STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065231	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK CARE CENTER	**945 DESERT FLOWER BLVD PUEBLO, CO 81001**

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** Based on interview and record review the facility failed to honor a resident's right to refuse services for one (#1) of three residents reviewed for resident rights out of 13 sampled residents. Specifically, the facility failed to refrain from its attempts to take Resident #1 to a doctor's appointment, despite her refusal, which ultimately had been cancelled. Findings include: I. Facility policy The Admission/Transfer/Discharge Procedures & Nursing Documentation policy, undated, was provided by the director of nursing (DON) on 8/26/2020 at 3:18 p.m It read in pertinent part, the resident had a right to refuse treatment and had a right to be treated with dignity and respect. II. Resident #1 A. Resident status Resident #1, less than [AGE] years of age, was admitted on [DATE] and readmitted on [DATE]. The August 2020 computerized physician orders [REDACTED]. According to the 7/28/2020 minimum data set (MDS) assessment she had moderate cognitive deficits with a brief interview for mental status (BIMS) score of 12 out of 15. She was totally dependent for transfers with a Hoyer-lift; which required two-person staff assistance. She used a wheelchair for mobility. B. Family and resident interview A family member was interviewed on 8/25/2020 10:10 a.m. He said, on 3/30/2020 Resident #1 told him that the facility went to her room and told her it was time to get ready for her doctor's appointment. She told the facility the appointment was cancelled, she did not want to go and she wanted to talk to her sons. She told him the facility would not call them. He said she told him the facility took her to the doctor's office anyway. When they arrived at the doctor's office the facility found out that her appointment was cancelled. She told him she felt like no one listened to her. He said the facility never called him or his brother to confirm what she said; they never called to check to see if what his mom said was true. He said there was no emergency situation that warranted the facility to force his mom to go to her appointment. Resident #1 was interviewed on 8/24/2020 at 12:21 p.m. She did not recall information about a doctor's appointment. C. Staff interviews The van driver (VD) was interviewed on 8/26/2020 at 8:30 a.m. He said he took Resident #1 to an appointment in March 2020 that had already been cancelled so he had to bring her back to the facility. The staffing coordinator (SC) was interviewed on 8/26/2020 at 8:52 a.m. She said, on 3/30/2020, Resident #1 was to be taken to a doctor's appointment and so she went into her room to transfer her to the wheelchair; certified nurse aide (CNA) #11 and CNA #12 had finished dressing her and the unit care coordinator (UCC) was in the room. Resident #1 expressed concerns as to why she had to go to an appointment. The UCC told Resident #1 that it was a critical appointment she had to go to. The SC said the UCC told everyone in morning report Resident #1 had a critical appointment that day. Resident #1 was not aware of the appointment and said she wanted to call her son to see if there was an appointment. Resident #1 was upset, did not want to get into her wheelchair. CNA #11 helped her (SC) transfer Resident #1 into her wheelchair anyway. Once the staff found out her appointment had been cancelled; the van driver brought her back and told staff it was cancelled. CNA #11 was interviewed on 8/26/2020 at 9:12 a.m. She said CNA #12 and her along with the UCC were in Resident #1's room the day she had doctor's appointment in March 2020; the VD came to Resident #1's room and told them Resident #1 had an appointment. Resident #1 said she did not want to go. CNA #12 and she got the resident dressed, then she and the SC used the Hoyer lift to transfer her into her wheelchair even though she did not want to go to the appointment. She (CNA #11) told the SSD the nurses said she had an appointment that was critical. VD told the staff he was bringing Resident #1 back because her appointment had been cancelled. CNA #11 said it was confusing to help Resident #1 get ready for the appointment because they (her nor CNA #12) had not looked at the van schedule (which CNAs were to do before appointments) to see if she had an appointment and where it was located. She and CNA #12 apologized to Resident #1 for sending her to the doctor's office when she returned to the facility. The SSD was interviewed on 8/25/20 at 4:50 p.m. She said Resident #1 was taken to the cancelled appointment at the end of March 2020 but she was out of the facility at that time; she said she found out about it when she returned to the facility. Resident #1 could make her own choices and she wanted staff to immediately notify her if a resident did not want to go to an appointment. She said residents had the right to refuse to go to appointments. The facility had ongoing training of staff regarding Resident #1's refusal to go to an appointment; which had already been cancelled. D. Grievance The 4/3/2020 Concern and Comment Form, provided by the nursing home administrator (NHA) on 8/25/2020 at 12:00 p.m. documented a family member was upset Resident #1 was sent to a doctor's appointment on 3/30/2020; an appointment which had already been cancelled. E. Nursing home administrator (NHA) and director of nursing (DON) interview The NHA and DON were interviewed on 8/26/2020 at 3:20 p.m. He said, on 3/30/2020, one of Resident #1's sons said Resident #1 was forced to go to a doctor's appointment. Both he and the DON were not told Resident #1 was upset about having to go to an appointment; they did not know she was upset. They said the facility needed to make sure Resident #1 was not taken to an appointment if she did not want to go to it. F. Record review According to the care plan, initiated on 1/28/2020, it identified she could make her needs known. Interventions included she had a phone in her room she used to keep in touch with family. III. Facility follow-up According to the 8/25/2020 and 8/26/2020 training on a Resident Right to Refuse, provided by the SSD on 8/26/2020 at 9:00 a.m. all staff were re-educated on: -The Resident's Right policy and the resident's right to refuse treatment; -Staff were to report, to the nurse providing the care, when a resident refused to go to a doctor's office; -A resident cannot be forced to do anything they refuse to do; -The nurse was to notify social services, verbally or by phone, if a resident refused to go to a doctor's office; and, -Social services would immediately follow up with the resident.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure one (#4) of three residents were kept free from abuse out of 13 sample residents. Specifically, the facility failed to prevent a resident-to-resident physical abuse incident between Resident #4 and #5. Findings include: I. Facility policy and procedure The Abuse policy and procedure, no revised date, was provided by the director of nursing (DON) on 8/26/2020 at 3:18 p.m. It revealed, in pertinent part, Each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation of type by anyone. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subjected to abuse by anyone. This includes but is not limited to: staff, other residents, consultants, volunteers, and staff from other agencies serving our residents, family members, the resident representative, friends, or any other individuals. II. Resident #4 A. Resident staus Resident #4, age 60, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the

