STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065196	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE AND REHAB-MALLEY	401 MALLEY DR NORTHGLENN, CO 80233

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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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** Based on observation and interviews the facility failed to treat one (#1) resident with dignity and respect out of seven sample residents. Specifically, the facility failed to ensure privacy was maintained for Resident #1 by posting a sign in a public area with his name and a private care message. A. Observation On 8/5/2020 and 8/6/2020 a sign was posted inside the doorway of Resident #1's room exposed from the hallway for the public to read, Do not give silverware (to) (resident name). B. Resident #1 interview Resident #1 was interviewed on 8/5/2020 at 8:30 a.m. He said he did not like the sign, it was embarrassing and he wished someone would take it down. C. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/6/2020 at 2:05 p.m. She said she was aware of the sign posted in Resident #1's room. She said the sign was put up to communicate with the staff about the residents' care. She said she did not know putting up a sign of personal matters where it could be seen by everyone was wrong. She said the sign was posted to make sure staff did not give metal silverware due to the concern that the resident would not use the silverware in a safe manner. She stated she did not know having his name on a sign was considered a dignity issue and the sign would be removed. She said the process moving forward would be to provide the information verbally to the staff during shift change meetings. Certified nurse aide (CNA) #1 was interviewed on 8/6/2020 at 2:08 p.m. She was listening to LPN #2 being interviewed about the sign on Resident #1's wall. CNA #1 said it made sense that the sign did not keep the resident's information private. She said we could communicate this type of information in our shift change meetings. CNA #1 said she should have noticed the sign and putting up information with the resident's name was a dignity issue. CNA #1 took the sign down in Resident #1's room. The director of nursing (DON) was interviewed on 8/6/2020 at 6:00 p.m. She said she understood having this sign up in the resident's room was a dignity issue. She said many families want notes written in their loved ones' rooms. She said there are other ways to communicate with the staff including folders or notes not in public view. She said she understood private information should be protected.
F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure the highest practicable quality of care for two (#4 and #10) of three out of 10 sample residents. The facility failed to prevent pressure injuries Resident #4 acquired while in their care. The resident's risks for developing pressure ulcers/pressure injuries (PU/PIs), were identified at the time of admission. However, the prevention measures specific to her needs were implemented 4 months after the resident was admitted and had acquired the pressure injuries to three places of her body. The resident required additional clinic appointments for care and treatments of the wounds. Three pressure injuries with the worst injury identified at a stage three by an outside provider. The facility failed to prevent development and worsening of in-house acquired pressure ulcers which resulted in Resident #10 experiencing an increase in pain and ensure the resident had a specific care plan for communication. Findings include: I. Professional reference The National Pressure Injury Advisory Panel (NPUAP) Prevention and treatment of [REDACTED].cvph.org/data/files/NPIAP% 9.pdf (retrieved on 8/12/2020). It read in pertinent, -Once individuals are confirmed as being at risk or pressure injury development, a prevention program that aims to minimize the impact of modifiable risk factors identified as increasing the individual's pressure injury risk should be developed. These risk factors should be monitored regularly. In addition to a comprehensive skin assessment, a brief skin assessment of the pressure points should be undertaken during repositioning. Maintaining healthy skin requires comprehensive assessment and care planning. -Excess moisture on the skin surface (e.g. due to increased perspiration or incontinence) also increases skin vulnerability to damage related to skin maceration, pressure, and shear forces. Maintaining skin integrity is essential in the prevention of pressure injuries. -Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues, and ultimately, in tissue damage. Repositioning involves a change in position of the lying or seated individual at regular intervals, with the purpose of relieving or redistributing pressure and enhancing comfort. Mobilization involves assisting or encouraging a person to move or shift into a new position. Individuals who cannot reposition themselves will require assistance in this activity. -No support surface provides complete pressure relief. Pressure is always applied to some area of the skin. Turning and repositioning for pressure redistribution must therefore occur regularly. -Pressure and shear forces are important considerations in the development of pressure injuries in seated individuals. Limit time spent sitting out of bed for