STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONACO PARKWAY HEALTH AND REHABILITATION CENTER	895 S MONACO PKWY DENVER, CO 80224

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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** Based on record review and interviews, the facility failed to ensure one (#1) of one resident out of eight sample residents received the care and services necessary based on professional standards of practice. Specifically, the facility failed to ensure Resident #1 was properly assessed for a skin condition prior to discharge. Findings include: I. Facility policy The Skin Management System policy, revised July 2017 was provided by the nursing home administrator (NHA) on 8/13/2020 at 10:57 a.m. It read, in pertinent part, Residents receive care to aid in the prevention or worsening of wounds and/or pressure ulcers. Individuals at risk for skin compromise are identified, assessed and provided treatment to promote healing, prevent infection, and prevent new ulcers from developing. Ongoing monitoring and evaluation are provided for optimal resident outcomes .A Weekly Skin Check will be completed in the resident's record using the Head to Toe Skin Check (UDA). II. Family interview Resident #1's private caregiver was interviewed on 8/10/2020 at 2:10 p.m. She said she worked for a home health agency as a caregiver and took care of Resident #1 in her home for [AGE] years. She said on 12/7/2020 Resident #1 fell and broke her hip and she had rehabilitation stay at (the name of facility) for 10 to 11 days. She said she visited the resident several times while she was at the facility. She said she would find her soiled she would have to clean her up. She said the day Resident #1 was discharged home she went to the facility late afternoon to transport the resident home. She said that evening she went to change Resident #1's brief, put her pajamas on and assist her to bed when she saw an opened wound on Resident #1's back. She said when Resident #1 was discharged from the facility no one told her she had an open wound so she called the resident's daughter. Resident #1's daughter was interviewed on 8/12/2020 at 4:40 p.m. She said the day her mother was discharged home she received a call from Resident #1's caregiver about her mother having a wound on her back and was unhappy with the care that was proved by the facility. III. Resident status Resident #1, age 85, was admitted on [DATE] and discharged on [DATE] to home. The December 2019 computerized physician orders [REDACTED]. According to the 12/27/19 minimum data set (MDS) assessment, Resident #1's mental status was not conducted. She did not exhibit any behavioral symptoms. She required one-person assistance will all activities of daily living (ADLs). She was frequently incontinent of bladder and always incontinent of bowel. The resident was at risk for pressure ulcer development. She had a surgical wound present and received surgical wound treatment. The resident's overall expectation was to be discharged to the community. IV. Record review Review of the January 2020 CPO revealed an order which read, Head to Toe UDA (user defined assessment) every evening shift at 2:00 p.m. Review of Resident #1's skin assessments revealed the last skin assessment was completed on 1/9/2020 and it documented the resident's skin was intact. The discharge physician note dated 1/15/2020 documented Resident #1's unsafe discharge to home was reviewed with Resident #1's daughter and Resident #1's hip incision was healed. It also documented Resident #1 had been sitting in her wheelchair for hours in the hallway; however, no further documentation about positioning or skin was found in the record on or after that day. Review of Resident #1's January 2020 treatment administration record revealed staff documented completion of a skin assessment on 1/15/2020 at 2:00 p.m.; however, documentation of the resident's skin condition was not in the resident's record. The 1/15/2020 skin assessment was requested and not proved. The nurse's note dated 1/16/2020 at 3:02 p.m., revealed Resident #1 discharged against medical advice (AMA) at 2:45 p.m., AMA paperwork was given to the resident. Although Resident #1 discharged against medical advice (AMA) there was no documentation of Resident #1's skin condition (other than incision site by the physician 1/15/2020 see above) or documentation of the resident refusing to have her skin assessment completed prior to discharge. V. Staff interviews The NHA and interim director of nursing (IDON) were interviewed on 8/11/2020 at 12:35 p.m. The DON said she had been the interim DON since late June 2020. The NHA said he had stepped in as the NHA the week of survey. He said he could not speak to the deficient practice prior to his arrival but would assist as able in the investigation. He said he could not speak to the reasoning of incomplete skin assessments and they had started education with licensed staff on shift for completion of skin assessments. They acknowledged staff should have completed or attempted to complete skin assessment prior to discharge.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that one (#2) of one out of eight sample residents received treatment and care in accordance with professional standards of practice and comprehensive person-centered care. The facility failed to ensure: -Resident #2 (a non-english speaking resident), was provided with an adequate tool to communicate his needs on a regular basis; and, -Staff anticipated Resident #2's needs to prevent a decline in overall health and well being as the resident suffered multiple falls (cross-reference F689) and weight loss. Findings include: I. Facility admission agreement Resident #2's signed admission agreement, last revised in January 2020 read in part, English Translation: Point to your language. An interpreter will be called. The interpreter is provided at no cost to you. II. Resident #2's status Resident #2, older than [AGE] years old, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The resident was wrongly care planned as Armenian speaking instead of Albanian/Italian. The 8/4/2020 minimum data set (MDS) assessment, coded the resident as moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident did not reject evaluation or care. The resident required two persons physical assistance with transfers. He required extensive assistance of one person with bed mobility, dressing, eating, toilet use and personal hygiene. III. Observations Resident #2 was observed on 8/6/2020 at 10:44 a.m. lying in his bed. The resident had a certified nurse aide (CNA) #4 who was providing one-on-one (1:1) care in the room with him. The resident had a bruise to his right eye which was red and dark purple/black in color and an undressed stitches to the upper corner, just above his right eyebrow. The resident waved and spoke in a language (unknown). His gesture suggested he was greeting. There was nothing suggestive of the resident having a communication deficit. -At 3:35 p.m. observed Resident #2 awake in his wheelchair with his lunch tray on the bedside table in front of him. CNA #4 was sitting in a chair in front of him encouraging him to eat. CNA #4 said it had been his fourth time working with the resident. Resident #2 was speaking an unknown language, and CNA #4 said he had an App (application) on his phone which was supposed to detect what the resident was trying to say. He said the App was in Italian. CNA #4 said there was a Health Care Communication Board under Resident #2's food tray. The Health Care Communication Board had colored various pictures of items including signs of pain, food/fluids, family, clothes, equipment, and activities. CNA #4 said that was the first time he had seen the communication form and believed it was provided by the therapy department; however he did not attempt to use it. He said the App was not detecting what the resident was saying only words, so he was not sure what the resident wanted. He said the resident would point using hand gestures to communicate. He said the resident would shake his head no and put his hand up when he did not want anything to eat or drink, point to his brief if he needed to be changed and point

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