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** - Few	(continued... from page 1) 6/29/2020 minimum data set (MDS) assessment, the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident had mild depression with the resident scoring five of 27 on the patient health questionnaire (PHQ-9). The resident had no behavioral symptoms. He required extensive assistance for bed mobility, transfers, grooming and toilet use. He was frequently incontinent of bowel and bladder. B. Record review The care plan, initiated 11/15/18 and revised 7/7/2020, identified the resident could become physically aggressive and resistive to care. He can become agitated when he was told it was too soon for him to have pain medications. He will hoard things in his room and will take things that do not belong to him and he will become physically aggressive when staff will try to retrieve things that do not belong to him. Interventions include anticipating care needs and providing them before the resident becomes overly stressed. If reasonable, discuss behavior with the resident. Explain/reinforce why behavior was unacceptable. Intervene as needed to protect the rights and safety of others. Approach in a calm manner, divert attention, remove from the situation and take to another location as needed. Observe behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, etc. The care plan, initiated 11/15/18 and revised 7/7/2020, identified the resident had a [DIAGNOSES REDACTED]. He was currently on [MEDICATION NAME]. He may display behaviors of isolation, anger towards others, feeling restless, fidgety, repetitive requests as well as physical aggression. Interventions include allowing choices as much as able. Monitor for adverse side effects from medication & document every shift. Notify a medical doctor (MD) if it occurs. Report changes in mood & behavior to social services as needed (PRN). Use alternate staff if acting out or refusing cares. Come back later. Assess for any physical causes for the behavior such as hunger, needing to use the bathroom, pain, illness etc. and resolve as able. C. Incident on 5/28/2020 between Resident #4 and Resident #5 Record review Event note dated 5/28/2020 at 6:35 p.m. Reported by CNA that Resident #4 was assaulted by Resident #5. CNA reports that patient was sitting in the doorway of the room and was elbowed by Resident #5. Residents were separated for safety. Head to toe assessment, neurological assessment completed. The director of nursing (DON), executive director (ED) and police department (PD) notified. Resident #4 was interviewed and through questioning Resident #4 reported that Resident #5 had grabbed his arm, pushed him out of the way. Patients were separated for safety. Head to toe assessment, neurological assessment, DON, ED and PD notified. The 5/28/2020 incident report, completed by registered nurse unit care coordinator (RNUCC) revealed Resident #4 and Resident #5 were both in the doorway to the resident's room. Resident #4 did not want to move and Resident #5 then elbowed him in the arm and made verbal threats against Resident #4. The two residents were separated and his roommate was moved to a different room. Residents were assessed by the RNUCC on 5/28/2020. No injuries noted. Support reassurance was provided to Resident #4. Roommate relocated to a different room. Safety protocol put into place the two residents were separated and the aggressor was moved to a different room.Resident #4 indicated he was not fearful of Resident #5 and indicated he was okay.No significant issues noted in the 72 hours prior to the event. -The facility failed to prevent a resident-to-resident physical abuse altercation. D. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 8/26/2020 at 10:40 a.m. She said Resident #4 can be difficult at times and he would refuse care. She said Resident #4 was very hard to redirect at times. She said she said the residents' were put into their own rooms after the altercations. Licensed practical nurse (LPN) #1 on 8/26/2020 at 10:55 a.m. She said Resident #4 had a history of [REDACTED]. She said Resident #4 was used to having his own room and was not happy he was going to get a roommate. She said she was not present for the incident on 5/28/2020 but had been informed to monitor Resident #5. III. Resident #5 A. Resident status Resident #5, age 55, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the 7/14/2020 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had mild depression with the resident scoring three of 27 on the patient health questionnaire (PHQ-9). The resident had delusions. He required supervision assistance for bed mobility, transfers, grooming and toilet use. B. Record review The care plan, initiated 11/20/19 and revised 7/21/2020, identified the resident may experience hallucinations/delusions related to a [DIAGNOSES REDACTED]. He can become verbally aggressive towards others. He has a history of making sexually inappropriate statements and has displayed some paranoia with staff. Interventions include assisting the resident to develop more appropriate methods of coping and interacting such as leaving an area if he was upset or talking to a staff member about what he is feeling. Encourage the resident to express feelings appropriately. If reasonable, discuss the resident's behavior. Explain/reinforce why behavior was inappropriate and/or unacceptable to the resident. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from the situation and take it to an alternate location as needed. C. Interviews Licensed practical nurse (LPN) #1 was interviewed on 8/25/2020 at 8:37 a.m. She said Resident #5 had his good and bad days. He was resistive of care at times but he pretty much stays to himself. She said she was aware of the altercation between Resident # 4 and Resident #5 but he would stay in his room and occasionally come out once in a while. Certified nursing aide (CNA) #14 was interviewed on 8/25/2020 at 11:23 a.m. she said the resident does have good and bad times but he pretty much stays to himself. She said she was not familiar with the incident on 5/28/2020. The nursing home administrator (NHA) was interviewed on 8/26/2020 at 3:26 p.m. The NHA said they had tried to place both residents in the same room as they were moving residents because of COVID-19. He said Resident #4 blocked access to the room and that was when Resident #5 elbowed him to get him out of the way. He said Resident #5 was relocated to another room after the altercation.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have evidence that all alleged abuse/neglect violations were thoroughly investigated for one (#6) of two residents reviewed for abuse of 13 sample residents. Specifically, the facility failed to thoroughly investigate an altercation between Resident #6 and Resident #7. Findings include: I. Altercation between Resident #6 and Resident #7 Nursing log note dated 8/16/2020 at 3:15 p.m. Resident #6 had wandered into Resident #7's room and was told by Resident #7 to get out and asked to please leave. Resident #7 followed Resident #6 out of the room and swung her leg forward and made contact with the heel-back of her shoe. Resident #7 apologized and started crying telling the resident that she did not mean to hit her heel. Resident #6's feet and heel had no red marks Afterwards, the resident was asked if she felt any pain, she could not recall what had happened and continued to pace up and down the hallway. On 8/26/2020 at 8:27 a.m. a request was given to the director of nursing (DON) for the incident on 8/16/2020. -No facility abuse investigation was initiated regarding Resident #6. II. Resident #7 A. Resident status Resident #7, age 90, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The resident had wandering behaviors. She required limited assistance for bed mobility, transfers, grooming and toilet use. B. Record review The care plan, initiated 4/8/19 and revised 6/30/2020, identified the resident was admitted to the secured unit due to elopement risk and her wandering and not being able to find her way back. Interventions include if the resident tries to get out the door redirect her to the patio as she likes to be outside. She also likes to have snacks. Inform social services staff of increased behaviors for appropriate follow up/intervention prn. The care plan, initiated 4/8/19 and revised 6/30/2020, identified resident #7 can become physically aggressive towards others. The resident can become resistive to care at times especially after she was in bed for the night. The resident can also make accusations that staff has pulled her hair or otherwise mistreated her. Interventions include care to be provided in pairs. If agitated and resistive to care, leave for a few minutes and try again later. Inform social services staff of increasing behavior for appropriate intervention and follow up. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from the situation and take to an alternate location as needed. III. Resident #6 A. Resident status Resident #6, age 79, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. According to the 8/11/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of five out of 15. The resident had minimal depression with the resident scoring three of 27 on the patient health questionnaire (PHQ-9). The resident had no behaviors. She required extensive assistance for bed mobility, transfers, grooming and toilet use. B. Record review The care plan, initiated 11/9/18 and revised 8/18/2020, identified the resident resides in a locked unit due to elopement risk, wandering and exit seeking. Presents danger to self and others, less restrictive alternatives unsuccessful. Interventions included allow the resident to personalize her room with belongings. Inform SS (social services) staff of escalating behavior for appropriate follow up/intervention prn. Redirect to an activity, offer a snack, take her for a walk, give her a baby doll to attend to. IV. Staff interviews CNA #11 was interviewed on 8/26/2020 at 9:00 a.m. CNA #11 said she was familiar with Resident #6. She said she had heard of the incident on 8/16/2020 concerning the altercation between Resident #6 and Resident #7. She said Resident #6 had wandering behaviors and was exit seeking. She said Resident #6 wandered in and out of residents rooms and rummaged through their