individuals at high risk of pressure injuries. II. Facility pressure ulcer protocol The Pressure Ulcers/Skin Breakdown protocol, last revised April 2013, was provided by the nursing home administrator (NHA) via email on 8/6/2020. It read in pertinent part, For assessment and recognition, staff and the attending physician will assess and document a resident's significant risk factors for developing pressure sores. The physician and staff will examine the skin of a new admission for ulcerations or indication of a Stage I pressure area that has not yet ulcerated at the surface. -For cause identification, the physician will help identify factors contributing or predisposing residents to skin breakdown and will help clarify relevant medical issues. -For treatment and management, the physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressing and application of topical agents. -For monitoring, the physician will evaluate and document the progress of wound healing and help staff modify the care plan as appropriate. III. Facility pressure ulcer risk assessment The Pressure Ulcer Risk Assessment procedure, last revised October 2010, was provided by the NHA via email on 8/6/2020. It read in pertinent part, A pressure risk assessment will be completed upon admission, with each additional assessment; quarterly, annually and with significant changes. Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Staff will maintain a skin alert, performing routine skin inspections daily or every other day as needed. Nurses are to be notified to inspect the skin if skin changes are identified. Nurses will conduct skin assessments at least weekly to identify changes. Because a resident at risk can develop a pressure ulcer within 2 to 6 hours of the onset of pressure, the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers. -Documentation in the resident's record should include the type of assessment, date and time and type of skin care provided. Documentation should also include any problems, complaints, or refusal made by the resident. Observations of anything unusual should be documented. IV. Facility prevention of pressure ulcers The Prevention of pressure ulcers procedure, last revised October 2010, was provided by the NHA via email on 8/6/2020. It read in pertinent part, Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) Once a pressure ulcer develops, it can be extremely difficult to heal. Pressure ulcers are a serious skin condition for the resident. The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician and family and addressed. -For a person in bed: change positions at least every two hours or more frequently if needed and determine if a special mattress is needed. -For a person in a chair: change positions at least every hour. Use foam, gel or air cushion as indicated to relieve pressure. -Refer residents to a rehabilitation program, or a restorative nursing program as indicated. Encourage the resident to participate in active and passive range of motion exercises to improve circulation. V. Resident #4 A. Resident status Resident #4, age 87, was admitted on [DATE]. According to the computerized physician orders (CPO), the [DIAGNOSES REDACTED]. The 6/9/2020 quarterly minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 15 out of 15. Her mobility devices were a walker and wheelchair. She required extensive assistance with one person physical assistance with bed mobility, transfers, locomotion on the unit, dressing and toilet use. The resident had one moisture associated skin damaged area and one open lesion. The preventative measures included a pressure reducing cushion for the wheelchair and mattress for the bed, barrier cream and dressings applied to the wound. The resident received oxygen therapy, antidepressant, diuretic and opioid medications since admission. She had an indwelling urinary catheter and continent of bowel. The previous admission MDS, dated [DATE] assessment revealed the resident had a risk for developing pressure sores/injuries. The resident did not have wounds documented under pressure ulcers or injuries and no other wounds or skin problems were documented as zero. B. Resident observations and interviews On 8/5/2020 at 11:00 a.m. Resident #4 was sitting in her recliner in her room and began to fall toward her right side. She said she needed a pillow on that right side under her arm to hold her up from falling to the right because her back surgeries make it difficult for her to move and hold herself up. She said she preferred her wound treatments to be done at the wound clinic because she trusted her care with that wound team. On 8/6/2020 at 9:00 a.m. Resident #4 sat up in bed and faced forward with her breakfast meal on her bedside table in front of her. She started to lean towards her right side. She said, I need something like a pillow to hold me up on the right side. It feels awful like this. CNA came in to assist the resident and put a pillow under her right arm to the right side of her body. She said, Now that feels better, I can actually eat. On 8/6/2020 at 1:30 p.m. Resident #4 was assisted with one staff member and stood up from her recliner to have the wound on her left buttocks dressed. RN #1 took off the old dressing from the wound. It had a red base with soggy pale skin around the wound area. RN #1 cleansed and applied the gauze dressing to the wound. C. Record review