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) to the bed when he wanted to lie down. The room did not have any other personalized activities in the room. The resident continued to yell out in his language, then CNA #4 pointed to the resident's bed and assisted him back to bed. IV. Record review A review of the resident's care plan, initiated on 7/13/2020 documented Resident #2 had a communication problem related to (r/t) language barrier. The goal portion of the care plan reported Resident #2 will be able to make basic needs known by (translator/son) on a daily basis through the review date. The intervention portion of the plan reported that nursing staff should anticipate and meet needs. It also documented to allow adequate time to respond, repeat as necessary, and do not rush. Request clarification from the resident to ensure understanding; Face when speaking, make eye contact, turn off television/radio to reduce environmental noise; Ask yes/no questions if appropriate; Use simple, brief, consistent words/cues; Use alternative communication tools as needed; Encourage resident to continue stating thoughts even if resident is having difficulty. Focus on a word or phrase that makes sense, or responds to the feeling resident is trying to express. -Resident #2 was wrongly care planned as Armenian speaking instead of Albanian/Italian. An additional care plan related to the resident's communication was initiated on 7/18/2020 and revised on 8/10/2020 (during survey). The care plan reported that Resident #2 was unable to communicate all of his needs, due to a language barrier, but he does communicate with head nods and body gesture, so staff anticipate his needs. His primarily language is Albanian with Italian. He wears glasses and hearing is intact. Resident's family calls him frequently and are supportive. Per hospital paperwork, it was noted that he speaks Armenian but care plan has been corrected to Albanian. The progress note documented on 7/18/2020 at 8:29 a.m. read Resident #2 was unable to communicate all of his needs, due to a language barrier, but he does communicate with head nods and body gesture, so staff anticipate his needs. His primary language was Armenaian. He need assistance to/from activities. He wears glasses and hearing is intact. Resident #2's family calls him frequently and are supportive. Resident #2 enjoys spending time with his family. He also enjoy watching sports on TV. His care plan has been created and will continue through the next review. An additional progress note dated 7/30/2020 at 6:52 a.m. read Language barrier, resident is agitated, screaming most of the time. Sometimes make signs that is well understood, poor sleep this shift. Furthermore, a progress note dated 8/11/2020 at 11:12 a.m. read Updated note: Resident #2 was unable to communicate all his needs, so staff use the assistance of a communication board or I-Pad/cell phone to communicate with him, however he does understand some English. He responds to question ask with yes or no answers, or pointing to a communication board, or listening to an interpreter talking in Italian to him. He also does head nods and hand gestures, staff also anticipate his needs. His primarily language is Italian. A review of the neurological records dated 7/10/2020 through 7/13/2020; 7/21/2020 through 7/25/2020 and 8/1/2020 through 8/4/2020 all reported resident had a confused conversation. The nursing daily skilled charting was reviewed. The chart revealed contradictory information was documented under the level of communication portion of the assessment. The assessment asked the question Making Self Understood - Verbal. The response documented on 7/11/2020 reported unable to determine. However, the assessment dated [DATE], 7/13/2020, 7/14/2020, 7/15/2020, 7/16/2020, 7/17/2020, 7/18/2020, 7/19/2020, 7/20/2020, 7/21/2020, 7/23/2020, 8/2/2020, 8/3/2020, 8/4/2020, 8/5/2020, 8/6/2020, 8/8/2020, 8/9/2020, 8/10/2020 and 8/11/2020 reported understood. Conversely, the assessments dated 7/21/2020, 7/24/2020, 7/25/2020 and 7/26/2020 reported Resident #2 was rarely/never understood. Moreover, the assessments dated 7/28/2020, 7/29/2020, 7/30/2020 and 8/1/2020 documented Resident #2 was sometimes understood The social services assistant (SSA) provided a telephone call log between herself and Resident #2's family member. The log listed Resident #2's family member was called on 7/14/2020 at 11:57 a.m., 7/15/2020 at 12:05 p.m., 7/15/2020 at 12:29 p.m., 7/17/2020 at 10:24 a.m., 7/17/2020 at 10:31 a.m., 7/20/2020 at 9:07 a.m., 7/20/2020 at 10:12 a.m., 7/21/2020 at 8:57 a.m., 7/21/2020 at 1:58 p.m., 7/22/2020 at 8:32 a.m., 7/23/2020 at 11:43 a.m., 8/7/2020 at 11:49 a.m. and 8/8/2020 at 10 a.m. The call log reported the aforementioned calls lasted 13, 24, 1, 6, 7, 8, 1, 13, 14, 1, 2, 2, 4 and 1 minute consecutively. The SSA acknowledged that these were the only time interpretation in a language Resident #2 understood occurred. A review of the hospital discharge record dated 6/28/2020 recorded Resident #2's weight as 57 kilograms (KG) which is equivalent to 125.66 Lbs. There was nothing in the hospital record that documented Resident #2 had [MEDICAL CONDITION] in his bilateral lower extremity (BLE). A review of Resident #2's vitals revealed his weight was documented as 118.4 pounds (Lbs) using a chair scale on 7/10/2020 (admission weight). It further revealed Resident #2 weighed 108.9 Lbs using mechanical lift on 7/17/2020. In addition, a weight of 105.6 Lbs was recorded for the resident on 7/30/2020 and 8/6/2020 (means of measurement was omitted in the record) A review of Resident #2's nutrition care plan initiated 7/14/2020 (four days after admission) documented Resident #2 had a potential and /or was at risk for inability to maintain his Nutrition due to (d/t) cardiovascular accident ([MEDICAL CONDITION]), humerus fracture (fx), dementia, [MEDICAL CONDITION] (HLD), [MEDICAL CONDITION] (AFIB), limited mobility, advanced age and hypertension (HTN). The goal portion of the nutrition care plan documented Resident #2 would maintain his nutritional status through the review date. He will experience weight loss/fluctuations related to resolving [MEDICAL CONDITION]. The intervention portion of the nutrition care plan documented to observe/document/report as needed (PRN) any sign/symptom (s/sx) of dysphagia, pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals. Furthermore, it documented to observe/record/report to medical director (MD) PRN s/sx of malnutrition emaciation, cachexia, muscle wasting, significant weight loss. In addition, it documented to provide and serve diet as ordered, to monitor intake and record per (q) meal. To monitor and record weight per facility guidelines, to provide and serve supplements as ordered, to provide food in a form that is acceptable and culturally acceptable (Resident #2 likes Italian food). Registered dietitian (RD) to evaluate and make nutritional recommendations as needed. Finally, it documented Resident #2 required 1:1 feeding, he was dependent on eating. A review of the nutrition progress note dated 8/6/2020 at 5:09 p.m. documented Average per oral (PO) and oral nutritional supplement (ONS) intake is extremely sporadic 25-100%; resident had been refusing his house supplement at breakfast and lunch but completing 75-100% at dinner. Resident #2 did have recent significant weight (wt) loss -13 (-11%) over last month since admission that was anticipated related to (r/t) resolving [MEDICAL CONDITION] & nursing noting resident was weighted using a different method after leaving admission COVID isolation room and admission weight may be inaccurate. The resident had an initial weight loss of 9.5 lbs which is 8.0% in one week and from 7/10/2020 to 7/17/2020 and an additional 3.3 lbs weight loss from 7/17/2020 to 7/30/2020. There was no weight obtained 7/24/2020. A re-weight was not completed each time the resident lost weight to determine whether the resident had true weight loss or it was an inaccuracy in the scale. Overall, the resident lost 12.8 lbs since his admission to the facility which was an 11% weight loss. The resident was on a supplement, however additional nutritional interventions were not implemented and evaluated when the resident continued to have weight loss each week. Skin assessments: A review of the hospital referral document from 6/28/2020 did not reveal an order for [REDACTED]. Nursing daily skilled charting dated 7/11/2020 at 12:35 pm reported the resident's skin was intact and there were no changes to the resident's skin integrity An head to toe skin assessment dated [DATE] (a day after resident's admission) reported the resident had no skin issue. The same assessment dated [DATE] and 7/25/2020 reported the resident's skin was intact. V. Family interview The resident family member was interviewed on 8/6/2020 at 2:03 p.m. when the family member visited the facility. The family member described the resident as a strong and agile individual for his age. He said the resident could do most of his activities of daily living (ADLs) with no/to limited assistance. He said the resident was able to independently walk on the stairway in the house, he needed help setting up meals but could feed himself. The family member added that the resident got in and out of the bathroom independently/required assistance sometimes. The family member said the resident urinated on the bathroom floor at home and slipped. He said the resident recovered well from the injury before he was discharged to the facility. He said on admission, he (family member) made the facility aware of the resident's needs. He said he emphasized the resident needed an interpreter, and that the facility acknowledged and guaranteed to make provision to accommodate the resident. He said the facility called him on multiple occasions to report that the resident had a fall. The family member said he interviewed the resident and was made aware that when the resident used his call light system to call for help, nursing staff responded to the call light but for the language barrier and lack of understanding of the resident's expressed needs, they would turn off the call light and walked out of the resident's room. The family member said, the resident reported that he fell because he attempted to care for himself. (Cross-reference F689) He said the staff member whom the facility relied on for interpretation did not speak the same language as the resident. He said Resident #2's health deteriorated because of lack of access to an interpreter. He emphasized the resident's lack of ability to communicate his needs had frustrated the resident and had led to him to feeling abandoned and in a state of mental breakdown. He said the resident now required hospice service that could have been prevented if the facility had adequately accommodated the residents needs. The family member said he was worried the resident had lost weight because the facility could not understand the resident when he communicated his meal preference and had not eaten well enough since his admission. The family member said he communicated the resident's meal preference to

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) the facility as Italian meal. He said the meal preference was not accommodated as he had spoken to the resident and had also observed the resident got the same meal as the other population of residents at the facility. He emphasized that instead of accommodating the resident's meal preference, the facility placed the resident on oral nutritional supplement which the resident often declined. The family member identified CNA #2 as the individual whom the facility relied upon to interpret the resident conversation. He (family member) spoke briefly in Italian/Albanian to CNA #4 when the CNA exited the facility to access his car, and the CNA said he did not understand a complex statement spoken in the aforementioned languages. After the brief conversation, Resident #2's family member stated he faulted the facility's reliance on CNA #2 as a translator. He said CNA #2 could not even interpret How are you doing? which was what he asked in Albanian. VI. Resident interview Resident #2 was interviewed on 8/10/2020 at 1:47 p.m., with a translation service via telephone. The phone interview was conducted with facility staff (CNA #8) present and the entire conversation was done while the phone was on speaker phone. The interpreter spoke in Armenian language (the initial care planned language for the resident). In an attempt to speak to the resident in the aforementioned language, the interpreter identified the resident was not speaking Armenian but instead he spoke Albanian/Italian. She connected the call with an Albanian/Italian speaking translator. The translator then asked Resident #2 his name, what time of the day it was, how staff cared for him and finally, how the resident felt about his overall care. The resident responded coherently stating his name, the time of the day (afternoon) and also said staff walked out on him when he called for help. He reported a staff shoved food deep in his throat which caused him to throw up. The resident also reported that one of his fall resulted from nursing staff letting go of his hands when he attempted to stand. VII. Staff interviews CNA #4 was interviewed on 8/6/2020 at 10:23 a.m. He said he had worked with the resident on each of the shifts he came to work for approximately five weeks now. He said resident was able to use his call light. He said when he responded to the resident's call light, he was unable to understand the needs expressed by the resident. He said as most staff of the facility, he took it that the resident was confused and he would turn off the resident's call light and ensure the resident's call light is placed within the reach of the resident and that his bed was in a low position before he exited the room. The CNA said he was assigned as a one-on-one caregiver to the resident because the resident has had multiple falls since his admission to the facility. He acknowledged that language barrier made it difficult to address the residents needs. He said body language was what he utilized to have a peripheral understanding of some limited needs of the resident. He said he was not made aware to use a translation line or communication board with the resident. CNA #2 was interviewed on 8/6/2020 at 11:21 a.m. He said he was sometimes assigned to care for Resident #2 because he spoke three languages. He listed the languages he spoke as Spanish, Catalan and English. He said he was aware Resident #2 understood and communicated in Italian language, He clarified that his understanding was that Italian language had some input of Spanish and thus, he was able to pick some lines from what Resident #2 communicated. CNA #2 acknowledged he was not a satisfied interpreter. He said when he worked the shift, he was called to help interpret what the resident said. He said he had no idea how the resident was managed when he was away. He said the resident family member had a write up on a board which the resident read and helped calm the resident down when he is agitated but due to room change, the write up was misplaced and had not been found. Social services director (SSD), social services assistant (SSA) and DON were interviewed on 8/10/2020 at 11:25 a.m. The SSA said when a resident newly admitted to the facility she went over the referral packet and reviewed the diagnoses, medications and needs. Then they will meet with family, friends, guardians for needs and complete assessments for future plans and needs. She said when a resident was non-english speaking, the tool they used is family and language line. The DON, SSD and SSA said the information for the language line was posted at the nurse's station and CNA's who were one-on-one with the resident had a copy of the language line in their possession at all times. SSA said she completed the communication assessment and found out the resident spoke Italian and Armenian but spoke primarily Italian. She said the son was the best contact and the one who knew his needs best. She said she used the family member as an interpreter and she used the language line two days after. She said the language interpreter only understood a few words out of the resident's sentences. She said she would rely on Resident #2's family member for interpretation because the hospital did not have much luck with communicating with the resident. She said Resident #2's family member would call him once a day or every other day to speak with him. She said if they had any concerns she would bring her cell phone to the room to help with communication. She said Resident #2's family member would express frustration as he could not visit in the beginning, he was upset that he could not sit in the room with the resident for long hours while he spoke with him on the phone. The family member was also worried he could not eat enough, physically getting weaker. The DON went in Resident #2's room on 8/10/2020 at 11:36 a.m. At the time, CNA #8 who was one-on-one with Resident #2 was interviewed. He said he tried to use the google translation application to interpret what the resident