every shift. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This was ordered by the physician on 4/15/22, during the survey process. VI. Additonal inteviews The interim director of nursing (IDON) was interviewed on 4/18/22 at 4:30 p.m. She said she did not know who was in charge of the restorative program in the building. Unit manager (UM) was interviewed on 4/19/22 at 2:30 p.m. She said she did not know who was in charge of the restorative nursing program. Nursing home administrator (NHA) was not available for an interview on 4/19/22. Medical director (MD) was interviewed on 4/19/22 at 1:30 p.m. He said the restorative program was important for the maintenance of mobility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, record review and interviews, the facility failed to ensure one (#13) of three residents received adequate supervision to prevent accidents out of 33 sample residents. Specifically, the facility failed to conduct a root cause analysis and implement person-centered interventions after Resident #13, who had five falls in four months. Findings include: I. Facility policy and procedure The Falls Practice guide, dated December 2011, was provided by the regional nurse manager (RNM) on 4/13/22 at 12:15 p.m. It revealed in pertinent part, Events considered to be a fall include when a patient: unintentionally comes to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force; loses balance and would have fallen, if not for staff intervention; and is found on the floor, unless there is evidence suggesting otherwise. Fall reduction and injury prevention strategies that can be implemented upon admission may include, but are not limited to the following: orientation to surroundings and use of call light; placement of call light within reach and visible; placement of light cord within reach and visible; placement of personal care items within reach; provision of environmental modification, if clinically indicated (low bed, cushioned floor mats next to bed, removal of trip hazards); use of appropriate footwear; availability of eyeglasses and hearing aids within reach, if applicable; use of hip protector products, as clinically indicated; review of ordered medications for potential fall risk side effects; provision of assistive devices, as clinically indicated (wheelchair, cane, walker, crutches); and referral to physical, occupational and speech therapy. The interdisciplinary team designs the patient's care plan to focus on all of the patient's issues including those associated with fall prevention and fall risk management. Input from the patient, family or legal guardian is included to maintain consistency and build on past successes. Caregivers are also asked for suggestions about interventions they have successfully used in managing a patient's fall risk. The approaches for fall interventions are clear, specific and individualized for the patient's needs. Managing falls can be complex as many falls do not have a single cause but include a combination of risk factors and causes. Regardless of the interventions that are put in place, a key factor to success is the timely review of the interventions as the patient's condition and needs change. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Some environmental factors which may be associated with falls or the risk of falling may need to be reviewed and considered as ongoing fall prevention strategies. These factors may include, but are not limited to: bed height; improper footwear; inadequate lighting levels; loose carpeting or moveable rugs; uneven flooring; use of side rails; wet floors; access to grab bars in the bathroom; and furniture arrangement. Upon the completion of the evaluation, the physician is notified and orders and documented, noted and implemented, as indicated. The family and responsible party is notified of the fall event of change in fall risk factors and the patient's current condition. The patient's condition, response to interventions and subsequent care provided is documented in the patient's clinical record. The interdisciplinary care plan team reviews the patients most currently falls or fall evaluation in PointClickCare (the electronic resident charting program) to determine if the patient's present condition or status has changed and therefore requires the completion of a new fall evaluation. If the current fall evaluation still describes the patient accurately, then a narrative summary of the patient's condition and circumstances surrounding the vent are documented in the patient's clinical record. The care plan is revised as clinically indicated to meet the patient's current needs. II. Resident #13 status Resident #13, over the age 65, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO) diagnoses included anxiety, heart disease, gastro-esophageal reflux disease, myalgia (muscle aches/pain) and hypothyroidism. The 4/19/22 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of four out of 15. He required extensive assistance of one person for bed mobility, transfers, dressing, toileting, personal hygiene and one person limited assistance for locomotion. He had hospice services. It documented the resident had not had any falls since his prior admission. -However, record review revealed Resident #13 had sustained four falls in the last 90 days. A. Resident representative interview The resident's representative was interviewed on 4/7/22 at 3:37 p.m. He said the resident has had a couple falls. He said the only intervention the facility put into place was to keep his bed in a low position. He said he visited the resident everyday and sometimes when he entered the resident's room his bed was not in the lowest position. B. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, initiated on 4/12/21 and revised on 7/27/21, revealed the resident required assistance with ADLs. The interventions included: assisting with showers as needed; providing extensive assistance with bed mobility, transfers, toileting, daily hygiene, and grooming; transfering the resident with one person assistance with a gait belt; and to use assistive/adaptive equipment (wheelchair and walker). The cognitive care plan, initiated on 4/16/21, revealed the resident had cognitive loss related to terminal illness. The interventions included: allowing extra time for the resident to respond to questions, to approach the resident in a calm manner, attempting to provide consistent routines, explaining care procedures prior to starting, and providing cueing and prompting as needed. The fall risk care plan, initiated on 4/14/21, documented the resident had a history of falls. The interventions included placing dycem (non-slide mat) to the recliner chair, encouraging the resident to transfer slowly, place commonly used items within reach, and to reinforce the need to call for assistance. 1. Fall incident on 1/10/22-unwitnessed The 1/10/22 nursing progress note documented at 1:48 p.m., Resident #13 had an unwitnessed fall. He was found on the floor next to his recliner trying to eat his lunch. The facility implemented a dycem pad to the resident's recliner following the fall. It indicated the resident did not sustain any injuries at this time. The 1/10/22 incident report indicated the resident was found on the floor near his recliner by a certified nurses assistant (CNA). The resident was assisted back to his recliner after a dycem pad was placed in the chair. The resident's family and physician were notified. The 1/10/22 fall assessment documented that the resident had difficulty maintaining a standing position and had impaired balance during transitions. It documented the resident was on cardiovascular medications and had multiple conditions that could relate to falls. It indicated the care plan was updated. The 1/10/22 investigation report indicated dycem was placed in the resident's wheelchair, the resident was to be monitored for positioning in his recliner during meals, and to provide frequent checks. According to the resident's plan of care, the intervention of placing a dycem pad in his recliner was initiated on 1/10/22, which was also reflected on the resident's kardex (staff directive). Frequent checks were documented on the kardex. -However, the facility was unable to provide documentation that the frequent checks had been completed or identified the parameters of the frequent checks. 2. Fall incident on 3/6/22-unwitnessed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/6/22 nursing progress note documented, licensed practical nurse (LPN) #3 heard a loud noise from the hallway. Upon entering the room with a CNA, the resident was found with his back laying on the ground and his feet on the bed. It indicated the resident was assessed by the charge nurse, neurological checks were initiated and the resident was assisted back to bed. The resident's family and physician were notified. It indicated the resident did not sustain any injuries from the fall. The 3/6/22 fall assessment revealed the resident did not have any physical performance limitations, medications that could relate to a potential fall, comorbidities, or environmental factors that were related to the fall. It indicated the care plan was not updated after the fall. -However, according to the 1/10/22 fall assessment, the resident had multiple physical performance limitations, medications and comorbidities that would have contributed to the resident's fall. The 3/7/22 incident report reviewed the fall documented the events of the fall as indicated in the nursing progress note. -It did not include any post-fall interventions put into place. -The resident's plan of care was not updated with any person-centered preventative fall intervention following the resident's fall on 3/6/22. -A review of the resident's EMR on 4/18/22 at 9:00 a.m. did not reveal documentation of an interdisciplinary team review of the unwitnessed fall or a root cause analysis completed to determine the nature of the unwitnessed fall and implementation of an effective intervention post-fall. 3. Fall incident on 3/21/22-unwitnessed The 3/21/22 fall assessment was documented by licensed practical nurse (LPN) #1 at 3:36 p.m., revealed the resident had difficulty maintaining a sitting balance, difficulty maintaining standing position, and had impaired balance during transitions. It documented he was on cardiovascular and diuretic medications, had a decline in function, incontinence, cognitive impairment, fatigue, muscle weakness, arthritis, depression, and impulsivity or poor safety awareness. It documented the care plan was not updated after the fall. The 3/21/22 fall incident report, revealed the resident was found on the floor when the LPN entered the resident's room to administer medications. The resident was laying on the floor next to his bed on his left side. It documented he fell out of his bed as he was leaning to the left while eating breakfast in bed. He sustained a half dollar size skin tear to the left side of his head. The family, hospice, and physician were notified of the fall. The 3/22/22 fall investigation report documented the interdisciplinary team recommended to continue with the current fall interventions, which included frequent checks (which was not defined nor documented in the resident's medical record) and ensuring the bed was in the lowest position. -Review of the resident's progress notes did not reveal the resident had a fall on 3/21/22. Cross-reference F658: the facility failed to ensure residents were assessed for injury by a registered nurse (RN) immediately following a fall and prior to being moved off the ground. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. Fall incident on 4/14//22-unwitnessed The 4/14/22 nursing progress note documented the resident was found by the hospice RN on the floor next to the bed, on the floor. It documented the resident did not sustain any injury from the fall. -It did not indicate how the resident fell out of the bed or any new interventions put into place. -A review of the resident's EMR on 4/18/22 at 9:00 a.m. did not reveal documentation of an interdisciplinary team review of the unwitnessed fall or a root cause analysis completed to determine the nature of the unwitnessed fall and implementation of an effective intervention post-fall. The care plan was not updated to ensure effective interventions were in place, especially since the resident now fell from the bed on three occasions. III. Staff interviews CNA #1 was interviewed on 4/13/22 at 4:51 p.m. She said the nurse was responsible for assessing the resident for injuries following a fall. She said the CNAs assisted the nurse in moving the resident off the floor and onto the bed. She said fall interventions for Resident #13 included placing his bed in the lowest position and providing frequent checks every hour. She said the frequent checks were not documented. She said he also had a non-slip pad to his recliner, but he had not been sitting in his recliner recently as his mobility was declining. She said he preferred to spend more time in bed the last few weeks. LPN #2 was interviewed on 4/13/22 at 5:42 p.m. She said when a resident sustained a fall, she would immediately check the resident's vital signs. She said an assessment should be conducted, including a skin check after she transferred the resident from the ground back to bed. She said after the assessment was completed, the physician and resident's family would be notified. She said an incident report was completed after each fall. She said Resident #13 did not have any current fall interventions in place. She said the resident had not sustained any recent falls. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:10 p.m. She said after a resident sustained a fall, the interdisciplinary team should meet to review the situation and place an intervention in place to prevent future falls. She said fall interventions should be reviewed for effectiveness and implemented. She said the resident's care plan should be reviewed to remove ineffective interventions She confirmed new interventions were not put into place after Resident #13 had sustained several falls.