The care plan, initiated 3/5/2020 and revised on 3/5/2020, revealed the resident had diabetes mellitus with neuropathic pain. Pertinent interventions included checking all body parts for breaks in skin and treating promptly as ordered by the doctor; Do not use over the counter remedies for corns and calluses, refer to podiatrist to treat; Inspect feet daily for open areas, sores, pressure areas, blisters, [MEDICAL CONDITION] or redness; Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails. The care plan, initiated on 7/13/2020 and revised on 7/22/2020, revealed the resident was at risk for impaired skin integrity related to chronic [MEDICAL CONDITION], diabetes mellitus, [MEDICAL CONDITION], venous ulcers to the right lower extremities, wounds to the right buttocks with sheering that was intermittent and a pressure area to the left heel that is recurrent with dry cracked skin. Interventions included: -effective date 7/13/2020: Educate resident/representative about proper skin care to prevent skin breakdown; encourage resident to frequently shift weight; Evaluate skin; Monitor for moisture, apply barrier product as needed; Provide skin care per facility guidelines and as needed; Utilize compression suggestions per order. -effective date 7/22/2020: Alternating air mattress for pressure reduction on setting to two. The August 2020 CPOs contained the following pertinent orders: -order start date 3/13/2020: apply bunny boot to the left heel to prevent recurring pressure ulcers when in bed; -order start date 6/23/2020: apply protectant cream to both feet two times a day; -order start date 6/30/2020: weekly skin audits to be done once every Tuesday; -order start date 7/3/2020: inspect gluteal region dressings for intactness, if missing please replace the dressing using medicated ointment per instructions; -order start date 7/8/2020: alternating air mattress set on two and alternating for pressure reduction; -order start date 7/10/2020: to the left calcaneus(heel) to cover with bordered foam and assist the resident to apply multipurpose boot; -order start date 7/22/2020: per advanced wound care, the treatment for [REDACTED]. Also, apply a small border foam dressing to the left heel every other day. -order start date 7/27/2020: to treat the right gluteal wound with barrier cream application to periwound (the skin around the wound), apply [MEDICATION NAME] to wound bed with alginate, cover with bordered foam. -order start date 7/28/2020: please have the resident wear multi-podus boots only at night for skin integrity. -No physician order was found regarding a wheelchair cushion and no physician order was found regarding pressure reducing interventions for the resident while in the recliner, where she spends most of her time, see observation and interviews above. The 4/10/2020 nurse progress note read there was no opening at site, is on the right buttock, approximately the size of a dime. Barrier cream applied and order entered to the site to have cream applied two times a day. The 4/27/2020 nurse progress note read that the resident had an open area to her right buttock. However, no physician orders and/or documentation was found regarding the interventions put in place to prevent the right buttocks wound from opening 17 days after the facility identified the wound as a red area, see note above. The 6/8/2020 nurse progress note read that the weekly skin check was completed with open area to the right ankle and barrier cream was applied to the reddened area of the buttocks. The 6/18/2020 Braden Scale for Predicting Pressure Sore Risk form revealed that the resident's score was 17 out of 23 and that the resident was at a low risk for developing pressure sores, however she had recurring PU/PIs. The risks identified included skin was exposed to moisture occasionally, activity restriction because her ability to walk was severely limited, her ability to control body position was slightly limited and a potential problem for friction and shear. The 6/21/2020 nurse progress note read that an approximate nickel size blister was identified on her upper buttock area/iliac crest area. The 7/2/2020 nurse progress note revealed that the resident had refused dressing changes and treatments as recommended by the wound care clinic. The 7/2/2020 wound progress note revealed the resident had a stage 3 pressure ulcer on the right buttock/ischium with new wound care orders to include frequent repositioning. Right lateral malleolus with chronic venous ulcer. The left calulenous wound with orders to apply protective dressing and to apply podus boot on the left foot. The 7/3/2020 nurse progress note read the resident did not want the facility wound team to treat the wounds on her buttock and trochanter however allowed the team to assess the wounds. However, the resident did agree to let the facility wound team treat the wound as long as they followed the outside wound clinic physician orders. The 7/7/2020 physician wound orders read, Please turn patient every two hours to ensure offloading of bilateral heels and ischium. The 7/20/2020 physician wound orders read, Off load pressure on bottom, she (resident #4) needs help doing so. The 7/29/2020 Skin and Wound Evaluation form read that the resident had three in-house acquired wounds; one wound was related to moisture associated skin damage to her right buttock/ischium with 50% granulation