said. He does not think that the app made sense of what the resident said. He said the resident does talk, but that he mumbled and that might affect the effectiveness of the google translation application. He said in his five weeks of working with the resident, he had not been made aware to use a language line or communication book with the resident. He said he only got the translation line information transferred through text message few minutes prior to the interview. He said he had not been trained on how the language line was to be utilized. Resident #2 was interviewed on 8/10/2020 at 1:47 p.m. with (name of company) translation service via telephone. The phone interview was conducted with facility staff (CNA #8) present and the entire conversation was done while the phone was on speaker phone. The interpreter spoke in Armenian language (the initially care planned language for the resident). In an attempt to speak to the resident in the aforementioned language, the interpreter identified the resident was not speaking Armenian but instead he spoke Albanian/Italian. She connected the call with an Albanian/Italian speaking translator. The translator then asked the resident of his name, what time of the day it was, how staff cared for him and finally if the resident felt he was being abused. The resident responded coherently stating his name, the time of the day (afternoon) and also said staff walked out on him when he called for help. He reported a staff shoved food deep in his throat which caused him to throw up. The resident also reported that one of his fall resulted from nursing staff letting go of his hands when he attempted to stand. The DON was interviewed on 8/10/2020 at 12:17 pm. She acknowledged that the revision to the care plan above which addressed the the real language spoken by the resident was done because the facility agreed that they had care planned the wrong language for the resident. The aforementioned information of possible abuse was brought to the attention of the DON and the NHA on 8/10/2020 at approximately 2:02 p.m. and the NHA immediately reported to the State Survey Agency and likewise commenced and investigation into the alleged abuse. The nursing home administrator (NHA) and DON were interviewed on 8/11/2020 at 12:35 p.m. The DON said she had been the interim DON since late June, 2020. The NHA said he had stepped in as the NHA the week of the survey. He The NHA said he could not speak to the deficient practice prior to his arrival but would assist as able in the investigation. They acknowledged the staff had not provided consistent monitoring and communication for Resident #2. The NHA said the staff were aware Resident #2 could not speak English and the staff should have utilized every tool to communicate with the resident. He said Resident #2's cognition was poor at times, but could use gestures to communicate. They acknowledged Resident #2 could not see or point to the printed communication tool which staff used in the room. The NHA said while the staff attempted to utilize the interpreter line on 8/10/2020 (for the first time) they found out the resident had trouble understanding and he showed signs of dementia. They said moving forward they had a care conference with Resident #2's family and hospice about Resident #2's change in condition. They started education regarding use of the language line with the appropriate language the resident was used to. The NHA said they would continue to contact the son to interpret and use the resident's hand gestures to communicate and update the care plan.
F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents, affecting one (#2) resident reviewed out of the eight sample residents. The facility failed to implement interventions timely and follow implemented care plan interventions for Resident #2 who was admitted as a known high fall risk with a history of falls, dementia, unspecified left humerus fracture, muscle weakness, abnormalities of gait and mobility. The resident fell within days of being admitted , experienced multiple falls which the facility implemented one-to-one staff to be with Resident #2. The staff member left Resident #2 during this time and this failure contributed to Resident #2 falling and sustaining a head injury which required being sent to the hospital and requiring sutures, more than first aid. Furthermore,

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) fall assessments were not completed upon admission and the resident had multiple falls furthering his decline. Additional failures which added to failures of quality of care (cross-reference F684), the staff failed to effectively communicate with the resident. The resident tried to care for himself due to the communication barrier and interventions not being followed, as the staff did not understand the resident's expressed needs in his language. Findings include: I. Failure to ensure fall intervention were in place timely and followed A. Facility fall policy The Fall Management policy, revised in July 2017 was provided by the director of nursing (DON) on 8/10/2020 at 3:30 p.m. The document read, The facility assists each resident in attaining/ maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/ or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident's fall risks. A care plan is developed and implemented, based on this evaluation, with ongoing review. An additional Fall Management policy, which was revised in November 2017 was provided by the DON on 8/10/2020 at 3:37 p.m. The document recorded practical guidelines for newly admitted residents and read A proactive approach will be taken for newly admitted residents with regards to fall risk. Newly admitted residents will be considered at risk for falls until they are reviewed by the interdisciplinary team. It further enumerated that: -Upon admission, the admitting nurse will complete the Fall Risk User Defined Assessment (UDA), the nursing initial plan of care, address risk factors related to the resident in the plan of care and implement appropriate interventions as identified. -The kardex will be updated to reflect the resident's risk status and individualized fall risk interventions -If the resident is determined to be at high risk, then the resident is referred to rehabilitation services. -The resident and the resident's representative are provided education on fall risk and interventions in place to reduce the potential for falls. -Residents will be assessed quarterly, annually and with significant change using the Fall Risk UDA. The care plan is updated as appropriate. The document listed the facility's procedure in the event of an actual fall and documented in pertinent part The IDT reviews all resident falls within 24-72 hours at the IDT meeting to evaluate circumstances and probable cause for the fall. The IDT will complete the interdisciplinary post fall review. The IDT designee will discuss recommended significant changes to the care plan to minimize repeat falls with the resident and/ or resident's representative. The care plan will be reviewed and/ or revised as indicated. Care Kardexes are updated as appropriate. B. Resident #2's status prior to admission The referral note dated 6/28/2020 documented the attending physician reported a [DIAGNOSES REDACTED]. No loss of consciousness. laceration to the left post parietal area. Cognition at baseline per family member. small right frontal subarachnoid hemorrhage. The precaution portion of the note also documented Resident #2 was Albanian speaking only. Had dementia and falls, left [MEDICAL CONDITION] upper extremities. Prior level of function portion of the note reported Family member states he assists resident with dressing and bathing. resident is able to step over shower ledge and walks in home independently at times. The resident has had falls. Family member present as much as possible, but the family member is struggling to care for him. Resident is independent for self feeding after setup using the right upper limb (RUL) only. Family member reported the resident got up at night, urinated on the bathroom floor then slipped. The living situation portion of the note reported resident lives with family member in house with stairs to enter. The resident had walk-in shower, no chair, hand held shower head. -This note indicated the facility was aware this resident was a high fall risk prior to being admitted to the facility. A review of the hospital referral document from 6/28/2020 did not reveal an