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) belongings. CNA #11 said Resident #7 refused care at times and accused staff of being rough with her. CNA #11 said she physically striked out at staff and other residents especially if they were in her area. She said Resident #7 was very possessive about her room and belongings and did not like other residents in her room. CNA #11 said Resident #7 did have a history of kicking staff and other residents. Registered nurse (RN) #1 was interviewed on 8/26/2020 at 9:36 a.m. She said she was familiar with the incident on 8/16/2020. She said Resident #6 does wander throughout the secured unit. She said she does go into other residents ' rooms which does at times cause problems. She said both residents do have aggressive behaviors. She said Resident #7 was very possessive of her personal area and let people know when they were not supposed to be in her area. The social service director (SSD) was interviewed on 8/26/2020 at 10:03 a.m. She said she was in the facility on the date of the incident. She said she was called back to the secured unit and spoke with staff who were involved in the alleged altercation. She said after talking with staff she felt the act of kicking was not a purposeful act and more of an accident. She said Resident #7 even apologized for kicking Resident #6. She said both residents had [DIAGNOSES REDACTED].#6 did not even remember the altercation. She said something had to trigger Resident #7, which may have been when Resident #6 was in Resident #7's room and she struck out at Resident #6. The SSD said she did not have any documentation or interviews with staff or other residents about the altercation. The SSD did not respond to questions of history of Resident #7 kicking staff and residents. The SSD said it would be her expectation that there should have been documentation of her conversations with staff and residents. The nursing home administrator (NHA) was interviewed on 8/26/2020 at 12:00 p.m. The NHA said, I am the major abuse prevention proponent. He said all abuse allegations come through him. The NHA was told of the incident on 8/16/2020. He said there was no investigation in reference to the incident on 8/16/2020 because the incident was an accident as Resident #7 self-propelled herself in her wheelchair and she accidently kicked Resident #6 as she was chasing her out the door. The NHA was asked what may have been a trigger for Resident #7. He said it could have been when Resident #6 wandered into her room, which triggered her lash out. The NHA said he did not know what to report or what not to report as every incident is different.
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.** Based on interview and record review, the facility failed to provide direct care services which followed professional standards of quality for one of four units in the facility. Specifically, the facility failed to train nursing staff and have a system in place to monitor licensed practical nurse (LPN) #4 with an allegation on 5/14/2020 that LPN #4 was drunk during his shift on Station 3 and when the facility received prior complaints that LPN #4 had not administered medications in a timely manner. Findings include: I. Facility policy The Admission/Transfer/Discharge Procedures & Nursing Documentation, undated, was provided by the director of nursing (DON) on 8/26/2020 at 3:18 p.m It read in pertinent part, the resident had a right to receive treatments and supports for daily living safely. II. Facility awareness of former professional standard concerns with LPN #4 A. Record review According to an undated, typed statement by registered nurse (RN) #5, provided by the NHA on 8/26/2020 at 3:18 p.m., RN #5 stated that on 5/6/2020 she witnessed LPN #4 marked medications were administered before he received a report from her. She identified it as false documentation and educated him. After she educated him, he administered the medications he had documented as having administered prior when he received a shift report from her. According to the 5/6/2020 Education Acknowledgement Form regarding LPN #4, provided by the NHA on 8/26/2020 at 3:18 p.m., it involved false documentation, RN #5 educated LPN #4 on not documenting medications as given until actually administered and he would not document prior to administering medications. RN #5 and LPN #4 signed the form on 5/6/2020. There was no documentation LPN #4 was continually monitored by the facility to ensure he no longer falsely documented medication administrations and no documentation he was deemed competent of the 5/6/2020 education he received regarding false documentation. B. Resident interviews Resident #11 was interviewed on 8/25/2020 at 11:17 a.m. He said the facility got rid of a male nurse (could not recall his name), in May 2020, who had not given medications on time; he was not affected by it, he was not diabetic. Resident #12 was interviewed on 8/25/2020 at 11:25 a.m. She said she complained to the facility (did not say to who) that a male nurse (she could not recall his name) had not taken her blood sugar during his morning shift in May 2020; the next nurse did it soon after (in that morning shift; she did not recall their name) and her sugars were controlled at that time even though he (the male nurse) was late. He (unidentified male nurse) no longer worked at the facility after that. III. LPN #4 continued to work unsupervised on 5/14/2020 to 5/15/2020 A. Record review According to the staffing sheet for 5/14/2020, LPN #4 worked on Station 3. According to the recorded timesheet for LPN #4, he worked on 5/14/2020 from 5:56 p.m. to 6:33 a.m. on 5/15/2020. B. Staff interviews RN #4 was interviewed on 8/25/2020 at 10:00 a.m. She said the former DON (FDON) and current DON were aware of the concerns that LPN #4 did not administer medications on time in May 2020. The facility did not train her on what to do if a staff member appeared impaired. She did not know about a suspicious behavior checklist, and was not trained on how or when to use it. RN #6 was interviewed on 8/26/2020 at 11:05 a.m. He identified he worked the same night shift as LPN #4 on the night of 5/14/2020 to the morning of 5/15/2020. He said the FDON called and was concerned LPN #4 could be intoxicated; she wanted him to check on LPN #4 every hour on the hour; something he could not do and did not do because he had to provide resident care during his shift as well. He did not document the times he could check on LPN #4; times which were not consistent and varied because he was providing resident care. The FDON did not ask him to call her if LPN #4 was intoxicated; the FDON just said to check on LPN #4. The facility did not train him on what to do if a staff member appeared impaired. He did not know about a suspicious behavior checklist, and was not trained on how or when to use it. LPN #4 worked his entire night shift; from the evening of 5/14/2020 to the morning of 5/15/2020; he was not sent home and no administrative staff came to check on LPN #4. IV. Follow-up A. Failure to train RN #6 regarding the Reasonable Suspicion Checklist, failure to monitor LPN #4 from 5/14/2020 to 5/15/2020. According to an undated, unsigned, typed statement by the FDON, provided by the NHA on 8/26/2020 at 3:18 p.m., the FDON received a call on 5/14/2020 of concerns LPN #4 appeared off at the change of shift. She called RN #6, who was on duty at the time while LPN #4 was on duty, and walked him (RN #6) through the reasonable suspicion check-list. She asked that he (RN #6) do a thorough assessment on the nurse (LPN #4). She asked RN #6 to monitor him (LPN #4) throughout the shift. She texted the NHA to be on stand-by in case there was an issue. When she