tissue and 50% slough in the wound bed; one fluid filled blister to the right iliac crest; and one recurring deep tissue pressure injury to the left heel. C. Staff interviews Certified nursing assistant (CNA) #6 was interviewed on 8/5/2020 at 2:40 p.m. She said she received the shift report that included the residents who had been changed or repositioned. She waited for the residents to use their call to ask for assistance and as a way to check on them. She said Resident #4 is not repositioned unless she used her call light that was every three to four hours during the day. CNA #5 was interviewed on 8/6/2020 at 3:20 p.m. She stated that they do not have a specific routine to monitor or reposition residents. The resident was not repositioned unless they used the call light. She said she asked the CNA who was always on the floor, and knew how to care for a resident after she answered their call light. The wound ostomy certified nurse (WOCN) was interviewed on 8/6/2020 at 10:30 a.m. She said the risk assessment and weekly skin monitoring began when residents were admitted . Prevention measures for skin breakdown included a different mattress if the resident needed skin care or wound care as ordered at admission. The resident preferred to sit in her recliner for activities she loved to do such as knitted and talked on the phone. Staff helped with repositioning when she used the call light. Other skin breakdown prevention was implemented after staff identified pressure ulcers. Resident #4 trusted the wound clinic for directions and education rather than the facility staff. She said she was in contact with the wound clinic because the resident listened to the outside wound doctors instructions better. RN #1 was interviewed on 8/6/2020 at 10:50 a.m. She said the CNAs followed basic CNA tasks. They checked on the residents about every 2 hours to reposition them and provide care as needed. Residents who made their needs known, used the call light to be repositioned or other assistance needed. The unit manager (UM) #1 was interviewed on 8/6/2020 at 11:20 a.m. She stated the medication administration and treatment administration records had information about when residents needed to be repositioned. The nurse conducted a weekly skin check to monitor for skin problems. Resident #4 preferred to sit in her recliner most of the day there. She would be called She preferred her wound care treatments to be done by the wound clinic where she was an established patient. Even though this resident

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) could make her needs known, no staff members indicated that encouragement was given to reposition or offload her weight. Staff waited until this resident used her call light which could be three to four hours per on staff interview above. This would not be in alignment with Resident #4 care plan (encourage resident to frequently shift weight). VI. Resident #10 A. Resident status Resident #10, under the age of 50, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders (CPO), [DIAGNOSES REDACTED]. The 6/17/2020 minimum data set (MDS) assessment revealed the resident had no short and long-term memory problems. The resident was independent with cognitive skills for daily decision making. She had no difficulties to hear in normal conversation. She was able to make self understood and able to understand others. -The MDS failed to identify communication needs such as using the white board due to being hard of hearing. She was also coded to require extensive two-person assistance for bed mobility and total dependence for dressing and eating. She was at risk for developing pressure ulcers/injuries and had one unhealed pressure ulcer/injury of Stage 2 and moisture associated skin damage. She received pressure injury care, pressure injury treatment and had pressure injury devices to the bed. She did not reject evaluation or care that was necessary to achieve her goals for health and well-being. She had occasional pain, which did not limit her day-to-day activities. She rated her pain over the prior five days as three out of 10. (This would not be accurate coding according to interviews with resident and staff members, she grimaced and cried when repositioned). -She did not receive respiratory, psychological, recreational, speech, occupational, or physical therapy. She did not receive restorative nursing services. B. Failed to prevent development and worsening of in-house acquired pressure ulcers to right elbow 1. Observation and interviews On 8/5/2020 at 10:37 a.m., RN #2 provided wound care for Resident #10's right ear and right elbow. The resident was in her bed, lying flat and rested slightly on her right side. There was an air mattress on the bed and the head of the bed was not raised. A wedge pillow was on top of furniture against the wall. The resident had a [MEDICAL CONDITION] midline on her neck with oxygen attached. A CNA held the resident's head and right arm while the nurse removed the dressings, cleansed the sites and applied new dressings. RN #2 said the resident preferred to lie in one position and sometimes the drainage from the [MEDICAL CONDITION] site ran onto the resident's ear and caused the ear to stay moist. RN #2 said staff attempted to change the resident's position from right side lying and use foam wedges but she resisted. She said the resident complained