order for [REDACTED]. C. Resident #2's status Resident #2, over [AGE] years old, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. -The resident [DIAGNOSES REDACTED]. The 8/4/2020 minimum data set (MDS) assessment coded the resident as moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident has had a fall in the last month prior to admission. The resident has had a fracture related to a fall in the 6 months prior to admission. The resident has had two or more falls since admission. He has had one fall since admission which resulted in minor injury. No pain experience was recorded. The resident did not reject evaluation or care. The resident required two persons physical assistance with transfer. He required extensive assistance of one person with bed mobility, dressing, eating, toilet use and personal hygiene. D. Observation Resident #2 was observed on 8/6/2020 at 10:44 a.m. lying in his bed. The resident had a certified nurse aide (CNA) #4 who was providing one-on-one (1:1) care in the room with him. The resident had a bruise to his right eye which was red and dark purple/black in color and an undressed stitches to the upper corner, just above his right eyebrow. The resident waved and spoke in a language (unknown). His gesture suggested he was greeting. There was nothing suggestive of the resident having a communication deficit. -At 3:35 p.m. observed Resident #2 awake in his wheelchair with his lunch tray on the bedside table in front of him. Resident #2 had a bruise with a laceration above his right eye. CNA #4 was sitting in a chair in front of him encouraging him to eat. CNA #4 said it had been his fourth time working with the resident. Resident #2 was speaking an unknown language, and CNA #4 said he had an App (application) on his phone which was supposed to detect what the resident was trying to say. He said the App was in Italian. CNA#4 said there was a Health Care Communication Board under Resident #2's food tray. The Health Care Communication Board had colored various pictures of items including signs of pain, food/fluids, family, clothes, equipment, and activities. CNA #4 said that was the first time he had seen the communication form and believed it was provided by the therapy department; however he did not attempt to use it. He said the App was not detecting what the resident was saying only words, so he was not sure what the resident wanted. He said the resident would point using hand gestures to communicate. He said the resident would shake his head no and put his hand up when he did not want anything to eat or drink, point to his brief if he needed to be changed and point to the bed when he wanted to lie down. The room did not have any other personalized activities in the room. The resident continued to yell out in his language, then CNA #4 pointed to the resident's bed and assisted him back to bed. (Cross-reference F684) E. Record review A review of the resident's care plan revealed the facility failed to initiate fall interventions for the resident until three days after admission. The fall care plan, initiated on 7/13/2020 with a revision date of 8/11/2020 documented Resident #2 was a high risk for falls related to (r/t) confusion, deconditioning, gait/balance problems, incontinence, new admission, unaware of safety needs. The care plan documented Resident #2 had a fall on 7/10/2020 (admitted) and twice on 7/22/2020. The goal of the care plan documented Resident #2 would be free of falls through the review date. It also reported that Resident #2 will not sustain serious injury through the review date. In addition, goals of the care plan documented the resident's risks and injury potential will be minimized through the next review date. The fall intervention documented 1:1 staffing to monitor the resident for safety; To ensure all the resident's personal items in reach while in bed; Staff to anticipate and meet the resident's needs; Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed; The resident needs prompt response to all requests for assistance; Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs; Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility; and ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair. -Even though the resident had 1:1 (one-to-one) staffing to monitor resident for safety, resident continued to fall, and one-to-one was implemented for a little time after the resident would fall. The fall incident reports for Resident #2 were provided by the DON on 8/10/2020 at 2:48 p.m. There was no incident report provided for the fall sustained by the resident on 7/10/2020. A review of the resident's medical record on 8/11/2020 revealed a fall assessment was not completed for the resident since admission. A change of condition assessment was documented on 7/10/2020 at 8:43 p.m. The situation, background, assessment, recommendation (SBAR) summary reported the resident vital signs (blood pressure (BP), pulse (P), temperature (T), weight (W) and oxygen intake (O2 sat) at room air were within the normal range/limit. The RN assessment/ licensed practical nurse (LPN) appearance of the resident's portion of the SBAR reported What I think is going on with the resident is: New admit, history (Hx) of falls, dementia. Additional Nursing Notes as applicable: Evaluated by (name of RN). No injuries noted. Placed with 1:1 CNA. Family/Health Care Agent Notified: Message left at (cell number) on face sheet at 7/10/2020 at 5:50 p.m Primary care clinician (PCC) notified on 7/10/2020 at 5:45 p.m. Nursing daily skilled charting dated 7/11/2020 at 12:35 pm reported the resident's skin was intact and there were no changes to the resident's skin integrity. An head to toe skin assessment dated [DATE] (a day after resident's admission) reported the resident had no skin issue. The same assessment dated [DATE] and 7/25/2020 reported the resident's skin was intact. -These skin assessments indicate the injuries Resident #2 sustained were after admission A follow up note for the above mentioned fall dated 7/22/2020 at 9:42 p.m. documented monitoring resident for fall, no fall this shift. The resident alert, one-on-one with the resident all night. A change of condition assessment was documented on 7/22/2020 at 12:16 a.m. The SBAR summary reported the resident vitals signs (same as above) were within the normal range/limit. The RN/LPN assessment portion of the report documented What I think is going on with the resident is: I thought resident got out of bed himself due to his poor safety awareness, resident is not aware of his limitations. Bed was in low position, call light was within reach, resident did not use his call light. Additional Nursing Notes as

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) applicable: Res. was found lying on the mat by bed side by resident care staff (RCS), called this writer, getting to the resident's room, found him lying on the mat by bed side, assessment done by the RN, resident was helped back in bed, no sign and symptom (S/S) of pain at this time, neuro assessment initiated, comfortable in bed will continue to monitor. Family/Health Care Agent Notified: family member called on 7/22/2020 at 6:00 a.m. PCC notified on 7/22/2020 at 1:00 a.m. The fall report dated 7/22/2020 at 2:15 pm documented under the incident description portion of the report that Resident #2 was found on the floor mat, no injury. Bed in low position, call light was within reach. Resident did not use the call light button. Resident description portion of the report documented No change noted from residents base line, no sign and symptoms of pain noted. Although the care plan documented the resident fell twice on 7/22/2020 (see above), there was just one change of condition assessment and one incident report of the resident's medical record. An head to toe skin assessment dated [DATE] reported for the first time that the resident had existing bruises and existing abrasions. The site, type, length and width portion of the skin assessment recorded for the first time that the resident sustained [REDACTED]. It also recorded the resident has scabbed areas to his right shin which measured 14 cm in length and 2 cm in width. The assessment recorded the resident sustained [REDACTED]. Further description of skin issues portion of the assessment also recorded for the first time that Both bruises were fading. Area to R shin was multiple scabbed areas (had upon admission). The assessment recorded NO for the question Nail cleaned and trimmed. A fall incident