arrived the next morning on 5/15/2020, she had several statements (she did not identify from whom) under her door about LPN #4 regarding giving medications very late, not performing blood glucoses, and complaints (she did not identify from whom) of timing of their medications and insulins. The clinical complaints were significant. -There was no documentation RN #6 conducted a full assessment of LPN #4 nor continually monitored LPN #4 from 5/14/2020 to 5/15/2020. B. Reasonable Suspicion Checklist, dated 2016: no documentation of monitoring LPN #4 on 5/14/2020 and 5/15/2020; LPN #4 continued to work his night shift According to the 5/14/2020 Reasonable Suspicion Checklist, a two-page form, provided by the NHA on 8/26/2020 at 3:18 p.m., the form involved LPN #4 and the NHA signed page 1 of the checklist on 5/15/2020. The time of the observation of LPN #4 was not documented on the checklist. The checklist identified on page one, in handwriting: no concern of physical description-concern was overt blood sugars provided in a timely manner. It further identified an: associate was suspended pending investigation-however this was not done until 05/15/20 - original complaint was past 10 pm 5/14/20(20). RN #6 was listed as a witness on the checklist; there was no date, time stamp, nor signed witness statement by RN #6 documented on the form, or provided separately from the form. There was a hand written note on page 2 of walking with a limp *chronic; there was no date, time stamp, initial, nor signature by It; to identify who wrote it. There was no documentation the facility continually monitored LPN #4 during his night shift which began on 5/14/2020 and ended on 5/15/2020; no documentation RN #6 was involved in monitoring LPN #4. C. Station 3 resident census on 5/14/2020 According to the Detailed Census Report for 5/14/2020, provided by the NHA on 8/26/2020 at 3:18 p.m., there were 19 residents who resided in Station 3 of the facility; seven of which received routine finger sticks for blood glucose monitoring. D. Suspension of LPN #4 on 5/15/2020, after he had worked his entire night shift which began on 5/14/2020. According to the 5/15/2020 Suspension Pending Investigation From, provided by the NHA on 8/26/2020 at 3:18 p.m., the FDON documented LPN #4 failed to administer medications timely and there were multiple (unidentified) resident complaints. The consequence was loss of trust and potential for adverse effects. LPN #4 was placed on leave from work without pay due to the serious nature of the incident. Substantiation of the allegations could result in corrective action up to and including termination, as well as notification of all appropriate boards and/or authorities, if applicable. -The form was incomplete: there was no documentation the investigation was completed and an outcome was determined. There was no documentation of resident interviews, and no provider or family documentation of notifications regarding the reason for LPN #4's suspension. There was no documentation the facility reported this incident to outside authorities. D. Termination of LPN #4; absence of an investigation and reporting According to the 5/29/2020 Termination From, provided by the NHA on 8/26/2020 at 3:18 p.m., the

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK CARE CENTER	945 DESERT FLOWER BLVD PUEBLO, CO 81001

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) FDON documented LPN #4 was suspended, pending an investigation of (unidentified) resident complaints. LPN #4 had multiple complaints by (unidentified) residents of poor service. There was a lack of quality and reliability for the residents, regarding LPN #4. LPN #4 was terminated on 5/29/2020; the NHA signed off on his termination. There was no documentation the facility conducted a thorough investigation: the facility did not provide documented interviews of residents on Station 3 regarding their concerns, or reported the residents ' allegations of poor care by LPN #4. There was no documentation the facility reported this incident to outside authorities. E. Nursing home administrator (NHA) interview The NHA was interviewed on 8/26/2020 at 10:11 a.m. He said it was facility policy that any allegation against a nurse resulted in suspension; to keep residents safe. The facility had a reasonable suspicion checklist form which any staff member could fill out; it was to verify if a staff member was impaired. On 5/14/2020 there was an allegation LPN #4 was intoxicated. RN #6 filled out a reasonable suspicion checklist form for LPN #4 and RN #6 had no concerns of impairment. LPN #4 worked his entire night shift; which began on 5/14/2020 and ended the morning of 5/15/2020. He was not sure if the 5/14/2020 allegations made against LPN #4 were reported or investigated, did not know if residents were interviewed regarding the allegations, and did not know if physicians and families were notified; he would look into it. The facility process when resident concerns which involved an employee was: the facility would go to the residents and clarify to see if they felt it was intentional or crossed the line, and if they felt unsafe. If residents felt unsafe the facility suspended the employee off the bat (right away, immediately) to keep them safe. He was not sure of the 5/6/2020 allegation made against LPN #4, he did not know if it was investigated; he had to look into it. F. Training request made regarding the suspicious behavior checklist and supporting documentation A request was made on 8/26/2020 at 10:45 a.m. for a list of all the staff who were trained on the Suspicious Behavior Checklist form and any other training they received on what to do, and when, if they suspected an employee was impaired. The NHA did not provide documentation that the staff were trained on how and when to use the Suspicious Behavior Checklist. The NHA did not provide documentation that staff were trained on what to do, and when, if they suspected an employee was impaired. G. NHA second interview The NHA was interviewed a second time 8/26/2020 at 11:50 a.m. He said anytime the facility received a complaint of impairment of a staff member, the facility immediately looked into it. The facility process for an allegation of an impaired employee was to have a nurse or management person do a quick assessment and converse with them passively, watch them (he did not identify the frequency), and talk to them to see how they responded (he did not identify the frequency). If there were no concerns, then the facility had them monitored (he did not identify by whom nor the frequency). If the alleged impaired employee had an odor (of alcohol) or any of the items on listed on the reasonable suspicion checklist, the facility would pull them off of duty, they would be requested to get a urinalysis for a drug screen, and either take them home or call a taxi for them; they remained suspended until the drug results came back. The NHA identified he was not involved with the 5/6/2020 incident when LPN #4 documented medications prior to administering them, he was notified after the fact and he did not sign off on it; it was not reported and no laws were broken. He was not aware of any processes put into place to prevent it from happening again to protect the residents, except to educate LPN #4 and babysit him the whole time (while at work). The facility did not consider LPN #4's actions as grave. He identified he was not involved with clinical matters of the facility. The FDON and DON handled all clinical matters of the facility, discussed it with him, and they collectively decided how to move forward on them. When the facility decided to terminate LPN #4 they notified human resources; the facility did not report anything to the physician, ombudsman, or outside authorities; because the allegations against LPN #4 regarding medications could not be proven; there were no issues with temperatures and things like that. The NHA did not have paperwork on an investigation for the 5/14/2020 allegation made on LPN #4. There was no documentation the residents were interviewed regarding their allegations, physicians and families were not notified. He said he did not think there was a need for resident witness statements, did not think that there were adverse effects based upon the documentation he had and he was not involved in the 5/14/2020 allegation made against LPN #4. He said it just involved blood sugars and glucose and believed there were no adverse effects on residents so an investigation was done.The facility had used the reasonable suspicion checklist form since 2016.