of pain, especially with movement, such as position changes. She said the resident had orders for [MEDICATION NAME] three times a day and liquid [MEDICATION NAME] every 12 hours as needed for pain. Resident #10 was interviewed on 8/6/2020 at 1:55 p.m. Using a dry erase marker and a white board, 'yes' or 'no' questions were asked. She indicated with head nods that changing position caused pain to her right arm and foot. She confirmed she did not like to change positions or have the head of her bed elevated because of pain. 2. Record review On 3/18/2020 she had an actual skin impairment/pressure ulcer related to her preference of keeping her head positioned to her right side and disregarding staff encouragement to change positioning. The skin impairment/pressure ulcer care plan initiated 6/5/19 read that the resident was at risk for skin impairment/pressure ulcer related to her need for staff assistance with bed mobility secondary to the disease process. Interventions included: -effective 10/29/19, the resident was often resistant to repositioning but please continue to offer and educate on adjustments in position for wound prevention. -effective 2/25/2020, use an alternating air mattress. -effective 3/18/2020, encourage use of a repositioning wedge to offload the right ear. The 6/19/2019 admission Braden Scale for Predicting Pressure Sore Risk form scored her risk at 11.0, high risk, and had potential for friction and shearing. The 6/17/2020 annual Braden Scale for Predicting Pressure Sore Risk form scored her risk at 9.0, very high risk, and had problems of friction and shearing. The 7/1/2020 Skin and Wound Evaluation read that the resident had an in-house acquired Stage 2 pressure ulcer to her right elbow. The Stage 2 pressure ulcer involved partial-thickness skin loss and exposed dermis. On 7/15/2020 she had an actual skin impairment/pressure ulcer related to a stage 2 pressure ulcer/injury to her right elbow. The 7/28/2020 provider note read that the right elbow had not healed with a moderate amount of sero-sanguineous drainage. The care plan failed to identify pain relief as an intervention to treating the residents refusals to be repositioned. Resident stated she did not like to change positions or have the head of her bed elevated because of pain. (see resident interview above) Furthermore the pain care plan was not resident centered (see Pain section care plan below). The August 2020 CPOs contained the following pertinent orders: -order start date 2/24/2020: use a wedge foam to reposition as tolerated and alternate sides frequently as tolerated. -order start date 7/21/2020: use an alternating air mattress. The 8/3/2020 provider note read that the resident had ongoing resistance to repositioning including for wound care to her right elbow. The 8/4/2020 Skin and Wound Evaluation read that the pressure ulcer to her right elbow had worsened to a stage 3 pressure ulcer, stage 3 pressure ulcers involve full thickness skin loss. The resident had pain when the elbow was lifted from the bed. 3. Staff interviews CNA #4 was interviewed on 8/6/2020 at 2:00 p.m. She said Resident #10 had wounds on her right elbow and they changed her position in bed when she let them. The CNA said because she cries from pain, and she preferred to lay on her right side, sometimes they would let her stay in the same position. LPN #3 was interviewed on 8/6/2020 at 2:02 p.m. She said the resident received daily wound care and dressing changes to her right elbow. Staff were supposed to change her position but she refused often and cried in pain. The LPN said the resident did not like being touched or turned from her right side because of her pain. The wound care nurse (WOCN) was interviewed on 7/23/2020 at 8:54 a.m. She said skin assessments were performed weekly. After the assessments, interventions were implemented as needed and changed after wounds were noticed. Residents with wounds were seen weekly by the WOCN, unit managers and the wound care provider. Wound care treatments were changed as needed. The director of nursing (DON) was interviewed on 8/6/2020 at 5:45 p.m. The DON said Resident #10 preferred a particular position and wiggled out of the position changes and liked to lay flat. Staff have tried placing a pillow under her arm and put the elbow cup on but the resident wiggled out of that position. The DON stated it was difficult to balance the resident preferences and clinical needs. C. Pain 1. Observation and interview On 8/5/2020 at 10:37 a.m., RN #2 provided wound care for Resident #10's right elbow. The resident grimaced when the dressings were removed. RN #2 said the resident complained of pain, especially with movement, such as position changes. She said the resident had orders for [MEDICATION NAME] three times a day and liquid [MEDICATION NAME] every 12 hours as needed for pain. Resident #10 was interviewed on 8/6/2020 at 1:55 p.m. Using a dry erase marker and a white board, 'yes' or 'no' questions were asked. She indicated with head nods that changing position caused pain to her right arm and foot. She confirmed she did not like to change positions because of pain. 2. Record review The care plan, initiated 6/5/19, read that the resident was at risk for pain related to depression. Interventions included to assess for constipation, educate the resident to the cause of pain, management plan, expectations and