STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065202	A. BUILDING _____ B. WING _____	04/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CEDARS HEALTHCARE CENTER	1599 INGALLS ST LAKEWOOD, CO 80214

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to prevent staff to resident neglect for seven (#1, #2, #3, #4, #5, #6, and #7) of nine residents on the main unit. Specifically the facility failed to ensure residents received tube feedings (#1 and #2) and nutritional supplements (#3, #4, #5, #6, #7) as ordered. Cross reference F610 Abuse Investigations I. Facility policies The facility Abuse, Neglect, and Exploitation Prohibition and Prevention Policy, revised 9/1/19, was provided by the nursing home administrator (NHA) on [DATE]7/20 at 1:00 p.m. It read, in pertinent part: The purpose of the policy is to provide a mechanism for prompt identification, investigation, and reporting of any allegation of abuse, neglect, or exploitation. To educate staff and other individuals about state and federal regulations regarding reporting suspected abuse. The policy defined neglect as: the failure of the Community, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect may be intentional (such as withholding or omitting care) or unintentional (e.g., the caregiver should have known that care was needed, but it was not provided). If neglect is suspected, a determination is made as to what services were not provided and what physical harm, mental anguish, mental illness, or deterioration in the resident ' s mental or physical condition resulted. Neglect is also evaluated as a result of indifference, carelessness, or deliberate negligence. II. Facility Investigation On [DATE] the facility received a report from the registered dietician (RD) she had rounded with a couple residents (#1 and #2) around 7:30 that morning and she had discovered two residents had empty tube feeding bottles. She had also discovered multiple nutritional supplements (for residents #3, #4, #5, #6, and #7) in the unit refrigerator that had not been administered as ordered. Upon review of the identified residents medication administration records (MARs) the nutritional supplements for the dates had been signed off as administered by the nurse. The facility investigation revealed the identified nurse had not rounded or checked on residents #1 and #2 on her shift that day so she was not aware their tube feeding bottles had run out and needed to be replaced. The investigation also revealed the nurse had assumed the supplements were given to residents #3, #4, #5, #6, and #7 by the certified nurse aides and had not verified the supplements were given or the amount that had been consumed by any of the residents but had documented full consumption on the MAR. III. Resident status Resident #1 Resident #1, age 42, was admitted on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively impaired and unable to complete a brief interview for mental status (BI[CONDITION]) assessment. The staff assessment for mental status revealed the resident had a problem with long and short term memory, had modified independent decision making skills, and did not exhibit behaviors. He was totally dependent on two or more staff members for all activities of daily living (ADLs) and mobility. Resident #1 enteral tube feeding orders were written on 10/31/2020 and read two times a day [MEDICATION NAME] 1.5 @ 85 ml/hour via PEG tube for 14 hours, on at 9:00 p.m. off at 11:00 a.m. to provide 1190 ml/1785 cal over 24 hours. Resident #1 ' s enteral tube feeding was found by the RD to be empty and not running at 7:30 a.m. on [DATE]. Resident #2 Resident #2, age 99, was admitted on [DATE]. According to the April 2020 computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident was mildly cognitively impaired with a brief interview for mental status score of 12 out of 15 with no behaviors exhibited. She required extensive assistance or was totally dependent on two staff for ADLs and mobility. She received enteral tube feedings. Resident #2 enteral tube feeding orders were written on 1/31/2020 and read every shift 40 ml/hour water auto flush via J-tube over 18 hours on at 4:00 p.m. and off at 10:00 a.m. to provide 720 ml over 24 hours. Resident #2 ' s enteral tube feeding was found by the RD to be empty, not running, and disconnected at 7:30 a.m. on [DATE]. Resident #3 Resident #3, age 85, was admitted on [DATE]. According to the April 2020 CPO, the [DIAGNOSES REDACTED]. The [DATE] 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 one staff member with ADLs and mobility. an order for [REDACTED].#3 and dated [DATE]20 was found in the unit refrigerator by the RD on [DATE]. Review of resident #3 April MAR indicated [REDACTED]. Resident #4 Resident #4, age 84, was admitted on [DATE]. According to the April 2020 CPO, the [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status score of 10 out of 15. She was independent with her ADLs and mobility. an order for [REDACTED]. Review of resident #4 ' s April MAR indicated [REDACTED]. Resident #5 Resident #5, age 60, was admitted on [DATE]. According to the April 2020 CPO, the [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance of two staff members with his ADLs and mobility. an order for [REDACTED]. Review of resident #5 ' s April MAR indicated [REDACTED]. Resident #6 Resident #6, age 92, was admitted on [DATE]. According to the April 2020 CPO, the [DIAGNOSES REDACTED]. The 4/8/2020 MDS assessment revealed the resident was severely cognitively impaired with a brief interview for mental status score of four out of 15. She required extensive assistance of one to two staff members with ADLs and mobility. an order for [REDACTED]. Review of resident #6 ' s April MAR indicated [REDACTED]. Resident #7 Resident #7, age 76, was admitted on [DATE]. According to the April 2020 CPO, the [DIAGNOSES REDACTED]. The [DATE]20 MDS assessment revealed the resident was cognitively impaired with a brief interview for mental status score of five out of 15. She required supervision of one staff member with her ADLs and mobility. an order for [REDACTED]. Review of resident #7 ' s April MAR indicated [REDACTED]. IV. Interviews The RD was interviewed on [DATE]7/2020 at 11:45 and stated she was completing her weight monitoring rounds on the morning of [DATE] and discovered resident #1 and resident #2 both had empty tube feeding bottles and were not receiving their tube feedings as ordered. She stated both resident ' s tube feedings should have still been running. She stated she then discovered many nutritional supplements in the unit refrigerator that should have been given to residents #3, #4, #5, #6, and #7. She continued the resident MARs showed they had been given and were all signed off on the MARs by the same nurse who was working at the time of discovery and who had not replaced resident #1 and #2 ' s tube feeding bottles. She stated she reported the issues to the NHA immediately upon discovery. The NHA was interviewed on [DATE]7/2020 at 1:00 p.m. and stated the investigation was started immediately upon receiving the report from the RD regarding the tube feedings and supplements. She stated the identified nurse was interviewed regarding what had been discovered to which the nurse stated she had not checked on resident #1 or #2 on her shift and did not know their tube feedings were empty and had not been running. In regards to the supplements discovered, the nurse stated she assumed the CNAs had given the supplements to the residents and did not check to verify, but documented the supplements were given. The NHA confirmed facility policy and procedure allowed for CNAs to give residents ordered supplements, though the nurse was responsible for verifying the resident received the supplement and the amount consumed prior to documenting the MAR. The NHA continued the nurse was suspended and ultimately terminated for resident neglect and poor work performance. She stated all nurses and CNAs were re-educated related to shift change reports