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37166 Based on observations, record review and interview, the facility failed to ensure certified nurse aides (CNA) are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Specifically, the facility failed to evaluate the competencies of certified nurse aides on restorative tasks such as brace/splint application, active and passive range of motion. Finding include: I. Facility assessment The facility assessment identified the facility accepted residents with contractures, and identified the facility could provide support and care for individuals with limited range of motion. II. Record review Records of five random CNAs working in the facility were reviewed. Out of five CNAs, three CNAs had no records of restorative skills checklist. Out of 30 plus CNAs that signed residents medical records indicating that range of motion was provided to residents with contractures, only six have completed the Skills and Techniques evaluation upon hire. The other CNAs had no records that restorative skills and techniques were evaluated. III. Interviews CNA #12 was interviewed on 4/18/22 at 10:12 a.m. She said she had not had to demonstrate care skills such as brace/splint application, active and passive range of motion during her employment with the facility. The interim director of nursing (IDON) was interviewed on 4/18/22 at 4:10 p.m. She said the facility did not have a staff development coordinator and competencies for aides were managed by a human resources director. She said she recently started the position and to her knowledge the facility did not have anyone in charge of the restorative nursing program. She said it would be important to have the competencies to ensure the aides were providing the best care to the residents and to ensure the techniques were current with best practices. CNA #2 was interviewed on 4/19/22 at 9:55 a.m. She said she had not had to demonstrate any skills to anyone for as long as she could recall. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Human resources director (HRD) was interviewed on 4/19/22 at 10:30 a.m. She said upon hire CNAs were validated for certain skills and techniques, including restorative services such as bed mobility, splints and range of motion. She did not know the details on how exactly skills were validated. Agency staff who were not directly hired by the facility and constituted the majority of aides in the facility at the moment, completed a different check list of skills. She provided a copy of the checklist. The checklist did not include skills for a restorative nursing program.

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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 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** 46022 Based on record review and interviews, the facility failed to ensure five (#27, #81, #25, #59, and #37) out of five residents reviewed out of 33 sample residents were free from unnecessary medications as possible. Specifically, the facility failed to: -Identify and monitor targeted behaviors for psychotropic medications for Resident #27; and, -Ensure consents were obtained and contained black box warnings for the usage of psychotropic medications for Resident #27, #81, #25, #59, and #37. Findings include: I. Facility policy and procedure The Behavior Management policy and procedure, dated March 2022, was provided by the assistant nursing home administrator (ANHA) on 4/18/22 and 3:00 p.m. It revealed in pertinent part, The individualized comprehensive care plan addresses the behavior management program, the goal for behavior management, individualized interventions to address the patient's specific risk factors and the plan for the reduction of risk related to behaviors. Patients, families/responsible parties are educated regarding the risks/benefits of psychoactive medications prior to the first dose being administered. If required by the specific state, signed consents are obtained and retained in the clinical record. II. Resident #27 status Resident #27, age 66, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included bipolar disorder with depression. The 1/28/22 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. He required supervision for all activities of daily living (ADL). The resident did not exhibit any behavioral symptoms during the assessment period. The patient health questionnaire (PHQ-9) documented a score of 17 out of 27, which indicated the resident had moderately severe depression. A. Record review (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, initiated on 10/28/21 and revised on 1/13/22, revealed the resident was at risk for changes in mood related to bipolar disorder and depression. The interventions included administering medications per physician orders, assessing for physical and environmental changes that may precipitate change in mood, attempting a psychotropic drug reduction per physician orders, encouraging family and friends to increase support, and observing mental status/mood state changes. The April 2022 CPO revealed the following physician orders for psychotropic medications: -Divaloprex Sodium (Depakote ER) 500 MG (milligrams)-give four tablets by mouth at bedtime for depression-ordered on 3/30/22; -Divaloprex Sodium (Depakote) 500 MG-give two capsules by mouth one time a day for depression-ordered on 3/31/22; -Clonazepam 1 MG-give 1 mg by mouth at bedtime for anxiety-ordered 3/16/22; -Vraylar capsule 6 MG-give 6 mg by mouth one time a day for Bipolar disorder-ordered 10/24/21; and -Quetiapine Fumarate (Seroquel) 50 MG-give two tablets by mouth at bedtime for Bipolar disorder-ordered 10/23/21. The resident's medical record was reviewed on 4/13/22 at 3:00 p.m. There was no evidence the facility had identified behaviors for the Depakote, Clonazepam, Vraylar and Seroquel medications to track targeted behaviors for use of the medications ordered. The resident's medical record did not reveal consent for use of the medications had been obtained for the Depakote and the Clonazepam medications. The consent for the Vraylar and Seroquel was not signed by the resident or the resident's representative. -It did not document that the resident and/or resident's representative had been informed of the black box warnings for those medications. B. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 4/12/22 at 1:10 p.m. LPN #1 said she was not aware of any specific behaviors Resident #27 exhibited. She said she occasionally heard from the night staff that he had increased anxiety. She said she was not trained on the facility's process of obtaining consent forms for psychotropic medications. The social services director (SSD) was interviewed on 4/14/22 at 11:06 a.m. He said the nursing staff was responsible for obtaining consent forms for the residents that were admitted with psychotropic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He said the facility did not have a process for obtaining consent forms for psychotropic medications prescribed by the physician after the residents' admission to the facility. He said he should have taken the responsibility to ensure consent forms were being filled out for all psychotropic medications ordered since he was the head of the psychotropic/pharmacy committee. He said the consent forms did not have black box warning documentation. He said he would contact the pharmacy to obtain black box warning labels for all psychotropic medications. He confirmed Resident #27's CPO and care plan did not indicate specific targeted behaviors for the residents' multiple psychotropic medications. 45889 II. Resident #81 status Resident #81, age 80, was admitted on [DATE]. According to the April 2022 computerized physician orders (CPO), the diagnoses included generalized muscle weakness, chronic kidney disease and depressive disorder. The 3/26/22 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. She required extensive assistance from one or two people with mobility, transfers, dressing, toileting and personal hygiene. The MDS documented that the resident had no hallucinations or delusions. The MDS documented no behaviors with a total severity score of zero. A. Record review The depression care plan, initiated on 3/20/22 and revised 3/22/22, documented that the resident was at risk for changes in mood related to depression. Interventions included administration of medications per physician orders, assess for physical/environmental changes that may precipitate change in mood, observe for mental status/mood changes when new medication is started or with dose adjustments and offer choices to enhance sense of control. The care plan also documented that the resident was at risk for adverse effects related to the use of anti-depression medication. Interventions included evaluation of medication effectiveness and monitoring for side effects of medication. The April 2022 CPO included the following orders for psychotropic medications: Fluoxetine Hcl Capsule 20 milligrams (mg), give 20 mg by mouth one time a day for depression. Order date of 3/21/22. Mirtazapine Tablet 7.5 mg, give 7.5 mg by mouth at bedtime for depression/poor appetite AEB (as evidenced by) isolation. Order date of 4/7/22. -The record did not have a signed consent for the use of psychoactive medication therapy. -A signed consent for use of psychoactive medication therapy was presented on 4/14/22 dated 4/13/22 (completed during the survey process). (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Review of the resident's record did not include behavior tracking for signs and symptoms of depression or adverse effects of the psychotropic medication prescribed. B. Interview The SSD was interviewed on 4/19/22 at 2:50 p.m regarding behavior charting. He said that behavior tracking should be in the resident's medical record and that he would look for any documentation of behavior tracking for Resident #81. He was not able to find that any behavior tracking was completed for this resident. 38185 III. Resident #25 status Resident #25, age 93, was admitted on [DATE]. According to the April 2022 CPO, the diagnoses included Alzheimer's disease. The 1/27/22 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of five out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. A. Record review The April 2022 CPO revealed the following physician order: -Seroquel tablet (Quetiapine Fumarate): give 25 mg (milligram) by mouth at bedtime for dementia with behaviors-ordered 7/26/21. The psychotropic medication care plan, initiated on 11/5/2020 and revised on 3/16/21, documented the resident was on psychotropic medications related to the resident's diagnosis of dementia with behavioral disturbances. The interventions included monitoring for signs/symptoms of side effects related to psychotropic medication use and reporting to the physician as indicated. The antipsychotic medication care plan, initiated on 1/9/2020 and revised on 5/21/21, documented the resident was at risk for adverse side effects related to the resident's use of antipsychotic medication. The psychotropic medication consent, undated, documented that the resident was taking Seroquel medication. The consent did not document any black box warnings. A review of the resident's medical record on 4/13/22 at 8:45 a.m. did not reveal documentation that the resident and/or resident representative was informed of the black box warnings for the Seroquel medication. IV. Resident #59 status Resident #59, age 85, was admitted on [DATE] and readmitted on [DATE]. According to the April 2022 CPO, the diagnoses included generalized anxiety disorder. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/4/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. She required extensive assistance of two people with bed mobility, transfers, dressing, toileting and personal hygiene. It indicated the resident did not exhibit physical or verbal behaviors during the assessment period. The resident rejected care for four to six days during the assessment period. A. Record review The April 2022 CPO documented the following order: -Lorazepam tablet 0.5 mg-give one tablet by mouth four times per day for anxiety-ordered 3/31/22. The anxiety care plan, initiated on 2/25/21 and revised on 6/14/21, documented the resident was at risk for anxiety. The resident would call out for help despite using the call light. She would request for tissues to be picked up off the floor and to move her water. The interventions included: to administer medications as ordered by the physician, re-educate the resident that sometimes staff cannot be there right at the scheduled time to assist the resident with care due to having to assist other residents. The consent for the Lorazepam (Ativan) medication was completed on 1/4/18 and indicated the medication had been increased on 3/16/2020. The consent did not document any black box warnings. A review of the resident's medical record on 4/13/22 at 8:30 a.m. did not reveal documentation that the resident and/or resident's representative was informed of the black box warnings for the Lorazepam (Ativan) medication. V. Resident #37 status Resident #37, age 84, was admitted on [DATE]. According to the April 2022 CPO, the diagnoses included major depressive disorder. The 2/8/22 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. She required extensive assistance of one person with bed mobility and personal hygiene and extensive assistance of two people with toileting and transfers. A. Record review The April 2022 CPO documented the following order: -Duloxetine HCl capsule delayed release: give 60 mg by mouth one time per day for depression-ordered 2/3/22. The antidepressant care plan, initiated on 2/4/22, documented the resident was at risk for adverse effects related to the use of an antidepressant medication. The interventions included evaluating the effectiveness and side effects of the medication for a possible decrease or elimination of psychotropic drugs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's medical record on 4/13/22 at 11:50 p.m. did not reveal documentation that consent had been obtained for the Duloxetine medication by the resident and/or resident representative. VI. Staff interviews The nursing home administrator (NHA) was interviewed on 4/11/22 at 5:20 p.m. She said consent forms for psychotropic medications were stored in the resident's medical record. She said the SSD had a binder which contained copies of all psychotropic medication consents. She said targeted behaviors for each psychotropic medication use were documented on the resident's care plan. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:11 p.m. She said consents for psychotropic medications should be completed by the nurse upon the resident's admission to the facility. She said for any new medication order, the nurse who received the order should obtain consent for the medication from the resident and/or responsible party. She said every psychotropic medication required consent prior to administration and the consent should include the black box warnings for the medication. The SSD was interviewed on 4/19/22 at 2:49 p.m. He said it was the nurses' responsibility to document if a resident had behaviors. He said the targeted behaviors should be documented on the care plan and on the CPO.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45889 Based on observations, and interviews, the facility failed to ensure all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, in three out of five medication carts. Specifically, the facility failed to: -Label insulin vials and pens with an open date and store them according to manufacturer's recommendation; -Label inhalers and eye drops with an open date; and, -Remove expired medication from the medication cart. Findings include: I. Manufacturer's recommendations Advair HFA package insert read in pertinent part: Discard after 12 months, or when the dose counter displays 0. Humalog (Insulin Lispro) package insert for Humalog (Insulin Lispro) (2019) read in pertinent part Unopened Humalog should be stored in a refrigerator (36 to 46 F), but not in the freezer. Do not use Humalog if it has been frozen. In-use Humalog vials, cartridges, pens, and Humalog KwikPen should be stored at room temperature, below 86 F and must be used within 28 days or be discarded, even if they still contain Humalog. Protect from direct heat and light. Insulin Glargine package insert read in pertinent part: Insulin Glargine pen should be stored at room temperature, below 86 F and must be used within 28 days or be discarded. Isopto tears 0.5% drops package insert read in pertinent part: Use within one month after opening. Latanoprost eye drops package insert read in pertinent part: Store the unopened bottle in the refrigerator. You may keep the opened bottle in the refrigerator or at room temperature for up to 6 weeks. Spiriva Respimat inhaler package insert read in pertinent part: Use within 3 months after assembly of device. Timolol eye drops package insert read in pertinent part: Keep the bottle in its outer carton to avoid exposure to light. Discard the eye drops 4 weeks after opening. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Tuberculin purified protein derivative (PPD) package insert read in pertinent part: Date the tuberculin vial when opening and discard it after 30 days. Wixela inhaler package insert read in pertinent part: Throw away the inhaler 30 days after removing it from the foil pouch for the first time, when the dose counter displays 0, or after the expiration date on the package, whichever comes first. II. Observations of medications stored improperly and interviews 1.Cart #200 hallway On [DATE] at 3:13 p.m. the medication cart on 200 hallway was inspected in the presence of the licensed practical nurse (LPN) #1. The following observations were made: -One open pen of insulin, Humalog 100 units/milliliter (ml) was not labeled with the open date. -Two open pens of insulin, Glargine100 units/milliliter (ml) were not labeled with the open date. LPN #1 was interviewed during the observation and said she did not know why open insulin pens were not labeled with an open date and she said that there were already open pens in the medication cart for those residents. She said she always labeled medications when she opened them and it was important to label the medications above as these insulin pens expire after being open for 28 days. 2. Cart #300 hallway On [DATE] at 3:46 p.m., the medication cart on 300 hallway was inspected in the presence of the registered nurse (RN) #2. The following observations were made: -One open vial of insulin, Glargine (Lantus)100 units/milliliter (ml) was not labeled with the open date or the resident's name. -Two bottles of Isopto tears 0.5% drops were not labeled with the open date. -One unopened, unlabeled bottle of Latanoprost eye drops was in the cart. -Two Spiriva Respimat inhalers 2.5 micrograms (mcg) were not labeled with the open date. -One bottle of Timolol eye drops was not labeled with the open date. -Two open Wixela inhalers ,d+[DATE] micrograms (mcg) were not labeled with the open date. RN #2 was interviewed during the observation and said that she had no idea why medications needed to be dated when opened and would ask her unit manager for direction. She did not know why an unopened bottle of Latanoprost eye drops were in the cart and not stored in the refrigerator. 3. Cart #100 hallway (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 4:00 p.m., the medication cart on 100 hallway was inspected in the presence of the RN #1. The following observations were made: -One Advair inhaler ,d+[DATE] micrograms (mcg) was not labeled with the open date. -One open vial of insulin, Humalog 100 units/milliliter (ml) was not labeled with the resident's name and the open date was [DATE]. -One open vial of tuberculin purified protein derivative (PPD) the open date [DATE]. -Two open Wixela inhalers ,d+[DATE] micrograms (mcg) were not labeled with the open date. One of the Wixela inhalers was missing the medication box and stored in a plastic bag. RN #1 was interviewed during the observation and said that medications needed to be dated to know the timeframe in which they could be safely used. III. Administrative interview The interim director of nursing (IDON) was interviewed on [DATE] at 5:10 p.m. She said that nurses should label medications according to manufacturer recommendations and if they are not sure of the recommendations, every nurse has a cell phone to either look it up or seek direction from administration.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on resident and staff interviews and record review the facility failed to assist a resident to obtain routine or emergency dental services, as needed, for one (#51) of two out of 33 sample residents. Specifically, the facility failed to provide dental services for Resident #51. Findings include: I. Resident #51 A. Resident status Resident #51, age 62, was admitted on [DATE]. According to the April 2022 computerized physician order (CPO) diagnoses included cerebral vascular accident (CVA), and hemiplegia and hemiparesis following cerebral infarction affecting the right non- dominant side. The 2/22/22 minimum data set (MDS) assessment coded the resident with a brief interview for mental status of 15 out of 15. The resident required extensive assistance with activities of daily living. The resident had his own teeth both upper and lower. B. Resident interview The resident was interviewed on 4/7/22 at 10:32 a.m. The resident said he needed to be seen by a dentist. He said he had a tooth on his lower jaw that was growing out.He attempted to show his tooth however, it was difficult to see. He said he had not seen a dentist. C. Record review A consent was signed on 1/8/21 which indicated the resident wanted to be seen by a dentist. -The resident's medical record failed to show that the resident was offered and seen by the dentist. D. Interview The social service director (SSD) was interviewed on 4/12/22 at 10:08 a.m. The SSD said the social service assistance (SSA) handled all of the ancillary services. The SSA was interviewed on 4/12/22 at 11:00 a.m. The SSA said he did handle the ancillary items. He kept track of requests in a binder along with the consent forms. He said the nurses and residents would request to see the dentist to either himself or the SSD. The SSA reviewed the medical record and confirmed the resident had not seen the dentist. He said that the resident slipped through the cracks." He said the dentist was scheduled to come on 4/7/22, however, had to be canceled due to the COVID-19 outbreak. He said he would put him on the list to see the dentist. (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 4/14/22 at 2:55 p.m. The RN said the social service department handled all of the ancillary tasks. She said they informed the social service department and then the social worker arranged for the dentist to come to the facility or if needed the resident went to see the dentist.