dated 8/1/2020 at 6:30 a.m. documented under the incident description portion of the report that Resident #2 was found on the floor by his CNA. Resident was lying on the floor in the room very close to his bed. He did not hit his head and there was no injury observed. Bed in low position, call light was within reach. Patient did not use the call not use call light button. Resident description portion of the report documented Resident was unable to give description. Immediate action taken portion of the report documented Resident was helped off the floor by three or more staff members including a registered nurse (RN). RN did the first skin assessment, his vitals were obtained, and a sitter was asked to stay with him, he was given a cup of water which he refused. His doctor and family member was later informed. Although he had no injury, but since the fall was unwitnessed, neuros were being observed. Resident was alert and oriented x 1-2 which is his baseline. Intervention, designate 1:1 on schedule. Staff education in regards to following care plans. A fall incident dated 8/1/2020 at 8:00 a.m. documented under the incident description portion of the report that Resident #2 was found on the floor by a nurse. He had a skin tear to upper side of his left eye. He was sent to the hospital for evaluation and treatment. Resident description portion of the report documented Resident was unable to give description. Immediate action taken portion of the report documented Resident was helped off the floor by three to four (3-4) staff members including an RN. His vitals were obtained and resident medical doctor (MD) and family member were informed. Resident was sent to the hospital for evaluation and treatment. The progress note documented on 8/1/2020 at 7:20 a.m. reported Found resident sitting on the floor at 6:30am. it's in draw site. No injury when check body. No abnormal neurologic sign, no limited ROM when compared to his base. Started neuro V/S. Asked help for looking for a sitter to Charge nurse, text message to DON. Agency CNA and (name of staff) helped resident clean and support. Monitored resident condition continuously. A change of condition assessment was documented on 8/1/2020 at 7:24 a.m. The SBAR summary reported the resident vitals signs (same as above) were within the normal range/limit. The RN/LPN assessment portion of the report documented What I think is going on with the resident is: He's acting confused Additional Nursing Notes as applicable: He fell at 6:30 a.m. during morning report. Family/Health Care Agent Notified: family member called on 8/1/2020 at 8:15 a.m. PCC notified on 8/1/2020 at 8:05 a.m. The progress note documented on 8/1/2020 at 8:30 a.m. reported Resident fell again at 7:50 a.m. Right (Rt) eyebrow area laceration 4.5 cm (centimeters) x 2 cm, bleeding with redness Rt. eye around. pupil reflex active, No limited ROM when compare his baseline, no abnormal neurologic sign. Cleaned wound with wound cleanser, pat dry then cover with gauze then secured with tape, called medical director (MD) then notified resident condition, received order of transfer to hospital for evaluation. Informed family and DON. His family member wants to talk to the manager, informed the manager about it. -This fall the resident sustained [REDACTED]. He received stitches to his right eyebrow. (see below) A review of Resident #2's medical record revealed the facility failed to document the facility's decision to move Resident #2 closer to the nursing station for a closer supervision. There was no documentation of the facility's rationale for declining to ensure the resident continued to be on one-on-one supervision as his fall care plan directed. There was no amendment to the care plan which reversed the one-on-one supervision initiated for the resident on 7/13/2020. The head to toe skin assessment dated [DATE] reported for the first time that the resident had existing skin tear in addition to bruising and abrasion mentioned above. The site portion of the assessment reported for the first time that the resident sustained [REDACTED]. The assessment recorded for the first time that the resident had a scab to the frontal part of his right knee and a surgical incision to the back of his head. The progress note documented on 8/1/2020 at 12:42 p.m. reported Resident came back from the hospital at 12:10 p.m. His Rt. eyebrow area sutured (9 stiches) covered by gauze, no bleeding sign from wound, Started neuro vital signs (V/S), no abnormal neurologic sign/ limited range of motion (ROM) when compared with his baseline. Called MD and family, informed resident came back to the facility. Sitter in the resident side. Monitored resident condition continuously. F. Disciplinary action report for staff for failure to follow one-to-one for Resident #2 A disciplinary action record signed on 8/5/2020 was provided by the director of nursing (DON). The document reported that On 8/1/2020, employee pulled 1:1 care giver out of Resident #2's room to work the floor. Resident fell twice and was sent to emergency room (ER). Resident is careplanned to be a one-on-one at all times. Care plan was not being followed and the resident was injured. Care plan is to be followed at all times. An additional disciplinary action record that had the employee, supervisor and witness signatures and date portions of the document blank was provided by the DON on the same day as above. The document reported that On 8/1/2020, a resident had two falls, there were no incident reports completed. SBARS were filled out. On 8/1/2020, another resident roommate (RM) had his bilateral lower extremities dressings removed but not put on, nursing staff found him without a dressing on but it was documented that the dressing was completed. -This indicated the facility falsified documentation. G. Staff interview LPN #1 was interviewed on 8/10/2020 at 12:55 p.m. She said all residents were assessed for fall risk on admission, quarterly and with any changes in condition. She said all falls were reviewed by an interdisciplinary team (IDT) that developed interventions and updated the care plans. She reviewed fall assessment on admission for Resident #2 and stated it was not completed. She said based on the admitting history, such as the history of falls, unstable gait and use of medications, the resident should have had a fall assessment completed with him. She said it was not part of her responsibilities to review assessments. Registered nurse (RN) #3 was interviewed on 8/11/2020 around 9:43 a.m. She said all residents were assessed for fall risk on admission and after a fall. She said the accurate fall assessment would trigger a care plan for falls which did not happen with Resident #2. She said all falls were reviewed during an IDT meeting and care plan updates were a team effort. She said Resident #2 was placed one-on-one supervision following his fall on 7/10/2020. She said the resident was moved closer to the nursing station for a closer supervision. She said the resident went to the hospital and the facility did not place him back on the one-on-one supervision until after his recent fall on 8/1/2020. She reviewed the residents medical record and acknowledged there was no documentation on when the resident was moved closer to the nursing station. She also acknowledged that there was no amendment to the care plan which reversed the one-on-one supervision initiated for the resident on 7/13/2020. She said she would bring the observation to the attention of the facility's administration. The nursing home administrator (NHA) and DON were interviewed on 8/11/2020 at 12:35 p.m. The DON said she had been the interim DON since late June 2020. The NHA said he had stepped in as the NHA the week of the survey. He said he could not speak to the deficient practice prior to his arrival but would assist as able in the investigation. The NHA said 1:1 intervention was likely not the appropriate intervention with managing Resident #2's falls. He said 1:1 intervention should have been provided and care planned as needed. He said 1:1 intervention was not a long term intervention and should have only been utilized for agitation or just while he was in quarantine, until they established the resident's baseline. They acknowledged the laceration with stitches to the back of Resident #2's head was not assessed properly as the facilities first documentation was on 8/1/2020; and they were not sure if it had from his fall on 7/30/2020. He said prior to admission they were aware the resident had falls likely due to dementia. He said he could not speak to the reasoning of incomplete skin assessment and they had started education with licensed staff on shift for completion of skin assessments. The interim director of nursing (IDON) was interviewed on 8/11/2020 at 10:40 a.m. She acknowledged that Resident #2 did not have a fall intervention on admission. She said nursing staff documented an intervention in the resident's progress note when the resident fell on [DATE] (day of admission). She said a baseline care plan was to be completed within 48 hours of a resident's admission. She said the care plan should at least address the immediate needs of the resident. She said nursing staff were responsible for creating the care plan and that she would want to see a fall intervention in place because Resident #2 had a prior history of frequent falls. She