possible side effects; monitor, record, and report complaints of pain or requests for pain treatment to the nurse; perform pain assessment per protocol; administer pain medication for doctors orders; and reposition for comfort. -The care plan failed to provide resident specific treatment for [REDACTED]. The facility, knowing the limitations for medication, failed to implement alternative pain management interventions. The August 2020 CPOs contained the following pertinent orders: -order start date 11/7/2019, apply pain menthol gel to posterior neck two times a day for neck pain/spasm -order start date 6/19/2020, administer [MEDICATION NAME] three times a day for pain. -order start date 7/16/2020, administer [MEDICATION NAME] sulfate as needed for severe pain every twelve hours. -order start date, 8/6/2020, apply [MEDICATION NAME] to the right shoulder daily for arm pain. The 8/3/2020 skilled evaluation note read that Resident #10 reported pain to her neck, elbow and ear multiple times a day. The August 2020 Skilled Evaluations revealed: -8/1/2020, resident had pain when dressings were changed. No education was provided. -8/2/2020, resident had no indications of pain. -8/3/2020, resident's facial expression indicated pain. The resident reported pain occurred multiple times per day to her neck, elbow and ear. The resident refused to be repositioned and resisted head and neck movements. No education was provided. -8/4/2020, resident reported pain of five out of 10 which occurred daily. The resident refused non-medication interventions. No education was provided. -8/5/2020, the resident reported pain of three out of 10 and had protective body movements. The resident reported pain occurred daily. No education was provided. The 8/3/2020 provider note read that the resident had recurrent pain issues increasing resistance to moving and repositioning. Taking liquid [MEDICATION NAME] and [MEDICATION NAME] for management and comfort but still has pain and discomfort, grimacing and pushing the provider/nurse away while trying to evaluate. Activity level remains quite low No alternative pain management interventions were added as resident continued to grimace and cry out when repositioned. 3. Staff interviews CNA #4 was interviewed on 8/6/2020 at 2:00 p.m. She stated they changed her position when she let them, however because it hurt the resident when staff provided position changes or incontinent brief changes. She said sometimes they do no not change her position because she cried. LPN #3 was interviewed on 8/6/2020 at 2:02 p.m. She said the resident did not want to be touched or turned on her left side because of her pain. She said the resident grabbed her arms, grimaced, tensed up and cried a lot because of the pain. She said the

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) resident was given [MEDICATION NAME] three times a day and [MEDICATION NAME] every 12 hours if needed for pain. She said they recently received an order for [REDACTED].#3 was interviewed on 8/6/2020 at 2:09 p.m. She stated she did not know of interventions for pain other than [MEDICATION NAME] and [MEDICATION NAME]. She spoke with the physician's assistant (PA) and reported that he said the family was reluctant to give more pain medication because of the resident's history with narcotics and [MEDICAL CONDITION]. She reported that the resident was seen by the PA on 8/3/2020 and he had ordered a [MEDICATION NAME] for pain to the Resident #10's right arm. The (DON) was interviewed on 8/6/2020 at 5:45 p.m. The DON said the doctors worked with the resident's family regarding the resident's pain. The DON stated it is difficult to balance the resident preferences and clinical needs. D. Failed to update and ensure a resident specific care plan for communication 1. Observation On 8/5/2020 at 10:37 a.m., registered nurse (RN) #2 wrote messages to Resident #10 using a dry erase marker and a whiteboard. RN #2 stated the resident was very hard of hearing so they used a whiteboard to communicate. 2. Record review The communication care plan initiated on 6/5/19 and revised on 3/23/2020 read that the resident had a communication problem related to [MEDICAL CONDITION], stroke and ventilator dependence. The resident was able to answer simple yes/no questions. The intervention read that staff were directed to refer to speech therapy for evaluation and treatment. The communication care plan failed to include the use of a white board, sign language and cell phone to communicate with the resident based on observation, record review and staff interviews. The 8/3/2020 skilled evaluation note read that Resident #10 communicated with sign language and a white board. 