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F 0835 Level of Harm - Actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 20287 Based on observations, interviews and record review, the facility was not administered in a manner that enabled it to use its resources efficiently and effectively to attain and maintain the highest practicable physical, mental and psychosocial well-being of each resident. Specifically, the resources of the facility were not effectively and efficiently utilized as evidenced by findings that revealed in part: -The facility failed to protect residents from COVID-19 as evidenced by not having an effective infection control program. Cross-reference F880 -The facility failed to monitor each contracted staff member' vaccination status to ensure proper advanced personal protective equipment (PPE) strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. Cross-reference F888 -The facility failed to follow the Center for Disease Control (CDC) and the Centers for Medicare & Medicaid (CMS) guidance on staff testing for COVID-19. Cross-reference F886 -The facility had multiple systemic failures in its management of pressure injuries. These included the failure to timely assess and monitor for pressure injuries, prevent the development and worsening of pressure injuries for one resident. Cross-reference F686 These failures contributed to an environment where residents were at risk of contracting COVID-19 and worsening of pressure injuries. Findings include: I. Quality of care F686 Cross-reference F686. Facility administration failed to have a system/plan to ensure residents received care and services to prevent residents from developing facility acquired pressure injuries and worsening of pressure injuries. The facility failed to ensure thorough assessments and timely implement treatments to prevent pressure injuries from worsening. Interview The nursing home administrator (NHA) was interviewed on 4/14/22 at 3:18 p.m. The NHA said the facility was cited with a harm citation in December 2021. She said the corrective plan of care was to have another company oversee the pressure injuries. She said the other company came in on Tuesdays for weekly rounds and report in quality assurance. She said there was not an issue. She said the wound care rounds were a team effort. She was not aware if the contracted company was observing and overseeing all wounds or just the ones that the wound physician followed. (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	II. Infection control A. F880 Cross-reference F880. Facility administration failed to ensure staff were engaged in safe practices while care for residents to ensure residents received the care and services required to maintain their highest practicable level of well-being. Interview The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said she was aware the facility had been in a COVID-19 outbreak since 12/23/21. She said the facility has had a lot of staff turnover and that a lot of agency staff was being utilized. She said the agency staff did not have a lot of training, and were less informed. She said the agency staff were also quitting. She said that she was aware the building had infection control breaks, however, she was not aware of the extent it was. She said masks had been a challenge the entire pandemic. She said when the administration was not in the building the staff became lax in mask wearing. She said she was not aware of the problems with handwashing, and complete PPE. She said the regional governing body came into the facility to assist, however did not develop a plan to get out of outbreak. B. F886 Cross-reference F886. Facility administration failed to ensure all staff were tested bi-weekly as required by CMS while the facility was in a COVID-19 outbreak since 12/23/21 to help prevent the spread of COVID-19 to residents. Interview The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said she was aware all staff did not testing. The label system was put into effect, which would show which staff member did not get tested they would be aware. She said the director of nurses was keeping her eye on the system. However, the DON was not effective and was not completing all aspects of her job. The nurse consultant came in to help the DON, however, the testing continued to be a problem and then the DON resigned effective immediately. C. F888 Cross-reference F888. Facility administration failed to monitor each contracted staff member's vaccination status to ensure proper advanced personal protective equipment (PPE) strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. Interview (continued on next page)

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F 0835 Level of Harm - Actual harm Residents Affected - Few	The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said the corporation received the QSO updates (from CMS) and then sent them out to the facilities. She said she read them when she received them. She said did not understand what was needed with the policy changes and it was difficult to keep up with. She did not know what was expected for the F888 regulation. She said she believed attestations were ok to be used. She said she did not know that outside vendors such as physicians, volunteers and frequent visitors needed to have vaccination status on record and tracked. III. Additional interviews The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said she would be out of the building for the next ten days and unavailable for further interviews. The NHA said she had left the building and recently returned to the facility in February 2022. The NHA said she was told by the county that an outbreak was three individuals. She was not aware that CMS called an outbreak of one individual. She said nursing administration has had a lot of turnover. She said the facility hired a staff development coordinator however, she was terminated. The DON position had turned over several times within the year. She said the current DON had started in October or November 2021. Unit managers were also terminated as they were not effective. She said they could not find unit managers and were currently looking for a permanent DON. She said it was difficult to hire unit managers when the building did not have a DON. She said the biggest issue was the trust she had given the DON and she failed to carry out the job. The vice president of the region was interviewed on 4/19/22 at 3:50 p.m. The vice president said that she was aware there were concerns with the building, however, not to the level of immediate jeopardy. She said that the NHA reported to her and would be expected to hear of concerns from the NHA. She said the NHA and the DON were responsible for the management of the building.