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) acknowledged a one-on-one fall intervention was put in place for Resident #2's on 7/13/2020 (three days after his first fall at the facility). She also acknowledged that the incident reports provided revealed the resident was found on the floor in his room by himself on the four different occasions he had a fall after the one-on-one intervention was put in place. She said care plans were updated by the unit manager after each fall with additional intervention and CNA and nurses were responsible to make sure care planned interventions were carried out. The DON said she would educate nursing staff on the need to adhere and follow through with care planned interventions going forward. .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 to help prevent the possible development and transmission of Coronavirus (COVID-19) and other communicable diseases and infections in one of two units. Specifically, the facility failed to: -Ensure staff properly stored personal protective equipment (PPE); -Ensure staff followed proper hand hygiene process/practices while providing wound care for Resident #3 and while delivering room trays; -Ensure masks were worn by residents when out of their room (Residents #7 and #8); -Ensure masks or facial covering were worn/offered to residents during staff interaction; -Ensure mechanical lifts were sanitized for resident use; and, -Ensure oxygen tubing was properly stored. Findings include: I. Professional references The Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of Facemasks, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html (updated 6/28/2020, retrieved on 8/12/2020), read in part, HCP (healthcare personnel) should leave patient care area if they need to remove the facemask. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, retrieved from: https://www.cdc.gov/handhygiene/providers/guidelin.html (updated 1/30/2020, retrieved on 8/12/2020), read in part, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: Before moving from work on a soiled body site to a clean body site on the same patient, After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces and immediately after glove removal. The Centers for Disease Control and Prevention (CDC) Recommendations for Disinfection and Sterilization in Healthcare Facilities, retrieved from: http://www.cdc.gov/infectioncontrol/guidelines/disinfection/recommendations.html#rec5g (updated 5/24/19, retrieved on 8/13/2020) read, in pertinent part, Disinfect noncritical medical devices (e.g., blood pressure cuff) with an EPA-registered hospital disinfectant using the labels's safety precautions and use directions. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a regular basis (such as after use on each patient or once daily or once weekly). The Centers for Disease Control and Prevention (CDC) Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, retrievedfrom:http://www.cdc.gov/infectioncontrol/guidelines/disinfection/recommendations.html#rec5g (updated 5/24/19, retrieved on 8/13/2020) read, in pertinent part Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., healthcare personnel, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. II. Facility policy The Hand Hygiene policy and procedure, revised 2/2018 was provided by the staff development coordinator/infection control preventionist (SDC/ICP) on 8/10/2020 at 4:40 p.m. It read, in pertinent part, Purpose: To decrease the risk of transmission of infection by appropriate hand hygiene. Policy: Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. Antiseptics control or kill microorganisms contaminating skin and other superficial tissues .Using an alcohol-based hand rub is appropriate for decontaminating the hands before direct patient contact; before putting on gloves; before inserting an invasive device; after contact with a patient; when moving from a contaminated body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, non intact skin, or wound dressings (if hand aren't visibly soiled); after removing gloves; before eating, and after contact with inanimate objects in the patient's environment. III. Improper storage of extended PPE A. Observation and interview On 8/6/2020 at 11:20 a.m. CNA #1 was observed outside room [ROOM NUMBER] she had a surgical mask and face shield on. She used alcohol based hand rub (ABHR), reached in her pocket, pulled out a KN95 mask and placed it over her surgical mask, then she donned a gown and gloves. She knocked on the door and entered the room. -At 11:25 a.m. CNA #1 exited the room. CNA #1 did not have a gown or gloves on, but had her KN95 mask over her surgical mask and face shield on. She had a red bag of trash and she walked down the hall around the corner to the right hallway dirty utility room. Then she exited the dirty utility room (she no longer had the red bag of trash) and entered the clean utility room. When she exited the clean utility room she did not have on her KN95 mask or her face shield, she only had her a surgical mask on. CNA #1 was interviewed on 8/6/2020 at 11:30 a.m. She said the reason she went into the clean utility room was to wash her hands and she forgot her face shield there. She pulled out her KN95 mask from her pocket. She said she did not know where she was supposed to store her KN95 so she kept it in her pocket. She said she had not been trained by the facility on where to store her KN95 mask when it was not in use. She said she did receive training about COVID-19 infection control practices from the agency she worked for but none specifically on how to apply or where to store PPE. B. Administrative interview The (SDC/ICP) was interviewed on 8/10/2020 at 4:15 p.m. She acknowledged CNA #1 should not have stored her KN95 mask in her pocket while not in use. She said all staff were given paper bags to store their KN95 masks when not in use during their shift and they were to discard them after their shift. She said she did not know if CNA #1 had infection control training on COVID-19 infection control practices and PPE use prior to working at the facility or while working at the facility. She said she usually provided training, but they were down a unit manager position and that individual would help with training staff on the units. The scheduler was interviewed on 8/11/2020 at 9:30 a.m. She said when agency staff were hired, she did not check or ensure if any of them had any specialized COVID-19 training or let anyone know at the facility if training was needed. She said the agency would send her the staff member's name, license information and when they came to the building they would be provided additional training as needed. She said moving forward she would ask the agency if individuals were trained on COVID-19 infection control practices and if not would notify management to get them trained when they started working at the facility. IV. Improper hand hygiene practice during wound care A. Observation and interview 8/10/2020 at 10:24 a.m. observed RN #1 performing wound care to Resident #3 with the assistance of CNA #2 and nurse practitioner (NP). The resident was observed in bed on a bariatric air mattress. A clean field with supplies was observed on the bedside table. RN #1 said Resident #1 admitted with a stage 4 wound to her coccyx and a wound to the right buttock. She said the wound care treatment, after the wound was cleaned, was to pack the wound with [MEDICATION NAME] packing gauze and to apply Xeroform to the right buttock and cover with [MEDICATION NAME], change every morning. RN #1 and CNA #2 washed their hands donned gloves