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** Based on observation, interview, and record review the facility failed to provide toileting to dependent residents, in a timely manner, for two (#1 and #3) of three residents reviewed for toileting out of 13 sample residents. Specifically, the facility failed to provide toileting in a timely manner for Resident #1 and Resident #3, who were identified by the facility as activity of living (ADL) dependent for toileting and incontinent of urine and bowel. Findings include: I. Facility policy The Activities of Daily Living (ADL) policy, reviewed on 5/5/2020, provided by the director of nursing (DON) on 8/26/2020 at 3:18 p.m., residents would receive assistance as needed to complete ADLs. II. Resident #1 A. Resident status Resident #1, less than [AGE] years of age, was admitted on [DATE] and readmitted on [DATE]. The August 2020 computerized physician orders [REDACTED]. According to the 7/28/2020 minimum data set (MDS) assessment she had moderate cognitive deficits with a brief interview for mental status (BIMS) score of 12 out of 15. She was totally dependent for transfers by two persons and required extensive assist of two person staff for toileting. She used a wheelchair for mobility. She was frequently incontinent of bowel and bladder. B. Toilet assistance the morning of 8/24/2020 According to the 8/24/2020 Toilet Use Task form, Resident #1 was provided extensive assistance for toileting at 9:57 a.m. Review of the 14-day documentation on the form revealed Resident #1 required extensive assistance for toileting or was totally dependent for toileting. According to the 8/24/2020 Bowel and Bladder Elimination Task form, there was no documentation of time in which Resident #1 had voided or had a bowel movement on the morning of 8/24/2020. C. Observation A continuous observation of Resident #1 on 8/24/2020 from 11:42 a.m. to 1:45 p.m. revealed she remained sitting in her wheelchair, in her room and staff did not offer nor provide assistance with toileting for her. This represented a period of almost four hours of time had passed without Resident #1 being offered or provided toileting assistance; since the documented time of 9:57 a.m. on the Toilet Use Task Form. D. Staff interview The certified nurse aide (CNA) #13 was interviewed on 8/24/2020 at 1:50 p.m. She said staff could not provide toilet assistance to Resident #1 before lunch because they had to serve lunch. Staff were to provide toilet assistance for Resident #1 before and after meals; toilet assistance was to be provided every two hours to prevent skin breakdown. Resident #1 required a two person assist with the Hoyer mechanical lift to place her in bed for toileting when she was in her wheelchair. She did not tell anyone she was unable to toilet her before lunch; it was CNA #14 and her who were supposed to toilet her. The certified nurse aide (CNA) #14 was interviewed on 8/24/2020 at 2:02 p.m. She said she could not provide toilet assistance to Resident #1 because she had to serve the lunch trays. Resident #1 required two persons and the Hoyer for transfers when she was in her wheelchair. She did not tell anyone she was unable to toilet her before lunch; it was CNA #13 and her who were supposed to toilet her. E. Delayed toilet assistance provided the afternoon of 8/24/2020 According to the 8/24/2020 Bowel and Bladder Elimination Task form, Resident #1 was provided assistance for toileting at 1:59 p.m.; she was incontinent of urine and had a loose bowel movement. The next time the facility documented she was incontinent of urine was at 8:52 p.m. According to the 8/24/2020 Toilet Use form, there was no documentation at 1:59 p.m. Resident #1 was provided assistance for toileting (which would have coincided with the documentation found on the Bowel and Bladder Elimination Task form above). The next time the facility documented Resident #1 was provided assistance for toileting was at 5:04 p.m. which represented a period of three hours of time had passed without Resident #1 being offered or provided toileting assistance since the documented time of 1:59 p.m. on the Bowel and Bladder Elimination Task form. F. Resident record review According to the care plan, initiated on 2/9/2020 and revised on 7/31/2020, it identified she had an ADL self-care deficit due to a [MEDICAL CONDITION]. Interventions included she required extensive assistance by one to two staff for toileting. According to the care plan, initiated on 1/26/2020 and revised on 7/31/2020, it identified she had frequent bowel incontinence due to limited mobility. Interventions included to assist with toileting as needed. G. Director of nursing (DON) interview The DON was interviewed on 8/26/2020 at 1:10 p.m. She said if a CNA was unable to toilet a resident they should have notified someone. Staff were to pay more attention to residents who were not mobile. Resident #1 required a Hoyer lift (mechanical lift) for transfers, she was at times incontinent during the day, and was incontinent at night. III. Resident #3 A. Resident status Resident #3, age 62, was admitted on [DATE]. According to the August 2020 CPO,

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) [DIAGNOSES REDACTED]. Urinary tract infection [MEDICAL CONDITION], right hand contractures, nonalcoholic [MEDICAL CONDITION] spinal stenosis. According to the 6/10/2020 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had mild depression with the resident scoring eight of 27 on the patient health questionnaire (PHQ-9). The resident had no behavioral symptoms. She required extensive assistance for bed mobility, transfers, grooming and toilet use. She was frequently incontinent of the bowel and bladder. The MDS revealed the residents had a UTI in the past 30 days. B. Observations On 8/24/2020 at 9:43 a.m. The resident was observed sitting in her room next to her bed in her wheelchair. -At 10:15 a.m. The resident was sitting in her wheelchair next to her bed. No staff were observed to enter the resident's room. -At 10:54 a.m., the resident was in the same position. No staff were observed to enter the resident room. -At 11:18 a.m., the resident was sitting in her wheelchair next to her bed reading a magazine. No staff were observed to enter the resident's room. -At 12:00 p.m., registered nurse (RN) #7 entered Resident #3's room to administer medication. She did not provide care or offer to toilet the resident. -At 12:38 p.m., the resident observed sitting next to her bed in her wheelchair. -At 1:00 p.m., RN #7 entered the resident's room and administered medication. RN #7 did not provide personal care or offer to toilet Resident #3. -At 1:06 p.m., certified nurse aide (CNA) #8 walked into Resident #3's room and placed the resident's meal tray on her bedside table. CNA #8 exited the resident's room and did not provide any care. -At 1:42 p.m., CNA #14 entered the resident's room. She closed the door and provided perineal care. CNA #13 exited the resident's room at 1:53 p.m. CNA #14 said the resident was wet. The facility staff did not assess Resident #'3's needs related to toileting and personal care. Resident #3 was not offered or encouraged to be tolieted during the above observations. Resident #3 was not assisted timely. C. Record review The care plan, initiated 11/15/18 and revised 6/16/2020, identified the resident had an activity daily living (ADL) self-care deficit due to [MEDICAL CONDITION], obesity, spinal stenosis, history of laminectomy, lumbago with sciatica, limited mobility and weakness. Interventions include 1/4 bilateral positioning rails to assist with mobility in bed per her request. Electric wheelchair with rear anti-tippers, bilateral foot pedals, back cushion and custom seat cushion for mobility. The resident was totally dependent on one staff member to provide shower. She prefers showers every other day. The resident required the assistance of two staff to turn and reposition in bed upon her request. The resident had limited tone to her right side. Assist with placing splints. Check skin to area prior to placement and upon removal. Encourage