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F 0837 Level of Harm - Actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 20287 Based on record review and interviews, the governing body failed to implement policies regarding the management and operations of the facility. Specifically, the facility failed to ensure the governing body was providing effective oversight to the facility to ensure the facility was in compliance with state and federal regulations. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) practice guide was received from the assistant nursing home administrator from a sister facility on 4/21/22. The policy read in pertinent part, The governing body assures the QAPI program is adequately resourced to conduct its work. This included designation one or more persons to be accountable for QAPI; developing leadership and facility-wide training on QAPI; and ensuring staff time, equipment and technical trainings as needed for QAPI. They are responsible for etablings policings to sustain the QAPI program despite changes in personnel turnover. The governing body and executive leadership are also responsible for setting expectations around safety, quality, rights, choice and respect by balancing both a culture of safety and a culture of resident centered rights and choice. The governing body ensures that while staff are held accountable, there exists an atmosphere in which staff are not punished for errors and do not fear retaliation for reporting quality concerns. Cross-reference F867-failed to reassess and provide timely intervention to address repeated concerns related to quality of life and quality of care. II. Identified failures A. Findings in the area of abuse and neglect - failure of the facility to prevent abuse. Cross reference F603 at a harm level. Facility administration failed to have a system to ensure residents were kept free from involuntary seclusion which resulted in psychosocial harm. B. Findings in the area of skin integrity-failure to prevent facility acquired pressure injuries. This deficiency was cited previously during an abbreviated survey 12/21/21. Although the facility corrected the deficiency, based on the findings below, the facility has not maintained compliance with this regulatory requirement. Cross-reference F686. Facility administration failed to have a system/plan to ensure residents received care and services to prevent residents from developing facility acquired pressure injuries and worsening of pressure injuries. (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Few	The facility failed to ensure thorough assessments and timely implement treatments to prevent pressure injuries from worsening.This citation was cited at immediate jeopardy. III. Findings in the area of infection control-failure to have a system to ensure an infection control program whereby residents were protected from COVID-19. The following citations were cited at immediate jeopardy. Cross-reference F880. Facility administration failed to ensure staff were engaged in safe practices while care for residents to ensure residents received the care and services required to maintain their highest practicable level of well-being. Cross-reference F886. Facility administration failed to ensure all staff were tested bi-weekly as required by Center for Medicare Services while the facility was in a COVID-19 outbreak since 12/23/21 to help prevent the spread of COVID-19 to residents. Cross-reference F888. Facility administration failed to monitor each contracted staff member's vaccination status to ensure proper advanced personal protective equipment (PPE) strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. The assistant nursing home administrator (ANHA) from a sister facility was interviewed on 4/19/22 at approximately 1:30 p.m. She said the director of nurses (DON) was the person who was ultimately responsible for the infection control and skin integrity. A request to view the report from the clinical support registered nurse (RN) on the facility's findings, however, ANHA said a report was not written. The reports were only shared with the NHA and the DON. -However, the facility did not have a DON and the NHA was unavailable for an interview in regards to the clinical support RN. III. Leadership interviews A licensed nurse, who wished to remain anonymous, was interviewed on 4/12/22. The licensed nurse said the facility has had numerous changes in administration which included the director of nurses and the nursing home administrator. She said it made it difficult to receive direction and support. The nursing home administrator (NHA) was interviewed on 4/12/22 at approximately 1:30 p.m. The NHA said last week the DON had scheduled time off, however, she was informed the DON resigned the position effective immediately on 4/11/22. The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said she would be out of the building for the next ten days and unavailable for further interviews. The NHA said she had left the building and recently returned to the facility in February 2022. She said that she returned to the facility because of the vice president who was now over the region, she had a lot of respect for and wanted to work with her. She said the building had a lot of support and consultants from each department could be reached out to for assistance. She said the building had some restructuring when the two companies merged in either 2017 or 2018. She said the governing body was aware of the COVID-19 outbreak. She said they came to help with the outbreak but they did not help with the plan to get out of outbreak. (continued on next page)

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F 0837 Level of Harm - Actual harm Residents Affected - Few	The NHA said the other buildings within the company she worked for had a nurse practitioner (NP) for wound care. She said they had just extended an offer to a NP to be in charge of wounds. She said that having a NP for wound care depended on the regional director of the building. The interim director of nursing (IDON) was interviewed on 4/18/22 at 5:11 p.m. The IDON said she was a contracted registered nurse who was hired as a unit manager. However, when they no longer had a director of nurses, they offered her the contract position so she spoke to her agency and got the contract changed to the director of nurses. She said she had just started her contract on 4/11/22. The DON realized the facility had many care issues that needed attention. The DON acknowledged she had not yet been provided training on the corporate processes and was in the process of learning about the expectations of the corporate office. She said she received support from her agency company. The assistant nursing home administrator (ANHA) from a sister facility was interviewed on 4/19/22 at 9:34 a.m. The ANHA said she worked in another state for the corporation. She said she had not worked at the facility in the past. She was sent out to help the facility, as the current nursing home administrator (NHA) was out on leave. She said the governing body was structured in a way to have business office support, rehabilitation, social services, activities and clinical support. She said the quality assurance consultants were contracted for each region. She said the schedule was not set as to when the clinical support would visit, as it depended on the building and the request. She said the regional director supervised the NHA. She said there was an registered nurse (RN) who was assigned to the facility for clinical support. She was unable to answer when the clinical support RN came to the facility. The medical director (MD) was interviewed on 4/19/22 at 1:41 p.m. The MD said he had been the medical director for the facility for the past two years. He said that the facility had a change in corporations about two years ago. He said that the administration has overturned numerous times. He said he had not met with the vice president since she took over several months ago. He said it had been a while since he had met with the governing body, approximately three years. The request to speak with the clinical support RN was denied on 4/19/22 at 2:00 p.m. by the ANHA. She said the clinical support RN was a contractor and not employed by the facility and she could not answer questions. The vice president of the region was interviewed on 4/19/22 at 3:50 p.m. The vice president said that she recently assumed the position of vice present in January 2022. She said she was previously the regional director. She said since January 2022 she had been in the building every other week. She said that she was aware there were concerns with the building, however, not to the level of immediate jeopardy. She said that the NHA reported to her and would be expected to hear of concerns from the NHA. She said the NHA and the DON were responsible for the management of the building. She said the DON ran the nursing department and occasionally if there was an issue then the governing body would meet with the medical director. She said she was not sure if the regional clinical support would write a report detailing the findings. The report was only shared with the DON and NHA. She said the expectation was if there were problems, then the NHA would phone her as the vice president. She said she did not participate in the QA meetings. The interdisciplinary team participated in the QA meetings.

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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. 37166 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 address and include in the facility assessment an evaluation of the restorative nursing program. Findings include: I. Record review Facility assessment was provided by the assisting nursing home administrator (ANHA) on 14/19/22 at 4:05 p. m. Facility assessment contained a blank skills and techniques evaluation for nursing assistants that included a section of restorative services. The evaluation was meant to be completed and evaluated by the nurse upon hiring a new nursing assistant. The facility assessment did not include the description of the restorative nursing services that were offered in the facility. It did not include who was in charge of the restorative program, how the program was evaluated for its effectiveness and what residents were receiving services. Cross-reference F688-Failed to provide restorative services. II. Staff interviews NHA was not available for an interview. Interim director of nursing (IDON) was interviewed on 4/18/22 at 5:30 p.m. She said she was recent to this position and did not participate in the facility assessment review. III. Follow-up On 4/19/22 at 5:32 p.m. facility submitted an email, stating that Facility Assessment included information about the restorative nursing program. Specifically, Page 30 of 182 starts discussions of ADLs during nurse aide orientation. Page 88 and page 94 is the nurse aide skills and techniques which discusses ADLS. Pages 90-91 is the nurse aide skills and techniques which discuss Restorative.

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F 0841 Level of Harm - Actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 20287 Based on staff, medical director interviews and record review, the facility failed to ensure all responsibilities of the medical director were effectively performed, which had the potential to affect all residents of the facility. Specifically the facility failed to ensure: -The medical director fulfilled his responsibility for providing the implementation of resident care policies or the coordination of medical care in the facility; and, -Facility wide training in infection control. Cross- reference: F686-Treatment and services to prevent/heal pressure ulcers, F880-Infection control, F886-Testing resident and staff, and F888-COVID-19 vaccination. Findings include: I. Medical directors agreement The medical director (MD) independent contract agreement was signed on 8/28/17. The Medical director's duties and responsibilities were received on 4/18/22 at 10:00 a.m. which read in pertinent parts: Medical director shall be responsible for the implementation of resident care policies and the coordination of medical care in the facility. Medical director's specific duties and responsibilities shall include the following: 1.Overall coordination, execution and monitoring of physician services. Maintain effective liaison with attending physicians, and provides clinical guidance and oversight regarding the implementation of patient care policies. 2. In conjunction with the professional staff and consultants of facility, medical director collaborates in the development and implementation of written policies, procedures, rules and regulations to govern the skilled nursing care and related medical and other health services provided at the Facility and shall review the facility's policies, procedures, rules and regulations on an annual basis. Medical director is responsible for seeing that these policies reflect an awareness of and provisions for meeting the current needs of the patients of the facility. 5. Medical director shall actively participate as a member of the Facility's quality improvement process. Participation shall include regular attendance at, and reporting to the facility quality assessment and assurance committee. Monthly quality assurance meetings may include topics such as infection control, pharmaceutical services, dental care, patient care policies . (continued on next page)

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F 0841 Level of Harm - Actual harm Residents Affected - Few	8. Participate in in-service training programs as needed on request by facility . 12. Advise the nursing facility staff regarding communicable diseases, infection control and isolation procedures, and serve as a liaison with local health officials and public health agencies that have policies and programs that may affect the nursing facility's care and services to residents. II. Failures The facility was in the current outbreak of COVID-19 since 12/23/21. Cross reference F880 During the recertification survey on 4/19/22 the facility was cited for infection control at a L (immediate jeopardy) level. Cross reference F888 During the recertification survey on 4/19/22 the facility was cited for COVID-19 vaccination of facility staff at a L (immediate jeopardy) level. Cross reference F886 During the recertification survey on 4/19/22 the facility was cited for failure to COVID-19 test staff at a L (immediate jeopardy) level. Cross reference F686 Prevention of pressure ulcers During an abbreviated survey on 12/21/21, the facility was cited for prevention of pressure ulcers at a G (harm) level. During the recertification survey on 4/19/22 the facility was cited for prevention of pressure ulcers at a J (immediate jeopardy) level. III. Record review The facility was unable to provide any documentation which showed the medical director had been involved in the management and treatment of the pressure injuries. IV. Interview The medical director (MD) was interviewed on 4/13/22 at 1:41 p.m. The MD said he was aware the facility was in an outbreak for several months. He said that they told him what they were doing with infection control and can go to their website to view the policies. He said the administration had not asked for much advice. He said he came to the building at least monthly. (continued on next page)

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F 0841 Level of Harm - Actual harm Residents Affected - Few	He said he walked around the facility from time to time depending on the outbreak status. He said the last few times he was in the building he had not walked the building. He said when he did walk the building he looked for proper use of personal protective equipment (PPE). He said about three or four months ago when he walked the building there were no issues. He said when he was asked by the facility for education on infection control he would provide, however, he had not been asked for quite some time. He said the facility was a corporation and they had their policies they followed and he was not asked. He said he understands that he needed to be more involved in questioning the administration. The MD said that he was not aware the facility was not tracking all staff which included the contracted staff. He said he was aware the facility used a lot of agency staff as they had a turnover with staff including administration. The MD said he was not aware the facility was not testing the staff bi-weekly. He said he was aware the facility was in outbreak status for the the past several months. He said the facility was good about notifying him of the COVID-19 outbreak. He said he was not aware the facility was not testing all staff bi-weekly as required. He has also not observed how the testing was being conducted. The MD also said he had instructed to follow CDC guidance on testing, however, he was not sure if the facility had listened, as the facility was a corporation. He said he had not pushed the issue like he should have. The MD said he had been the medical director since 2007. He said he came to the building at least monthly. He said during the pandemic he had completed some of the meetings remotely. He said he attended the quality assurance meeting (QA) and the psych-pharmaceutical meetings. He said he did review policies, however, the facility was a corporation and that they had their own policies. He said the facility did not ask him for much stuff. He said the corporation was structured with their protocol and they tell him what they were doing. The nursing home administrator (NHA) was interviewed on 4/14/22 at 3:18 p.m. The NHA said the medical director was available for any questions. He participated in the quality assurance and the psych-pharmaceutical meeting. The medical director (MD) was interviewed again on 4/19/22 at 1:45 p.m. The MD said he was aware the facility received a directed plan of correction in December 2021 for the prevention of pressure injuries. He said he had not met with the hired consultant. He said a nurse practitioner had been hired to follow the wounds. However, he was not aware this nurse practitioner was hired as of 4/14/22. He said that he has not personally completed rounds on the wounds, as there were a lot of people rounding. He said he had not reached out to physicians about any concerns with the pressure ulcers.