and NP used ABHR and donned gloves, they positioned the resident on her right side, CNA #2 held Resident #3 in position and the NP helped position Resident #3's bilateral lower extremities (BLE). RN #1 removed the [MEDICATION NAME] from Resident #3's coccyx and she removed packing gauze which was moderately soiled with sanguineous drainage. She doffed her gloves and washed her hands. She donned gloves and cleansed the wound with a wound cleanser and 4 x 4 gauze. She doffed her gloves and donned gloves, she did not perform hand hygiene. She then applied skin prep to the periwound and doffed her gloves and donned new gloves. She did not perform hand hygiene. She then packed Resident #3's wound with the [MEDICATION NAME] gauze using her gloved fingers. She said she preferred to pack the wound that way because it was easier. She doffed her gloves and donned new gloves, she did not perform hand hygiene. She then placed a piece of Xeroform to Resident #3's right buttock and covered the wound with [MEDICATION NAME]. She doffed her gloves and donned new gloves. She did not perform hand hygiene. Then she placed a clean chuck underneath the resident. RN #1 and CNA #2 repositioned the resident on her back with pillows under each arm. She doffed her gloves and washed her hands. -RN #1 was interviewed on 8/10/2020 at 10:40 a.m. She said because she donned clean gloves in between each step of cleaning the wound, packing the wound and applying a clean dressing to Resident #3's wound she did not need to perform hand hygiene after removing her gloves. B. Administrative interview The (SDC/ICP) was interviewed on 8/10/2020 at 4:15 p.m. She acknowledged RN #1 should not have packed Resident #3's wound with her gloved fingers. She said RN #1 should have performed hand hygiene after, cleaning, packing the wound and after she doffed and changed her gloves. V. Failure to ensure residents wore masks or facial covering when outside their room On 8/6/2020 at 11:10 a.m. Resident #7 exited his room, he did not have a mask on or tissue covering his nose or mouth. Resident #7 said hello to the scheduler as she was

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MONACO PARKWAY HEALTH AND REHABILITATION CENTER	895 S MONACO PKWY DENVER, CO 80224

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) walking down the hallway and he took himself outside to the patio area to independently smoke in his wheelchair. -At 11:19 a.m. LPN #1 was observed at the medication cart in the hallway outside Resident #7's room. Resident #7 came in from the smoking patio and he and LPN #1 exchanged a few words. After brought to her attention she told Resident #7 that he had to wear his mask when he left his room which he agreed to do. -At 12:15 p.m. Resident #8 walked up to the nurse's station and asked LPN #1 where her nurse was. LPN #1 told Resident #8 her nurse was in a room with another resident. Resident #8 did not have on a mask or facial covering and LPN #1 did not encourage or offer the resident a mask or facial covering. VI. Failure to ensure mechanical lift were sanitized for resident use On 8/6/2020 at 10:45 a.m. there were two sit-to-stand lifts with dust debris, a commode, two fall mats, one mattress against the wall, two wheelchairs and two walkers, one of the walkers had the oxygen tubing strewn across the walker handlebars, there was no oxygen bag for the tubing at the end of North unit from room [ROOM NUMBER] to room [ROOM NUMBER]. The adjacent hallway with rooms #1 to room [ROOM NUMBER] had one Sara lift and one Hoyer lift observed with dust debris. -At 11:10 a.m. there was an electric wheelchair observed outside the therapy gym that was dusty with debris and a bariatric sit-to-stand lift device with dust debris. On 8/11/2020 at 9:35 a.m. three Hoyer lifts and three sit-to-stand lifts were observed on the North unit down the hallway of rooms #120 and #122. All were observed with dust debris. B. Administrative interviews The (SDC/ICP) was interviewed on 8/10/2020 at 4:15 p.m. She said in theory all staff should clean all equipment including the mechanical lifts after use and they were supposed to be cleaned by maintenance weekly. The NHA and director of nursing (DON) were interviewed on 8/11/2020 at 12:35 p.m. The DON said she had been the interim DON since late June 2020. The NHA said he had stepped in as the NHA the week of the survey. He said he could not speak to the deficient practice prior to his arrival but would assist as able with the survey investigation. They said CNA #1 should have stored her KN95 mask in a paper bag when not in use. They said they had started training on proper storage of KN95 mask and infection control policy and procedures. The NHA said all the mechanical lifts had been cleaned after concerns were brought to their attention during the survey. He said they were planning on completing more education regarding proper hand hygiene during meal service and continued encouragement with residents wearing their masks while out of their rooms and it was an ongoing process with resident non-compliance and training of the staff on infection control policy and procedure. VI. Failure to ensure proper hand hygiene while delivering room trays and masks were offered/worn by residents in their rooms. A. Observation and interviews On 8/10/2020 at 11:31 p.m., three certified nurse aides CNA #5, CNA #6 and CNA #7 were observed on the South unit of the facility as they served drinks to the residents prior to serving the noon meal. The drinks were served from resident room [ROOM NUMBER] through room [ROOM NUMBER] and room [ROOM NUMBER] through room [ROOM NUMBER], which were double occupancy rooms. The CNAs initially went into the residents' rooms to ask each resident about their drink preferences. The CNAs set the drinks on a tray that the residents had ordered. However, prior to serving the drinks to the residents, CNAs did not perform or offer any type of hand hygiene to the residents. The CNAs took the trays containing the drinks from the cart, opened each resident's door, greeted the residents, placed the drinks on their tables and left the room. The CNAs were observed as they repeated the sequence in each of the resident rooms mentioned above. The CNAs did not encourage the residents to cover their faces with a paper towel or wear their masks when they entered each of the residents' rooms. CNA #5 was interviewed on 8/10/2020 at 1:48 p.m. She said when she served meals to the residents, she would ensure residents were sitting upright and then she would ask the residents their preference of drinks. She said she would sanitize or offer hand washing to the residents prior to serving them. She said she would sanitize her own hands on the way out of each resident's room. She acknowledged she did not offer or perform hand hygiene with the resident prior to serving the meal. She said she would ensure to perform and or offer residents hand hygiene going forward. Licensed practical nurse (LPN) #1 was interviewed on 8/10/2020 at 1:52 p.m. She reported an overview of the required steps of meal delivery. She said staff must knock on doors, announce themselves, encourage the resident to wear a face mask when staff was present and ensure the meal card matched the meal and name of the resident of the room tray delivered. She said residents should have received hand hygiene at time of meal delivery to ensure their hands were free of contaminants when they ate their meal. She said staff should perform hand hygiene during meal delivery as needed and in-between helping residents. She said it was important for staff to encourage residents to cover their faces when staff entered their rooms to help curb the spread of infection. She said she would relay the concerns to the facility administration to ensure necessary training was provided. B. Administrative interview The DON was interviewed on 8/10/2020 at 2:14 p.m. The DON said hand hygiene must be conducted before resident meals. She said hand hygiene was done differently with residents based on their cognition. She said nursing staff was required to either utilize wash cloths or hand sanitizer. She said staff had been trained to offer hand hygiene at time of meal delivery to ensure residents ate their meal with clean hands to decrease the risk of transmission [MEDICAL CONDITION] or infections. She added that staff should perform hand hygiene for the same reason asserted for the residents. She said she would provide increased training to the identified staff.