residents to use a call light to ask for assistance. The care plan, initiated 11/15/18 and revised 6/16/2020, identified the resident was frequently incontinent of bowel due to limited mobility. Interventions include assisting with toileting as needed. Check the resident on rounds and assist with hygiene needs as needed. Wears undergarments. Perineal care (PERI) as needed. Provide PERI care after each incontinent episode. Toilet as she will allow. Encouragement to do self-range of motion as able during daily ADL activity. The resident needs assistance to change position upon her request. Alternate periods of rest with activity out of bed in order to prevent respiratory complications, dependent [MEDICAL CONDITION], flexion deformity and skin pressure areas as she chooses. D. Resident interview Resident #3 was interviewed on 8/24/2020 at 11:21a.m. She said she had to wait to get her call light answered on a daily basis. She said she had to wait anywhere from 20-30 minutes to get her call light answered. She said staff do not check on her on a regular basis because she was to use her call light when she needed help. Resident #3 said, Yes, I can use my call light when I need assistance but it was their job to still check on me. E. Staff interview Certified nurse aide (CNA) #14 was interviewed on 8/24/2020 at 1:42 p.m. She said all residents' who are dependent on staff are supposed to be checked and changed every two hours or as needed (PRN). She said Resident #3 was able to use her call light when she required assistance. She said Resident #3 should have been checked on and asked if she required assistance. Registered nurse #7 was interviewed on 8/25/2020 at 8:28 a.m. She said Resident #3 was able to use her call light when she required assistance. She said staff should check and change all dependent residents every two hours or as needed (PRN). The director of nursing (DON) was interviewed on 8/26/2020 at 12:51 p.m. The DON was told of the above observations of Resident #3. She said the facility did not have a policy per say on toileting and frequency. She said it would be her expectation all residents' should be checked and changed and repositioned every two hours or PRN. She said Resident #3 was extensive assistance with all ADL care and repositioning. She said Resident #3 was able to use her call light when she needed assistance but it was our responsibility to provide toilet and repositioning to Resident #3.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff to ensure the residents receive the care and services they required in keeping with their comprehensive plans of care, to achieve and maintain their highest practicable physical, mental and psychosocial well-being. Specifically, -Six interview able Residents (#1, #3, #8, #9, #10, and #11) of 13 sample residents and one family members said the facility failed to provide sufficient staff which resulted in delayed and/or inadequate care; -Observations made during survey revealed care and services not being provided timely; and -Facility documentation of staffing revealed multiple call-ins of certified nurse aides (CNAs), CNA staff being shifted and time punches verifying CNAs were assigned alone on a single unit for up to four hours. Cross-reference F677 the facility failed to provide toileting to dependent residents in a timely manner. Findings include: A. Resident Census and Conditions The census and conditions of residents form, provided by the facility and dated 8/24/2020, revealed 106 residents resided in the facility. Care needs of the residents were documented as follows: -71 residents were dependent on staff for bathing and 35 residents needed the assistance of one or two staff to bath; -Zero residents were dependent on staff for dressing and 106 residents needed the assistance of one or two staff to dress; -14 residents were dependent on staff to transfer and 92 residents needed the assistance of one or two staff to transfer; -Seven residents were dependent on staff for toilet use and 99 residents needed the assistance of one or two staff to the toilet; -Zero residents were dependent on staff to eat and 105 residents needed the assistance of one or two staff to eat; -90 residents were frequently incontinent of bladder; -67 residents were frequently incontinent of bowel; -88 residents were in their wheelchairs all or most of the time; -67 residents had a [DIAGNOSES REDACTED]. B. Resident interviews Residents, who per facility and assessment were interview able, made the following statements when asked if the facility provided sufficient nursing staffing: Resident #3 was interviewed on 8/24/2020 at 11:21a.m. She said she had to wait to get her call light answered on a daily basis. She said she had to wait anywhere from 20-30 minutes to get her call light answered. She said staff do not check on her on a regular basis. Resident #3 said, Yes, I can use my call light when I need assistance but it was their job to still check on me. She said staffing gets worse as the day progresses. She said staffing was okay during the morning shift but it got worse in the evening and graveyard shift. She said two weeks ago I was left on the toilet during shift change and the graveyard staff had to take me off of the toilet. Resident #11 was interviewed on 8/24/2020 at 9:02 a.m. He said it can take as long as 30-45 minutes to answer my call light. He said we have one certified nurse aide (CNA) for this hall and we require a lot of help on this hall. He said we have one light duty CNA who was unable to lift any residents ' so we have to wait. He said, I have called the corporate office on several occasions to express my concerns of lack of staff and the effect it had on our care, and my calls do not get returned. He said, I have had to wait an hour sitting in my own urine before I got any help. Resident #1's son was interviewed on 8/25/2020 at 10:10 a.m. He said approximately two weeks ago he had to call the facility to get his mother some help at approximately 7:00 p.m. He said, My mother said she needed to get toileted as no one was answering her call light. He said I called the facility and I finally got through to a gentleman who said he would go to the nursing station and tell them that his mother required assistance. He said staff did not provide any care for his mother until 10:15 p.m., and she reported she was still wet. He said he had received no follow up. Resident #8 was interviewed on 8/26/2020 at 2:00 p.m. She said they are having real problems with staffing. She said, I have been told that certified nursing aides CNAs are quitting and they are always calling off sick. She said, I will have to wait anywhere from 20-30 minutes to get help. She said sometimes CNA's would come in and turn the light off and never come back. Resident #9 was interviewed on 8/26/2020 at 2:19 p.m. She said the facility was short staffed. She said, I have to wait anywhere from 20-30 minutes to get my call light answered. She said a CNA just had a work injury so we for sure will be short staff this evening. She said we have even complained to the director of nursing (DON) and we still haven't heard any response from her. Resident #10 was interviewed on 8/26/2020 at 2:43 p.m. She said it does take a while to get my call light answered but the CNA ' s are busy. They have a lot of people to take care of. C. Record review 1. Daily staffing documentation The nursing daily staffing sheet schedules were reviewed from 8/1/2020 through