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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 0867 Level of Harm - Actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 20287 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 address concerns related to quality of life, quality of care and infection control. Findings include: I. Facility policy The Quality Assurance and Performance Improvement (QAPI) Program policy, issue date February 2019, read in pertinent parts, Quality assurance (QA) is a process of meeting quality standards and assuring that care reaches an acceptable level. Traditionally, we have a set thresholds to comply with the regulations. QA is a reactive, retrospective effort to look at why there was a system failure. QA activities do improve quality, but efforts frequently end once the compliance or standard has been met. Performance improvement (PI) is a proactive continuous process intending to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent or systemic problems. II. Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies and initiate a plan to correct F686 Prevention of Pressure Ulcers During a recertification survey on 12/21/21, prevention of pressure ulcers was cited at a G (harm) level. During the revisit survey on 12/21/21, the facility was cited again for prevention of pressure ulcers at a K (immediate jeopardy) level. III. Cross-referenced citations that were all cited at immediate jeopardy level Cross-reference F686. Facility administration failed to have a system/plan to ensure residents received care and services to prevent residents from developing facility acquired pressure injuries and worsening of pressure injuries. The facility failed to ensure thorough assessments and timely implement treatments to prevent pressure injuries from worsening. Cross-reference F880: The facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent infections, including the development and transmission of COVID-19. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	Cross-reference F886. Facility administration failed to ensure all staff were tested bi-weekly as required by Center for Medicare Services while the facility was in a COVID-19 outbreak since 12/23/21 to help prevent the spread of COVID-19 to residents. IV. Interviews The nursing home administrator (NHA) was interviewed on 4/14/22 at 3:18 p.m. The NHA said the facility was cited with a harm citation in December 2021. She said the corrective plan of care was to have another company oversee the pressure injuries. She said the other company came in on Tuesdays for weekly rounds and reported in quality assurance. She said there was not an issue. She said the wound care rounds were a team effort. She was not aware if the contracted company was observing and overseeing all wounds or just the ones that the wound physician followed. The NHA said she was aware the facility had been in a COVID-19 outbreak since 12/23/21. She said the facility has had a lot of staff turnover and that a lot of agency staff was being utilized. She said the agency staff did not have a lot of training, and were less informed. She said the agency staff were also quitting. She said that she was aware the building had infection control breaks, however, she was not aware of the extent it was. She said masks had been a challenge the entire pandemic. She said when the administration was not in the building the staff became lax in mask wearing. She said she was not aware of the problems with handwashing, and complete personal protective equipment (PPE). She said the regional governing body came into the facility to assist, however did not develop a plan to get out of outbreak. The NHA said she was aware all staff did not testing. The label system was put into effect, which would show which staff member did not get tested they would be aware. She said the director of nurses was keeping her eye on the system. However, the DON was not effective and was not completing all aspects of her job. The nurse consultant came in to help the DON, however, the testing continued to be a problem and then the DON resigned effective immediately. The NHA was interviewed on 4/14/22 at 3:18 p.m. The NHA said the corporation received the QSO updates (from Centers of Medicare & Medicaid) and then sent them out to the facilities. She said she read them when she received them. She said she did not understand what was needed with the policy changes and it was difficult to keep up with. She did not know what was expected for the F888 regulation. She said she believed attestations were ok to be used. She said she did not know that outside vendors such as physicians, volunteers and frequent visitors needed to have vaccination status on record and tracked. The medical director (MD) was interviewed on 4/13/22 at 1:41 p.m. The MD said he attended the monthly quality assurance (QA) meetings. He said during the meetings, he would review rehospitalization s, infections and antibiotics. He said the NHA and the director of nurses run the meeting. He said he did not review specific pressure wounds, he would review overall numbers. He said the QA was run as a corporation and they informed him of any changes, such as the COVID-19 outbreak. However, the facility did not seek his guidance. He said he had not pushed as much as he could for him to be more involved in the QA meetings. The vice president of the region was interviewed on 4/19/22 at 3:50 p.m. The vice president said she had not participated in a QA meeting. (continued on next page)