4. Staff interviews CNA #4 was interviewed on 8/6/2020 at 2:00 p.m. She said staff used a whiteboard to write messages and the resident used a cell phone to write the response if it required more than a yes or no answer. The MDS Coordinator (MDSC) #1 was interviewed on 8/6/2020 at 2:55 p.m. He said he initiated care plans when residents arrived. He was not responsible for updating care plans. The NHA was interviewed on 8/6/20 at 3:10 p.m. He said the interdisciplinary team (IDT) discussed resident concerns and interventions and the team consisted of social services, resident care managers (unit managers), the therapy department, and the dietary manager. The NHA said he thought care plans were continually updated with new interventions. VII. Facility high incidence of in-house acquired pressure ulcers/injuries A. Facility policy and procedure The Pressure Ulcer/Skin Breakdown Clinical Protocol, last revised in April 2013, was provided by the nursing home administrator (NHA) via email on 8/6/2020. It read in part, A person at risk for pressure ulcers should be repositioned every two hours while in bed or at least every one hour when in a wheelchair include to check and change absorbent pad or brief. Resident prevention of skin breakdown is to include . Use foam, gel or air cushion as indicated to relieve pressure; Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown; Immediately report any signs of a developing pressure ulcer to the supervisor; The care process should include efforts to stabilize, reduce or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as Appropriate. The risk factors for a chair fast resident include postural alignment, weight distribution, sitting balance and stability should be evaluat
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 observations, interviews and record review, the facility failed to ensure a safe environment and adequate supervision to prevent accidents for two (#3 and #5) of three out of 10 sampled residents. The facility failed to identify a change of condition and implement fall preventative measures with her known history of falling to prevent the Resident #3 from sustaining a fracture to the left shoulder, which resulted in the resident being sent out to the hospital for treatment. The resident returned to the facility from the hospital wearing a sling requiring increased staff assistance and had an increased level of pain which required the use of pain medications. Furthermore, when the resident returned from the hospital fall measures were not implemented by the facility when she was found face down on the floor of her room and had passed away. The facility failed to implement fall preventive measures for Resident #5 who had an increased poor safety awareness because of his dementia that resulted in several falls in a short amount of time. Findings include: I. Resident #3 A. Resident status Resident #3, age 56, was admitted on [DATE] and passed away on 5/28/2020. According to the May 2020 computerized physician orders [REDACTED]. The 3/26/2020 minimum data set (MDS) assessment revealed the resident had no short and long term memory problems. The resident was independent with cognitive skills for daily decision making. No behavioral symptoms noted. She was independent with setup assistance with bed mobility, transfers, ambulation, and personal hygiene. She required supervision with one person assistance with dressing, eating and toileting. She was occasionally incontinent of urine and frequently incontinent of the bowel and no toileting program. She experienced occasional pain with use of as needed pain medications. She fell prior to admission but had no falls since admission. She received during the last seven days antibiotics and two days of opioids. She received oxygen therapy, hospice services and was on isolation/quarantine for being newly admitted . No restraints or alarms in place. B. Record review The care plan, initiated on 3/20/2020 and revised on 5/28/2020, revealed the resident was at risk for falls related to history of falling, [MEDICAL CONDITION], back/hip pain, hard of hearing (deaf to left ear, hard of hearing in right ear, psychoactive medicinal usage and oxygen dependence. -Interventions included she was independent and needed no staff assistance for transfers or toileting, she needed set-up assistance with bathing. Staff were to monitor for dizziness, drowsiness, clumsiness, memory loss, blurred or double vision, lack of energy, and forgetfulness due to anxiety medication. Staff were to monitor for mobility due to her history of falls. Staff were to monitor for dehydration risk due to a history of dehydration/electrolyte imbalance due to end stage liver disease. Staff were to give encouragement or assistance with her oxygen use. The 3/19/2020 Fall Risk Evaluation form read the following risk factors were associated with the resident required hands on assistance to move from place to place, used an assistive device, confined to a chair and oriented, date of admission less than three months, history of falling at least once to twice in the last six months and [MEDICAL CONDITION] medication use. The 4/17/2020 and 5/5/2020 progress notes revealed an order of [MEDICATION NAME] (an antibiotic used to reduce the absorption of ammonia) was to be given 4 times a day for 45 days due to a high ammonia level. The 5/4/2020 ammonia level laboratory results revealed the resident 's ammonia level was 54 with an abnormal result of critically high. The laboratory report showed a normal range of nine to 33. The 5/25/2020 at 12:04 p.m. progress note read that the resident had an elevated temperature and the resident was sleeping a lot but without respiratory symptoms. The 5/25/2020 at 1:26 p.m. progress note read that the hospice nurse visited with the resident and stated that she was aware of the resident 's mood being down, incontinent episodes and elevated temperature. The 5/26/2020 at 5:25 p.m. the hospice nurse was in to see the resident because she had abnormal lung sounds. The resident slept most of the day and said she was bored. The