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) 8/26/2020 census was 106. There were numerous entries of staff calling-in, being shifted to other facility units or to be determined of scheduling times (written in but not verified with time punch). An example of these entries were the staffing sheets of Sunday 8/2, 8/3, 8.6, 8/7, 8/8, 8/11, 8/12, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/22, 8/23, and 8/24/2020. The staffing sheet showed on 8/16/2020 they had a five no call no show and on one of the three units there was one CNA from 2:00 p.m.-6:00 p.m., and one CNA from 2:00 p.m.-10:00 p.m., on station three. On 8/16/2020 there was one CNA on night shift on one of the three units. On 8/18/2020 they had one CNA from 10:00 p.m. to 4:00 a.m. and one CNA on night shift on one of the three units (station three). On 8/21/2020 the staffing sheet showed one CNA was on station one, two and three for graveyard shift. The secured unit had two residents ' who were on 1:1 ' s (one-to-one) for various behaviors. Nurse log note dated 8/9/2020 at 11:13 pm. Resident #1 son had called about six times this evening about things his mother stated to him on the phone. He stated that the evening CNA left his mother without any clothes on and in an upright position in her bed. The residents son had told her earlier that he would be able to do the video calling. She got very upset about that. The CNA that was taking care of her told this RN that he has to use several packs of wipes during a care episode and she still felt that she was not cleaned well enough. When this RN went in to see how we could help she (the resident) just responded that I did not know what I was doing. She did have a gown on and had a blanket on however she had tossed the blanket on the floor. Her son called again and stated he was going to call again after a female CNA went to the room to attend to her needs. D. Staff interviews CNA #2 was interviewed on 8/25/2020 at 12:30 a.m. He said they were short staffed and it was affecting the care of residents. He said they often pulled a CNA from other halls to help on a wing and then that would make them short on that hall. He said, an example would be we have the nurse from the secured unit working both the secured unit and then hall E as well. CNA #1 was interviewed on 8/25/2020 at 12:35 a.m. She said there were supposed to be three CNA's at night but for the past two months they had been working with two CNA's. She said the facility had a lot of call offs. She said, I covered for another hall and I had 25 plus residents ' I needed to cover by myself. She said,this slows the response time for call lights, which in turn gets the resident upset because we are not answering the call lights in a timely manner. Licensed practical nurse (LPN) #2 was interviewed on 8/25/2020 at 12:40 a.m. She said, Yes we are short staffed. She said the facility could hire more nurses and more CNA's. She said, Each hall should have three CNA's, which we do not have. She said the short staff affected care in activities of daily living (ADL) and affected the quality and quantity of care each resident received. CNA #5 was interviewed on 8/25/19 at 12:44 a.m. She said she worked as needed (PRN). She said they had been calling her frequently to fill call offs. She said she had been filling shifts by herself and had had to cover a complete hall by herself. She said she could get the work done but the care was rushed which was not fair to the residents. She said this hall had quite a bit of residents who used the Hoyer lifts which adds to the delay of care when we are short. CNA #6 was interviewed on 8/25/2020 at 10:56 a.m. She said they had two CNA's on their hall. She said, most of the time it was hard to get everything done. She said she was unable to pass ice water and provide showers regularly to residents'. She said, This was the hardest hall to work at which affected time light response because we have such a high rate of residents who use the Hoyer lifts and two person transfers. She said We have to pull a CNA from other halls to help us and then this puts them short on the other halls. She said, The result has been we have had a lot of falls because we can't get to them fast enough. She said they don't get ice passed or showers done. The staffing coordinator was interviewed on 8/26/2020 at 9:04 a.m. She said the facility had a lot of call offs. She said almost on a daily basis. She said when we are short staffed we try to bring in PRN staff or ask staff to work a double shift. She said the staffing was getting better but it was still a daily issue. The director of nursing (DON) was interviewed on 8/26/19 at 12:51 p.m. She was told of the observations and interviews above. The DON said they staffed the facility based on their census, acuity and the need of their residents'. She said all managers helped on the floor during the day and they worked as a team. She said if they had call-ins they tried to find coverage. She said they used a lot of PRN staff. She said it was a challenge of staffing to monitor burnout and ensure staff were not working too many hours. She said a negative outcome would be lack of care for all of the residents in the facility.
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 establish and maintain an infection control program designed to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections such as COVID-19 in two of six halls including an isolation room. Specifically, the facility; -Failed to offer face coverings for residents when entering rooms; -Failed to ensure face coverings were encouraged with residents when not in their personal rooms; and, -Failed to ensure resident equipment was cleaned between uses. Findings include: I. The Centers for Disease Control (CDC) recommended guidelines The CDC, Preparing for COVID-19 in Nursing Homes, updated June 25, 2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (8/18/2020). It read in pertinent part, Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP (healthcare personnel) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Implementing Social Distancing Measures. Implement aggressive social distancing measures (remaining at least 6 feet apart from others). Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene. Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas. The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (8/18/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update July 15, 2020) Implement Universal Source Control Measures. Patients may remove their cloth face covering when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room. II. Offer residents ' facial coverings when staff enter resident rooms A. Observations and interviews On 8/24/2020 at 9:00 a.m., certified nurse aide (CNA) #8 was observed entering room [ROOM NUMBER]. She asked the resident if that was all she wanted. She was observed approximately two feet away from the resident during this observation. She left the room at 9:05 a.m. On 8/24/2020 at 12:21 p.m. CNA #14 was observed in residents ' room providing perineal care (PERI). She was approximately three feet away from the resident as she was observed empting the urinal. The resident did not have a mask on while CNA was providing care. On 8/24/2020 at 1:06 p.m., CNA #12 was observed taking vitals of the residents. CNA #12 entered the room and placed the blood pressure cuff on the resident. She would not ask or offer the resident to put on a mask nor offer a Kleenex to the resident to cover her mouth. On 8/25/2020 at 9:36 a.m. housekeeping (HSKP) #1 was observed entering room [ROOM NUMBER]. She knocked on the door and entered the room. She did not ask the resident to cover her mouth with a mask or tissue. She finished cleaning the room at 9:42 and exited the resident ' s room. She said her training to enter a resident's room was to knock and announce herself and tell them what she was going to do. She said she had not received training to ask a resident to cover their face when she entered a room. Staff did not offer or ask residents ' to put on a mask or cover their nose and mouth with a kleenex while providing care. B. Interview CNA #8 was interviewed on 8/26/2020 at 8:56 a.m. She said residents are to wear their masks when they are outside their rooms. She said we were just told today that we are supposed to ask residents ' to put on a mask or cover their mouth with a Kleenex when we are providing care. The staff development coordinator was interviewed on 8/26/2020 at 9:23 a.m. She said residents are supposed to wear masks when they are out of their rooms and staff are to wear masks when they are providing care. She said it was her expectation that the staff would ask the residents to put on a mask or cover their nose with a Kleenex while care was being provided. She said a negative outcome would be the spread of infection and or disease. She said she would re-educate staff on offering face coverings and handwashing. The DON was interviewed on 8/26/2020 at 12:51 p.m. She said anytime a staff member broke the barrier of a room the expectation was for them to wash/sanitize their hands. She said she expected the staff to offer a face covering when entering the room. III. Failed to ensure residents had face covering while out of their rooms A. References The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (7/15/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065231	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PARK CARE CENTER	945 DESERT FLOWER BLVD PUEBLO, CO 81001