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F 0867 Level of Harm - Actual harm Residents Affected - Few	The assistant nursing home administrator (ANHA) from a sister facility and a regional support nursing home administrator (SNHA) were interviewed on 4/19/22 at 4:16 p.m. The ANHA said the quality assurance (QA) committee met monthly. She said the interdisciplinary team, the medical director and the pharmacist were in attendance. The ANHA said she was from another facility and had not been involved with the QA at the facility. The ANHA said abuse was covered for patient protection and it was a focus area in the QA. She said that at each meeting the risk management reports were reviewed, which was where the abuse allegations were documented. She said the reports were reviewed to ensure a thorough abuse investigation was completed. The ANHA said a performance improvement plan was put into place when an action item had been identified.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20287 Based on observations, record review and interviews, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections. Record review revealed the facility has been in outbreak status since late December 2021. Specifically, the facility was in outbreak status as of 12/23/21 when a staff member tested positive for COVID-19. On 12/27/21, another staff member tested positive for COVID-19. Thereafter, the following staff tested positive for COVID: one positive staff member (1/3/22), two positive staff members (1/11/22), one positive staff member (1/14/22), one positive staff member (1/20/22), two positive staff members (1/21/22), one positive staff member (2/15/22), one positive staff member (2/16/22), one positive staff member (3/8/22), one positive staff member (3/21/22), two positive staff members (3/22/22), two positive staff members (3/25/22), one positive member (3/29/22), one positive staff member (4/3/22), and one positive staff member (4/5/22). The current line listing on 4/6/22, showed 13 residents had tested positive for COVID-19. Results from the 4/8/22 tests showed two residents were positive. Results from the 4/12/22 test results included an additional five residents were positive. Results from the 4/18/22 revealed another three residents testing positive. Observations, record review and staff interviews, from 4/6/22 through 4/19/22, revealed multiple and repeated failures in the facility's infection control program. This created an immediate jeopardy situation with the likelihood of serious harm due to the potential for further transmission of the highly infectious COVID-19 virus to residents throughout the facility, staff, and others, if not corrected immediately. Specifically: -The facility failed to follow the Center for Medicare and Medicaid Services (CMS) outbreak testing guidance, beginning on 12/23/21, to routinely test staff bi-weekly while in outbreak status, creating a situation for the transmission of highly infectious COVID-19. Cross-reference F886L. -The facility failed to ensure staff properly wore personal protective equipment (PPE) throughout the facility and when caring for residents in isolation rooms. -The facility failed to ensure staff followed proper hand hygiene procedures for themselves and for the residents. -The facility failed to ensure equipment was sanitized between residents and dining room tables were cleaned properly prior to the next meal. -The facility failed to ensure resident rooms were properly cleaned. Cross-reference F886 and F888. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Findings include: I. The facility's COVID-19 status On 4/6/22, upon entry into the facility, the facility had the following confirmed positive cases of COVID-19: 13 residents in isolation; four residents in isolation who were roommates of residents who had tested positive; and nine positive staff members since 3/8/22. II. Immediate Jeopardy A. Findings of Immediate Jeopardy Record review revealed the facility has been in outbreak status since late December 2021. Specifically, the facility was in outbreak status as of 12/23/21 when a staff member tested positive for COVID-19. On 12/27/21, another staff member tested positive for COVID-19. Thereafter, the following staff tested positive for COVID: one positive staff member (1/3/22), two positive staff members (1/11/22), one positive staff member (1/14/22), one positive staff member (1/20/22), two positive staff members (1/21/22), one positive staff member (2/15/22), one positive staff member (2/16/22), one positive staff member (3/8/22), one positive staff member (3/21/22), two positive staff members (3/22/22), two positive staff members (3/25/22), one positive member (3/29/22), one positive staff member (4/3/22), and one positive staff member (4/5/22). The facility has had the following number of COVID positive residents since January 2022. Specifically, COVID positive residents were identified as follows: three residents (1/11/22), one resident (1/11/22), one resident (3/11/22), two residents (3/15/22), two residents (3/18/22), four residents (3/22/22), one resident (3/23/22), four residents (3/25/22), one resident (3/29/22), one resident (3/31/22), one resident (4/1/22), one resident (4/2/22), three residents (4/5/22), and two residents (4/8/22). Thereafter, during the survey, there were five residents positive on 4/12/22 and another three residents on 4/18/22. Observations, record review and staff interviews, from 4/6/22 through 4/19/22, revealed multiple and repeated failures in the facility's infection control program, including the facility's failure to follow outbreak testing guidance, failure to properly and appropriately use PPE and perform staff and resident hand hygiene, failure to clean equipment and sanitize the dining room tables using proper technique, and failure to properly clean resident rooms. The above failures in the facility's infection control program created an immediate jeopardy situation with the likelihood of serious harm and the potential for further transmission of the highly infectious COVID-19 virus to residents throughout the facility, staff, and others, if not corrected immediately. B. Facility notice of immediate jeopardy On 4/12/22 at 7:43 p.m. the nursing home administrator (NHA) was notified that the failures identified above in infection control created an immediate jeopardy situation that placed all residents in the facility at risk for serious harm (COVID-19). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	C. Facility plan to remove immediate jeopardy On 4/14/22 p.m. the NHA provided a plan to remove the immediate jeopardy. The plan read: Observations and monitoring of PPE usage (which included N95 respirator masks, eye protection, gowns and gloves) and handwashing was conducted by members of the interdisciplinary team (department managers) during the overnight shift on 4/12/22. On 4/12/22, the door code was changed by the maintenance director on the service hall door and a sign posted for all staff to enter the facility through the front door of the facility only to ensure screening is being conducted for every staff member prior to starting their shift and entering resident areas. The screening will be conducted by the supervisor on duty or receptionist and will ensure each staff member has donned an N95 respirator mask and eye protection prior to entering a resident area. All resident equipment was disinfected with Eco Lab's Peroxide Multi-Surface Cleaner disinfectant on 4/12/22 by the interdisciplinary team (department managers). All dining tables were disinfected with Eco Lab's Peroxide Multi-Surface Cleaner disinfectant on 4/12/22 by the interdisciplinary team. Housekeeping Supervisor or designee will observe for proper cleaning of the dining room tables after each meal, every shift. Housekeeping Supervisor or designee will monitor through audits the observation completed for proper cleaning of the dining room tables after each meal, every shift. Education with return demonstration was completed on 4/12/22 to 52 out of 71 total facility staff members regarding the facility policies and procedures for PPE use, including the requirement for N95 respirator masks and eye protection to be worn in all resident areas, the procedures for the donning and doffing of PPE, discarding single-use gowns after each use, sanitization of eye protection, proper handwashing procedures, equipment sanitization in between resident use, and providing residents with hand hygiene prior to meals. All staff will complete the education with return demonstration prior to the start of their next scheduled shift. The director of nursing and/or designee will track and monitor each staff member who has received or not yet received the training to ensure compliance. Education was started on 4/12/22 with the housekeeping staff regarding the disinfecting of dining room tables after each meal, performing hand hygiene in between resident rooms when delivering linen and personal laundry and performing hand hygiene prior to donning and after doffing gloves. Education will be provided to new staff during orientation. The education for all the housekeeping staff will be completed by 4/13/22. The director of nursing and/or designee will monitor facility staff for infection control practices 3 times every shift and on the spot education with return demonstration will be provided upon a negative observation. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The interdisciplinary team to include the medical director will conduct a root cause analysis to determine the progress of the corrective action and will provide a report to the quality performance improvement committee to discuss recommendations and additional C. Removal of immediate jeopardy On 4/14/22 at 1:00 p.m. the NHA was notified that the immediate jeopardy was lifted based on the facility's plan to address the immediate jeopardy (see above). However, deficient practice remained at F level, widespread with the potential for more than minimal harm. II. Failure to maintain an effective infection prevention and control program A. The facility failed to follow CMS and CDC outbreak testing guidance, as well as the Residential Care Facility (RCF) Comprehensive Mitigation Guidance, revised on 4/8/22, to routinely test all staff bi-weekly, creating a situation for the transmission of highly infectious COVID-19. Cross-reference F886. Professional reference: Consistent with CMS and CDC testing guidance, the Residential Care Facility (RCF) Comprehensive Mitigation Guidance, revised on 4/8/22, read: When one or more positive tests are identified in a resident or health care professional (HCP) (regardless of vaccination status), the facility moves to outbreak testing and following additional response measures outlined below. -Asymptomatic HCP (including ancillary non-medical services providers) and residents who are up to date with all recommended COVID-19 vaccine doses should test twice weekly for SARS-CoV-2 using a lab-based PCR test. If HCP work infrequently at the facility, the lab-based PCR test should be performed within three days before their shift. -A HCP who tests positive, regardless of vaccination status, should be excluded from work and instructed to isolate at home. HCP should self-report positive results to any additional employer so that disease control measures can be implemented if necessary. Contrary to the above testing guidance, the facility failed to test all staff following notification of an outbreak as of 12/23/21. Specifically: -A line list, dated 4/12/22, was provided by the consultant director of nursing (DON) on 4/12/22 at 3:15 p.m. It documented that only 18 staff members had been tested for COVID-19 that day (4/12/22), out of 72 total staff members who worked at the facility. -A line list for Friday, 4/8/22, documented 32 staff members had a COVID-19 PCR test out of 72 total staff members. The facility was unable to provide documentation that the staff who were not PCR tested had been POC (point of care) tested (alternative testing that does not require sending the test to the lab) until the next testing date on 4/12/22. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-A line list for Tuesday, 4/5/22, documented 22 staff members had a COVID-19 PCR test out of 72 total staff members. The facility was unable to provide documentation that the staff who were not PCR tested had been POC tested until the next testing date on 4/8/22. The facility was unable to provide documentation that the staff members who were not tested had been contacted, provided education, been removed from the schedule, or had disciplinary action to ensure compliance with the testing requirements. Moreover, the facility failed to ensure staff were conducting self-testing in accordance with testing guidelines and in a manner to prevent the spread of infection. Observations showed staff members failed to swab their nose with five circular motions in each nostril to ensure the testing was effective and would produce an accurate result. Staff failed to complete appropriate hand hygiene during and after the testing process and staff interviews showed that not all staff were aware of the testing day and admitted to not completing a PCR test. The last PCR test results were on 4/8/22, and 22 out of 70 staff were tested . Ten staff were within the 90 days of testing positive for COVID-19 and the facility had two staff members with religious exemptions. As a result of testing, three residents tested positive for COVID-19 and upon observation, a fourth resident had been placed in isolation after testing positive for COVID-19. B. The facility failed to ensure staff properly wore personal protective equipment (PPE) throughout the facility and when caring for residents in isolation rooms. And, the facility failed to ensure staff followed proper hand hygiene procedures for themselves and for the residents. On 4/12/22 at 10:40 a.m., CNA #3 was interviewed. He said he had been working at the facility for a month and the facility had been in outbreak status the entire time. He said he had not been told by nursing management at the facility to wear a N95 respirator mask or eye protection until the survey process started. He said he had worn a surgical mask since his first day at the facility. CNA #3 said he said he had observed housekeeping staff entering COVID-19 positive rooms and not donning any PPE. He said when he arrived in the morning, the night shift never wore any masks or eye protection. 1. Professional References and facility infection control manual PPE: CDC and CMS Guidance on PPE when COVID-19 has been identified in the building: The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (updated 2/2/22), retrieved on 4/22/22 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, read in pertinent part, HCP (health care provider) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a National Institute for Occupational Safety and Health (NIOSH) approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Facilities should provide instruction, before visitors enter the patient's room, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The exact contribution of hand hygiene to the reduction of direct and indirect spread of coronaviruses between people is currently unknown. However, hand washing mechanically removes pathogens, and laboratory data demonstrate that ABHR formulations in the range of alcohol concentrations recommended by CDC, inactivate SARS-CoV-2. ABHR effectively reduces the number of pathogens that may be present on the hands of healthcare providers after brief interactions with patients or the care environment. The CDC recommends using ABHR with greater than 60% ethanol or 70% isopropanol in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. The facility infection control manual received on 4/6/22 from the NHA at a sister facility (NHA#1), read in pertinent part, Standard precaution principles are designed to reduce the risk of transmitting microorganisms from both recognized unrecognized sources of infection in healthcare settings. Standard precautions are designed to protect both healthcare personnel and patients from contact with infectious agents. Standard precautions include: -Hand hygiene (handwashing with soap and water or use of an alcohol-based sanitizer) before and after patient contact and after contact with the immediate patient care environment. -Perform hand hygiene between tasks and procedures on the same patient to prevent cross-contamination of different body sites, if necessary. -Wash hands or use alcohol-based hand sanitizer upon completion of patient contact and before caring for another patient -Perform hand hygiene before touching a patient, performing an invasive procedure or manipulating an invasive device. -Perform hand hygiene after contact with patient's intact or non-intact skin, after touching items or surfaces in the immediate care environment, even if you did not touch the patient. 2. Observations revealed staff failed to properly wear and dispose of PPE and perform hand hygiene to prevent the transmission of infectious COVID-19. a. Observations 4/6/22 - Hand hygiene failures (i) During a continuous observation on the 200 unit on 4/6/22 starting at 12:04 p.m. and ending at 12:44 p.m., the following was observed: -At 12:04 p.m. the lunch meal cart was delivered to the 200 unit nursing station. -At 12:16 p.m. CNA #3 opened the cart and started passing trays. He donned gloves and entered room [ROOM NUMBER]. He did not perform hand hygiene prior to donning the gloves. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The CNA set up the resident's meal, asked her if she needed anything else and left the room. With the same gloved hands, he returned to the meal cart and picked up another tray for the same room. He entered the room and delivered the meal to the resident in bed B. He grabbed the bed controls and raised the head of the bed, then took the lids off the beverages and poured the beverages into a sippy cup. He set up her meal and left the room. He had not offered either resident in room [ROOM NUMBER] hand hygiene prior to the start of their meal. The CNA doffed his gloves, threw them into the trash, reached into his pocket, pulled out a new pair of gloves and donned the gloves. He did not perform hand hygiene prior to donning the gloves. The CNA returned to the meal cart, picked up another tray and entered room [ROOM NUMBER]. He delivered the meal tray to bed A. He placed the tray on the over bed table and left the room. He did not offer hand hygiene to the resident before leaving the room. He doffed his gloves, reached into his pocket and donned new gloves. He did not perform hand hygiene prior to donning the gloves. The CNA then entered room [ROOM NUMBER] and walked to bed B. He delivered the meal tray, took off the plate cover and the covers for the beverages. He did not offer the resident hand hygiene. He left the room and returned to the meal cart and picked up the meal tray for the resident in bed A. He placed the meal tray in front of the resident. He left the room, doffed his gloves, went to the nursing cart and took a handful of gloves and put them in his pocket. He donned a new pair of gloves. He did not perform hand hygiene prior to donning the gloves. -An unidentified CNA took a meal tray from the meal cart and entered room [ROOM NUMBER]. She did not offer the resident hand hygiene prior to the resident's meal. (ii) During a continuous observation on the 200 unit on 4/6/22 beginning at 12:15 p.m. and ending at 12:29 p. m., the following was observed: -CNA #2 delivered a meal tray to room [ROOM NUMBER], removed personal items from the bedside table, provided set-up meal assistance for the resident and upon exiting the room, she did not perform hand hygiene, but rather, went back to the food cart for another tray; -CNA #2 delivered two meal trays to bed A and B in room [ROOM NUMBER]. She did not perform hand hygiene upon exiting the room; and -CNA #2 put on a gown and gloves and entered room [ROOM NUMBER] to deliver the last meal tray. She did not sanitize her hands before donning her gloves. b. Observations 4/7/22 - Hand hygiene failures On 4/7/22 at 9:55 a.m. certified nurse aide (CNA) #4 failed to perform hand hygiene after doffing personal protective equipment (PPE) and upon leaving room [ROOM NUMBER], a Covid 19 isolation room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/7/22 beginning at 9:45 a.m. and ending at 10:43 a.m., an unidentified CNA entered numerous resident rooms without performing hand hygiene before entering or after exiting. Observations were as follows: -The CNA entered room [ROOM NUMBER] and removed the resident's breakfast tray. No hand hygiene was performed before entering the room or after exiting. -The CNA entered room [ROOM NUMBER] with a pen and paper to obtain the resident's lunch order. No hand hygiene was performed before entering the room or after exiting. -The CNA then entered and exited room [ROOM NUMBER] quickly, without performing hand hygiene, and immediately entered room [ROOM NUMBER]. The CNA exited room [ROOM NUMBER] with the resident's meal tray and returned to the room to obtain the resident's lunch order. No hand hygiene was performed before entering the room or after exiting. -The CNA entered and exited room [ROOM NUMBER]. No hand hygiene was performed. -The CNA entered room [ROOM NUMBER] with vital sign equipment. No hand hygiene or cleaning of vital sign equipment was performed. -The CNA entered and exited room [ROOM NUMBER] without performing hand hygiene. -The same CNA entered room [ROOM NUMBER] with vital sign equipment. No hand hygiene was performed after exiting room [ROOM NUMBER]. -The CNA then entered room [ROOM NUMBER]. No hand hygiene was performed before entering or after exiting room [ROOM NUMBER]. c. Observations 4/10/22, 4/11/22 and 4/12/22 - PPE and hand hygiene failures (100, 200 and 400 units) On 4/10/22 at 11:34 p.m. CNA #9 was observed in a resident area on the 400 unit, in the hallway near resident rooms, without wearing eye protection. On 4/10/22 at 11:34 p.m., upon entering the 200 nursing station, registered nurse (RN) #4 was observed putting a surgical mask on her face. She was not wearing a N95 respirator mask or eye protection. She said she was aware the facility was in outbreak status. She then doffed the surgical mask and donned a N95 respirator mask and goggles. On 4/10/22 at 11:35 p.m., RN #4 was observed at the nurses' station on the 200 unit. Her surgical mask was below her nose and mouth. An unidentified CNA also was observed in the area, wearing a surgical mask below her nose which was changed to a N95 at 11:53 p.m. On 4/10/22 at 11:38 p.m. an unidentified nurse and an unidentified CNA were observed at the 100 unit nursing station without a mask and face shield. Upon prompting, they began to don a N95 respirator mask and a face shield. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/11/22 at 10:30 a.m., CNA #11 was observed sitting at the 400 unit nurses' desk. She was not wearing a face mask. She said she had just sat down and she had to get a drink of water. She said a break room was available to use when she needed to remove her mask, although she had not gone there to remove her mask. On 4/11/22 at 11:12 a.m., the maintenance director (MTD) was in his office across from the 400 unit nurses' station. He did not have his mask on and his door was wide open. Residents walked by his office. At 11:30 a. m., he continued to sit at his desk with his mask off. On 4/11/22 beginning at 11:25 a.m., licensed practical nurse (LPN) #4 was observed passing medications and providing care to residents wearing a N95 mask with the straps cut off and covered with a cloth mask. On 4/11/22 at 1:15 p.m., an unidentified laundry worker was observed to enter resident rooms on the 400 unit without sanitizing prior to entering rooms and upon exit. She was touching the doors, and removing hangers and other laundry from the rooms. On 4/12/22 at 9:05 a.m. an unidentified housekeeper was observed in the hallway of the 100 hall. Her mask was below her nose and mouth. d. Observation 4/11 and 4/12/22 on the 200 unit - isolation rooms - PPE and hand hygiene failures. On 4/11/22 at 10:32 a.m., LPN #2 was observed entering room [ROOM NUMBER], an isolation room for COVID-19. She put on a gown, gloves, and booties. She then took off the gloves and put new gloves on without performing hand hygiene. She disposed of the gown, booties, and gloves in the room prior to exiting. However, she did not sanitize her face shield upon exiting the isolation room and returning to the nurses' station. On 4/11/22 at 10:43 a.m., LPN #2 was observed entering room [ROOM NUMBER], an isolation room for potential norovirus. She put on a gown, booties, and gloves. She disposed of the gown, booties, and gloves in the room prior to exiting. However, she again did not sanitize her face shield. She also did not perform hand hygiene upon exiting the room. She returned to the nurses' station to chart. On 4/11/22 at 10:45 a.m., CNA #8 was observed in room [ROOM NUMBER], an isolation room for presumptive COVID-19. She had a gown, gloves, N95 mask, and a face shield on. She was observed pulling down her mask to speak to the resident. On 4/11/22 at 10:57 a.m., an unidentified CNA was observed entering room [ROOM NUMBER], an isolation room for COVID-19. She put on gloves, a gown, then booties. She did not change gloves or perform hand hygiene after touching her shoes to put the booties on. On 4/11/22 at 11:11 a.m., CNA #8 was observed leaving room [ROOM NUMBER], an isolation room. She disposed of the gown and gloves in the room. She replaced her mask in the hallway. She did not perform hand hygiene after leaving the isolation room. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/11/22 at 11:49 a.m., the director of rehabilitation (DOR) was observed entering room [ROOM NUMBER], an isolation room for presumptive COVID-19. He put on a gown and gloves. He disposed of his gown and gloves inside the room. However, upon leaving the room, he did not sanitize his face shield or perform hand hygiene. On 4/11/22 at 12:18 p.m. CNA #8 was observed in room [ROOM NUMBER], an isolation room for COVID-19. Her PPE gown was not tied and was falling off her shoulders. Upon exiting the room, she hung her gown in the room and stated she would use it again. She left the room, without sanitizing her face shield or performing hand hygiene. -CNA #8 then picked up a tray for room [ROOM NUMBER], an isolation room for presumptive COVID-19. She entered the room and put on a used gown which she did not tie. The gown kept falling off while she was in the room. She did not put gloves on. She helped the resident set up the lunch tray, but did not encourage hand hygiene for the resident prior to eating. CNA #8 left her used gown in the room. She did not sanitize her face shield or perform hand hygiene upon leaving the room. On 4/11/22 at 12:25 p.m. LPN #2 put on a gown, booties, and gloves prior to entering room [ROOM NUMBER] which was an isolation room. Upon exiting the room, she disposed of the gown, booties, and gloves inside the room. She did not perform hand hygiene or sanitize her face shield upon exiting the room. On 4/11/22 at 2:18 p.m. CNA #8 entered COVID-19 isolation room [ROOM NUMBER] again, this time with a clipboard and pen. She put on the gown she had left hanging in the room earlier. She did not put on gloves. She held the clipboard and used the pen to take the resident's meal order. Thereafter, she exited the room, leaving the used gown hanging in the room. On 4/11/22 at 2:55 p.m. the resident in room [ROOM NUMBER], an isolation room for COVID-19, activated her call light. CNA #8 knocked and opened the door. She stood in the doorway and asked the resident what she needed. A used gown was hanging on the wall. The CNA then entered the room and put on the used gown which was on the wall. She took the resident's meal order. Upon exiting the room, she hung her gown back up in the room. She then realized she had not turned off the call light. She re-entered the room and put the used gown back on but did not don gloves. Upon exiting the room, she hung up the gown. She did not sanitize her face shield. On 4/12/22 at 9:24 a.m. a small trash can was observed outside room [ROOM NUMBER], an isolation room for COVID-19; it was overflowing with used PPE. On 4/12/22 at 9:34 a.m. LPN #4 was observed on the 200 unit in the hallways and entering resident rooms. While she was in the resident area, she was wearing a N95 mask with the straps cut off and covered with a cloth mask to hold the N95 in place. On 4/12/22 at 2:30 p.m. CNA #5 was observed wearing a N95 mask below her nose while sitting at the nurses' station near the 100 and 200 unit with residents in close proximity. On 4/12/22 at 7:54 p.m. LPN #5 was observed in the 200 hallway with her medication cart with a N95 mask on her chin, below her nose and mouth. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 4/12/22 at 7:59 p.m. CNA #7 was observed in room [ROOM NUMBER], an isolation for presumptive COVID-19. CNA #7 did not have a gown or gloves on. Her N95 mask was below her nose and mouth. On 4/12/22 at 8:01 p.m. an unidentified nurse was observed standing at the medication cart on the 300 unit. She was pulling medications out of the cart and checking the computer. She was not wearing a facial covering or eye protection. Upon prompting, she donned a N95 respirator mask and eye protection. Upon entering the 200 unit nursing station, LPN #3 and an unidentified CNA were observed sitting at the nursing station. The CNA was scr