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

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

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) and procedures and supplements as a result of the investigation.
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** Based on record review and interviews the facility failed to thoroughly investigate neglect on the main unit. Specifically, the facility investigated and substantiated allegations of neglect for seven residents, though did not review or investigate the possibility of neglect for the remaining residents on the unit. Cross reference F600 Abuse and Neglect I. Facility Policy The facility Incident Reporting and Investigation policy was provided by the nursing home administrator (NHA) on [DATE]7/2020 at 1:00 p.m. it read in pertinent part: The purpose of the policy is to provide guidelines for the reporting of, and investigation of Incidents, Accidents and Adverse Events and establish quality assurance procedures to evaluate and implement root cause analysis and corrective and remedial action. Investigations of Incidents and Adverse Events. 1. Incidents and adverse events are promptly investigated in order to: a. Obtain factual information regarding the incident or adverse event: b. Provide the basis for reasoned judgment, if possible, as to how and why the incident or adverse event occurred and whether an allegation can or cannot be substantiated (i.e. root cause analysis); and c. Determine what remedial and/or corrective action, if any, may be appropriate to protect residents, prevent recurrence and improve quality of care. 2. The Executive Director/Administrator is ultimately responsible for initiating and overseeing the investigation process. 3. The investigation is conducted by an objective and neutral individual(s). The decision as to who will investigate a particular incident or allegation will depend on the nature of the incident/allegation and the identity of the individuals involved. In all instances, any individuals who were involved in, or potential witnesses to, the incident being investigated should not be involved in conducting the investigation. 4. Reasonable steps are taken to protect residents and others involved in the incident or adverse event, such as suspension of team members alleged to have committed wrongdoing or separation of residents after an Incident of aggression, etc. 5. Reasonable steps are taken to gather and preserve existing documentation and physical items (such as equipment) that may be relevant to the investigation. 6. Interviews are conducted with all parties and witnesses involved in the incident or adverse event. II. Record review A. Facility investigation The facility identified multiple incidents of staff to resident neglect on [DATE]. The facility investigation revealed the alleged neglect for seven identified residents was substantiated resulting in termination of the identified nurse. Further review of the investigation revealed no other residents on the unit were reviewed for the possibility of further neglect by the identified nurse. III. Interviews The NHA and interim director of nursing (IDON) were interviewed on [DATE]7/2020 at 1:00 p.m. and stated the investigation did not include other residents on the unit who were cared for by the nurse identified and substantiated for neglect. They stated the investigation would have been more thorough if all of the residents cared for by the identified nurse would have been reviewed to either rule out or possibly identify further neglect.