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) 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., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observations On 8/24/2020 at 8:55 a.m., observation of the facility revealed three residents' sitting in their wheelchairs on B hall. All three residents did not have on any face masks. -At 12:24 p.m. a male resident was in his wheelchair sitting at the end of C hall. He did not have a mask on. CNA #2 did not encourage residents to put on a mask as she walked by the resident. -At 3:13 p.m. A female resident was sitting in her wheelchair next to the bird Avery. No staff were observed to encourage residents to put on a mask as they walked by the resident. On 8/25/2020 at 3:30 p.m. CNA was observed taking a male resident in his wheelchair to the shower room. The male resident did not have a mask on during this observation. The CNA did not encourage or ask the resident to put on a mask. -During the above observations staff did not encourage residents to wear their masks when out of their rooms. C. Staff interviews Certified nurse aide (CNA) #10 was interviewed on 8/25/2020 at 9:29 a.m. He said all residents are supposed to wear masks when they are out of their rooms. He said if we see a resident without a mask we are supposed to encourage them to wear their masks or offer to get them a mask to wear. Licensed practical nurse (LPN) #1 was interviewed on 8/25/2020 at 10:16 a.m. She said, All the residents should have had their masks on while out of their rooms. CNA #9 was interviewed on 8/25/2020 at 10:29 a.m. She said, Some residents' would wear their masks and some residents wouldn't. The SDC was interviewed on 8/26/2020 at 9:23 a.m. She said all of the residents' should have a mask on while out of their room. She said staff get too comfortable with the residents they know who do not wear their masks. She said staff should encourage all residents when out of their rooms to wear a mask and they should encourage them to wear them. The DON was interviewed on 8/3/2020 at 1:00 p.m. The DON was informed of the observations above. She said all residents should be [MEDICATION NAME] safe social distancing. She said staff should ensure all residents; are six feet apart when they are in common areas. She said a negative outcome would be cross-contamination and spread of infections. IV. Failed to ensure resident equipment was cleaned between uses. The Centers for Disease Control (CDC) recommended guidelines The Center for Disease Control (2019) Guideline and Recommendations for Disinfection in Healthcare Facilities, accessed on 8/27/2020,retrieved from: https://www.cdc.gov/infectioncontrol/guidelines/disinfection. It read in pertinent part; -Disinfect non-critical medical devices (like blood pressure cuffs) with an EPA-registered disinfectant using the label ' s safety precautions and use directions. Most EPA-registered disinfectants have a label contact time of 10 minutes. However, multiple scientific studies have demonstrated the efficacy of disinfectants against pathogens with a contact time of at least 1 minute. 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). -If dedicated, disposable devices are not available, disinfect noncritical patient-care equipment after using it on a patient (who is in isolation) before using this equipment on another patient. However, multiple scientific studies have demonstrated the efficacy of disinfectants against pathogens with a contact time of at least 1 minute. 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). -If dedicated, disposable devices are not available, disinfect noncritical patient-care equipment after using it on a patient (who is in isolation) before using this equipment on another patient. Sani-Cloth Bleach Germicidal Disposable Wipe Features and Benefits (2019), retrieved from: https://pdihc.com/products/environment-of-care/sani-cloth-bleach-germicidal-disposable-wipe. It read in pertinent part, Disinfection level: EPA-registered intermediate level disinfectant. Overall contact time: four minutes. Pre-moistened wipes are ready to use. Efficacy claims: 50 microorganisms, including [MEDICAL CONDITION], norovirus and 14 multidrug resistant organisms. Formulation: 1:10 (one to 10 ratio of bleach to dilution). Not for use on skin. According to manufacturer's information regarding Clorox Pro, germicidal bleach, updated 2020, retrieved from: https://www.cloroxpro.com/products/clorox/germicidal-bleach/ it read, Causes severe [MEDICAL CONDITION] serious eye damage. Dwell times ranged from 30 seconds to five minutes. A. Observations On 8/25/2020 at 8:25 a.m., CNA #12 was observed going room to room on D hall taking resident blood pressures. She would exit each room and enter the next room without sanitizing or cleaning the mobile monitoring blood pressure machine. -At 9:20 a.m., A CNA was observed exiting room [ROOM NUMBER]. The CNA had a bag of soiled linens in one hand and pushed the Hoyer lift with the other hand. She plugged the Hoyer lift into the outlet and moved it next to the wall. The CNA did not wipe or sanitize the Hoyer lift after use. -At 9:40 a.m. CNA #12 again was observed going in and out of the resident's room with the mobile blood pressure machine. She would not sanitize or clean the mobile monitoring blood pressure machine. -At 12:16 p.m. A CNA was observed exiting room [ROOM NUMBER]. The CNA had a bag of soiled linens in one hand and pushed the Hoyer lift with the other hand. She plugged the Hoyer lift into the outlet and moved it next to the wall. The CNA did not wipe or sanitize the Hoyer lift after use. -At 4:01 p.m. CNA #13 was observed to enter room [ROOM NUMBER], which was an isolation room. CNA #13 proceeded to take the resident ' s vitals. She exited the resident room and proceeded to enter room [ROOM NUMBER]. She proceeded to take the vital signs of both residents in room [ROOM NUMBER]. CNA #13 did not sanitize or wipe the mobile blood pressure monitoring machine. B. Staff interview RN #7 was interviewed on 8/25/2020 at 1:02 p.m. RN #7 said, staff were supposed to wipe and sanitize the blood pressure machine before entering the residents room and after exiting the residents room. She said this would include the sit to stand and Hoyer lifts. RN #5 said when a resident was on isolation precautions the resident would have their own equipment as it would not be shared with others. CNA #13 was interviewed on 8/25/2020 at 4:11 p.m. She was supposed to sanitize the blood pressure machine before we go into a resident ' s room and when we exit the room. She said, I did not wipe or sanitize the blood pressure machine before or after exiting the resident ' s rooms. She said she was not aware of the proper procedure of checking blood pressure in a room which was in isolation. The SDC was interviewed on 8/26/2020 at 9:23 a.m. She was informed of the observations from the previous day. She said all of the resident equipment should be sanitized before and after for each use with the residents. She said the sit- to-stand and Hoyer lifts should be sanitized in the same manner. She said when a resident was in isolation they should have their own medical equipment as it was not to be shared. She said a negative outcome would be the spread of infections and disease.