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Perform COVID19 testing on residents and staff. 38185 Based on observations, record review and interviews, the facility failed to test staff, including individuals providing services under arrangement for Coronavirus (COVID-19). Specifically, the facility had been in a COVID-19 outbreak status since 12/23/21 that included positive cases for both residents and staff. The facility failed to conduct bi weekly PCR testing for all staff per the CDC and CMS guidance due to outbreak status since 12/23/21, to ensure the virus did not spread to residents within the facility. The facility failed to protect individuals, equipment and supplies, allowing individual and testing items within six feet of the testing area and each other. Observations showed staff performing testing in front of the testing supplies, therefore not protecting the testing equipment from being contaminated. The testing area was shared by two individuals with the testing occurring within six feet of the individuals and their desk area. In addition, the facility failed to ensure staff were conducting self-testing in accordance with testing guidelines. Observations showed staff members failed to swab their nose with five circular motions in each nostril to ensure the testing was effective and would produce an accurate result. Nursing management, in the room during the testing process, failed to instruct and provide education to facility staff members who were testing themselves incorrectly. The facility staff failed to complete appropriate hand hygiene during and after the testing process and staff interviews showed that not all staff were aware of the testing day and admitted to not completing a PCR test. The last PCR test results were on 4/8/22 and 22 out of 70 staff were tested . Ten staff were within the 90 days of testing positive for COVID-19 and the facility had two staff members with religious exemptions. As a result of testing, three residents tested positive for COVID-19 and upon observation, a fourth resident had been placed in isolation after testing positive for COVID-19. In addition, observations revealed numerous infection control breaches which led to the facility's failure to prevent the spread of COVID-19. Cross reference F880 (Infection control), F888 (COVID-19 vaccination), F835 (administration), F837 (governing body) and F867 (QAPI). Findings include: I. Immediate Jeopardy A. Findings of immediate jeopardy The facility had been in a COVID-19 outbreak status since 12/23/21 that included positive cases for both residents and staff. The facility failed to conduct bi weekly PCR testing for all staff per the CDC and CMS guidance due to outbreak status since 12/23/21, to ensure the virus did not spread to residents within the facility. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility failed to protect individuals, equipment and supplies, allowing individuals and testing items within six feet of the testing area and each other. Observations showed staff performing testing in front of the testing supplies, therefore not protecting the testing equipment from being contaminated. The testing area was shared by two individuals with the testing occurring within six feet of the individuals and their desk area. The facility staff failed to complete appropriate hand hygiene during and after the testing process and staff interviews showed that not all staff were aware of the testing day and admitted to not completing a PCR test. The last PCR test results were on 4/8/22 and 22 out of 70 staff were tested . Ten staff were within the 90 days of testing positive for COVID-19 and the facility had two staff members with religious exemptions. As a result of testing, three residents tested positive for COVID-19 and upon observation at the facility, a fourth resident had been placed in isolation after testing positive for COVID-19. In addition, observations revealed numerous infection control breaches which led to the facility's failure to prevent the spread of COVID-19. Cross-reference F880 and F888. B. Imposition of immediate jeopardy On 4/12/22 at 7:43 p.m., the nursing home administrator (NHA) and the regional nursing consultant (RNC) were notified of the immediate jeopardy situation created by the facility's failure to conduct COVID-19 testing as directed by the state health department, CMS and CDC guidelines while in outbreak since 12/23/21. C. Facility plan to remove immediate jeopardy On 4/14/22 at 11:15 a.m. the facility submitted a plan to remove the immediate jeopardy. The plan to remove the immediacy read: 1. Corrective action COVID-19 POC rapid testing (point of care) was completed on 4/12/22 for 22 of 72 employees. All staff members who did not complete the mandatory testing were contacted and educated that they were not able to work their shift without completing the mandatory COVID-19 POC test. All staff will complete the COVID-19 testing prior to the start of their scheduled shift. The supervisor on duty or designee will check each staff member before the start of their shift to ensure they have been tested . The supervisor on duty will contact the director of nursing and administrator for permission to remove a staff member from the facility if they refuse to comply with the mandatory COVID-19 POC test. Employee COVID-19 PCR testing will occur on Tuesdays and Fridays in the front entrance conference room. Notices will be posted at the time clock, on the director of nursing's office door and the employee bulletin board. On Monday and Thursday, the day prior to the testing day, reminders will be sent to all staff by utilizing a text messaging system. (continued on next page)

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A. Record review A sign, undated, was posted on the director of nursing's (DON's) office door indicating COVID-19 testing was on Tuesdays and Fridays in the DON's office. It documented all staff were required to be tested by 2:00 p.m. A line list, dated 4/12/22, was provided by the consultant DON on 4/12/22 at 3:15 p.m. It documented that only 18 staff members had been tested for COVID-19, that day (4/12/22), out of 72 total staff members who worked at the facility. A line list for Friday, 4/8/22, documented 32 staff members had a COVID-19 PCR test out of 72 total staff members. The facility was unable to provide documentation that the staff who were not PCR tested had been POC (point of care) tested (alternative testing that does not require sending the test to the lab) until the next testing date on 4/12/22. A line list for Tuesday, 4/5/22, documented 22 staff members had a COVID-19 PCR test out of 72 total staff members. The facility was unable to provide documentation that the staff who were not PCR tested had been POC tested until the next testing date on 4/8/22. The facility was unable to provide documentation that the staff members who were not tested had been contacted, provided education, been removed from the schedule, or had disciplinary action to ensure compliance with the testing requirements. B. Observations On 4/12/22 at 1:43 p.m., facility staff COVID-19 testing was observed. The social services assistant (SSA) getting ready to self-test in the DON office. The DON told the SSA to write his name and birth date onto the testing tube and also the bag. The DON did not provide the SSA with any other instructions. -He used the swab in a circular motion three times in each nostril. He then proceeded to place the swab in the tube and then placed the tube in the bag. He pumped the container to obtain hand sanitizer, however it made a sputtering sound, which indicated the hand sanitizer container was almost empty. -The door in the office, which led to the outside of the facility, was not open for ventilation. -The SSA left the room. The DON was informed that the SSA did not perform the COVID-19 self PCR test correctly. The DON said the swab should be twirled in a round fashion, five times in each nostril. She said he would have to return to conduct the test correctly to ensure an accurate result. At approximately 1:55 p.m. certified nurse aide (CNA) #12 came into the DON's office to conduct her COVID-19 test. The DON told her to make sure she twirled the swab in five full circles. The DON and the regional nurse manager (RNM) were in the room; they did not watch CNA #12 perform the self-test. CNA #12 swabbed each nostril four times. (continued on next page)

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Winding Trails Post Acute	2800 Palo Pkwy Boulder, CO 80301

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F 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	V. Failure to ensure the testing location followed CDC guidance for source control and failure to protect individuals, equipment and supplies, by keeping individuals and items six feet from the testing area and from each other. In addition, the failure to ensure infection control practices were observed during the testing process. A. Observations On 4/12/22 at 11:15 a.m. an unidentified housekeeping staff member was observed entering the DON's office for the COVID-19 PCR self-test. She approached the table, labeled the testing tube with her name as directed by the DON. -The DON was observed sitting at her desk, closer than six feet from the housekeeping staff member, with her face shield on the top of her head and the N95 respirator mask pulled beneath her chin. She was not wearing any other form of PPE. -The RNM was sitting at another desk in the room. She was wearing a N95 respiratory mask and a face shield. She was not wearing any other form of PPE. -The housekeeper, while performing the swab self-test, was informed by the DON she needed to turn around. The housekeeper turned to the area directly behind her. The area had boxes and packages of unopened PPE and testing supplies. She performed the swab self-test, placed the tube into a bag and then left the room. She did not perform hand hygiene after performing the test. At approximately 1:50 p.m., the SSA returned to complete the PCR test. He removed his mask and faced the DON while he did the swab test. He removed his gloves and then wiped down the table. He did not perform hand hygiene after testing. At 1:55 p.m., CNA #12 entered the DON's office to perform the COVID-19 self-test. After she was finished, she placed the swab in the tube and the tube in the bag. She did not perform hand hygiene following the self-test. VI. Staff interviews CNA #2 was interviewed on 4/12/22 at 3:43 p.m. She said staff were required to be tested twice a week on Tuesdays and Fridays. She said management informed staff they needed to be tested these days via the intercom system in the facility. She said testing was done in the DON's office. She said the testing supplies were set up and she tested herself each time. She said she used the swab in each nostril for three spins. She said she then placed the swab in a vial and handed it to the manager in the office. She said she then placed her mask back on and returned to work. She said she was required to get a rapid test prior to her shift when she had COVID-19 symptoms. The staffing coordinator (SC) was interviewed on 4/12/22 at 4:00 p.m. She said both direct hire and agency staff were notified in orientation that COVID-19 testing days were conducted on Tuesdays and Fridays. She aid then it was the staff' s responsibility to remember to get tested . (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure staff are vaccinated for COVID-19 38185 Based on observations, record review and interviews, the facility failed to develop and implement a COVID-19 staff vaccination process to address all facility staff, including unvaccinated staff who provided care, treatment and other services to facility and/or residents. Specifically, the facility failed to monitor each contracted staff member's vaccination status to ensure proper advanced PPE (personal protective equipment) strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. The facility was unable to provide a listing of the vaccination status of all contracted providers/staff who enter the facility on a regular basis and provide direct care to residents. The facility was non-compliant with the requirement of 100% vaccination rate, except those exempted, because of its failure to adequately track all employees (vendors and contractors) vaccination status to prevent the spread of COVID-19. A review of the facility vaccination policy and procedure revealed the facility did not require proof of vaccination for all contracted providers, but instead, required a generalized provider company attestation agreement which indicated the provider agreed to comply with the facility's vaccination policy. Cross-reference F880 (Infection control), F886 (COVID-19 testing), F835 (Administration), F837 (Governing body) and F867 (QAPI). The facility was non-compliant with infection control practices to protect residents from contracting COVID-19. Observations on 4/6/22 to 4/12/22 showed: -Facility staff did not consistently wear N95 or equivalent respirators while engaged in resident care and in resident areas and did not follow required use of eye protection in an outbreak. -Facility staff did not perform hand hygiene appropriately in between caring for residents and tasks; - Equipment (medical and non-medical) was not sanitized in between use; -Re-use of gowns in COVID-19 positive rooms and improper donning of gowns in COVID-19 positive rooms and lack of sanitization of face shields; -Facility staff not performing hand hygiene in between rooms/residents; -Facility staff were not providing residents with hand hygiene prior to meals; and, -Facility staff were not properly cleaning tables in the dining rooms after resident use. -Facility staff were not properly cleaning resident rooms. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Since 3/22/22, 18 residents have tested positive for COVID-19. Findings include: I. Immediate Jeopardy A. Findings of immediate jeopardy The facility failed to monitor each contracted staff member's vaccination status to ensure proper advanced PPE strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. During the survey, 4/6 through 4/19/22, the facility was unable to provide a listing of the vaccination status of all contracted providers/staff who enter the facility on a regular basis and provide direct care to residents. The facility was non-compliant with the requirement of 100% vaccination rate except for those exempted, because of its failure to adequately track all employees (vendors and contractors) vaccination status to prevent the spread of COVID-19. A review of the facility vaccination policy and procedure revealed the facility did not require proof of vaccination for all contracted providers, but instead, required a generalized provider company attestation agreement, which indicated the provider agreed to comply with the facility's vaccination policy. Observations revealed the facility was non-compliant with infection control practices to protect residents from contracting COVID-19.(Cross-reference F880) Observations on 4/6/22 to 4/12/22 showed: -Facility staff did not consistently wear N95 or equivalent respirators while engaged in resident care and in resident areas and did not follow required use of eye protection in an outbreak. -Facility staff did not perform hand hygiene appropriately in between caring for residents and tasks; - Equipment (medical and non-medical) was not sanitized in between use from a COVID-19 positive resident to a negative and unvaccinated resident; -Facility staff re-using gowns in COVID-19 positive rooms and improper donning of gowns in COVID-19 positive rooms and sanitization of face shields; -Facility staff not providing residents with hand hygiene prior to meals; and, -Facility staff not properly cleaning tables in the dining rooms after resident use or properly cleaning resident rooms. Since 3/22/22, 18 residents have tested positive for COVID-19. (continued on next page)

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F 0888 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	B. Imposition of immediate jeopardy On 4/13/22 at 1:00 p.m., the nursing home administrator (NHA) and the regional nursing consultant (RNC) were notified of the immediate jeopardy situation created by the facility's failure to monitor each contracted staff member's vaccination status to ensure proper advanced PPE strategies (as indicated in the facility's policy and procedure) were used to prevent the spread of COVID-19. C. Facility plan to remove immediate jeopardy On 4/14/22 at 2:32 p.m. the facility submitted a plan to remove the immediate jeopardy. The plan to remove the immediacy read: 1. Corrective action -On 4/14/22, the nursing home administrator and/or designee contacted all contracted providers to obtain verification of vaccination for all providers who enter the facility on a regular basis. This will be completed by 4/14/22 as any incoming vendor will be asked for proof of vaccination. The human resources director will continue to review and ensure outside contractors are fully vaccinated or have an approved exemption with a copy of their vaccination card and exemption on file. -On 4/14/22 a healthcare vaccine mandate vendor communication contract was developed and distributed to contracted vendors with the stipulations of the facility's requirements for verifying each provider's vaccination status, and the PPE strategies for those with accepted exemptions. Each contract will be signed and the facility will keep a copy by 4/14/22 or prior to allowing vendors into the facility. -All new contracted staff members' vaccination status and/or exemptions will be reviewed by the human resources director and documented on the vaccination log. -A list of contracted staff members' vaccination dates will be documented on the contracted staff member's vaccination log by the HRD or designee. -The receptionist or scheduler will validate the contracted staff member's vaccination status prior to having contact with the residents. -If a contracted staff member's vaccination status is unknown, the human resources director will request a copy from the contracted vendor prior to entering the facility. 2. Systemic changes -Education was provided to the nursing home administrator, director of nursing, and human resources director on the vaccination requirements and the Healthcare Vaccine Mandate Vendor Communication on 4/13/22. 3. Monitoring (continued on next page)

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