resident had a slight low grade temperature of 99.4 degrees Fahrenheit (F). The hospice nurse said that the low grade temperature was the resident 's baseline since admitting to hospice. The physician was notified and ordered a two-view chest x-ray, complete blood count (CBC) and basic metabolic panel (BMP). The 5/27/2020 at 6:24 a.m. progress note read that the resident was overheard yelling in the hallway for staff to help her. The resident was found lying in the bed stating that she had fallen twice to and from the bathroom. The physician was notified and ordered an x-ray of the shoulder. The resident 's left shoulder was assessed for pain, swelling and bruising. The resident was medicated for pain and neurological assessments were started. The 5/27/2020 Fall Risk Evaluation form read the following risk factors were associated with the resident having poorly fitting shoes, decrease in muscle coordination, medication use of anti [MEDICAL CONDITION]/antiepileptic, cathartics and narcotics, occasional incontinence of bowel and bladder. The 5/27/2020 at 4:11 p.m. progress note read, Patient fell on [DATE] in the early AM during shift change. Nurse (name of nurse) reported the patient fell unwitnessed when trying to get out of bed and go to the bathroom. Patient VS (vital signs) at 6:15 AM B/P (blood pressure) 123/80, Temperature 99.2, Pulse 109, Respirations were 24, shallow and irregular. (Clinic 's name) office called with a new order for x-ray and increase in PRN [MEDICATION NAME] (pain medication). Hospice notified and a hospice nurse came to the facility to evaluate the patient. Hospice nurse called the daughter. Left shoulder notable swelling and pain upon movement. Ice and pain medication administered per order. Xray result conclusion: [MEDICAL CONDITION] humerus and lateral displacement of the distal fracture fragment. Patient sent to hospital to be further assessed. The hospice (nurse) called the daughter to notify her that she has been taken off of hospice in case she needs surgery on her left arm. Patient returned with a sling for her left arm to stabilize the arm and decrease pain. Hospice notified. Daughter notified by hospice that the patient would need total shoulder replacement, the hospital would not operate on it acutely because it can be fixed outpatient. Immediately after returning to (facility name) from the hospital, when two assistants transferring

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	065196	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVAMERE TRANSITIONAL CARE AND REHAB-MALLEY	401 MALLEY DR NORTHGLENN, CO 80233

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) from the bed to wheelchair to use the bathroom, the patient's body stiffened, lost pallor (a pale color of the skin), became unresponsive to verbal name, head rolled back to the left, with fixed gaze. VS 71/37 B/P, 89 Pulse, 92% O2 (oxygen) on 2L (liters) NC (nasal cannula). PRN (as needed) 10 mg (milligram) [MEDICATION NAME] sublingual administered. Event lasted for 45 seconds. After the event, VS B/P 87/55, 93% O2 on 2L NC, pulse 119, RR (regular respirations) 18, Temperature 97.1(F). Patient returned to her baseline and was able to respond to her name. Called (clinic name) office and head CT (CAT scan) ordered upon daughter with approval and pain medication changed to PRN [MEDICATION NAME] 0.5 ml (milliliters) (10 mg) sublingual Q (every) 3 hours for pain. Patient sent out to (hospital name) for head CT. The 5/28/2020 at 12:45 a.m. progress note read that the resident returned from the hospital after getting the head CT. The results were negative. The blood pressure remained low at 87/56 but the resident required an increase of oxygen to 4 liters with a pulse oximeter reading of 90%. The resident was not able to communicate to the nurse during the assessment due to pain so she was administered pain medications upon return from the hospital. The hospital prescribed a new [MEDICAL CONDITION] medication to begin the next day along with following up with a neurosurgeon. The daughter was notified of the resident 's return to the facility and provided the CT results. Until the decision could be made about surgery to the left shoulder, hospice services remained on hold. The nurse wrote that if the resident continued with a change in her condition then she would contact the physician for recommendations. The 5/28/2020 at 3:20 a.m. progress note read, This nurse found the resident on the floor face down. NC (nasal cannula) was off, the resident had shallow and irregular breaths. This nurse turned the resident over to obtain apical pulse, the resident was unresponsive. Resident shows lactation on the left eyebrow. RN from North unit was called by (name of CNA) CNA (certified nurse aide), RN (name of RN) (registered nurse) assessed the resident and announced ceased VS (vital signs). MD (medical doctor) was called and daughter (name of daughter) was notified. Coroner office was also notified. Daughter will be coming in to view the resident then the mortuary (name of mortuary) will be notified for release of body. Review of the resident 's medical record revealed there was no additional intervention put in place by the staff, including the interdisciplinary team subsequent to the resident 's fall on 5/27/2020. C. Staff interviews The nursing home administrator (NHA) was interviewed on 8/6/2020 at 3:52 p.m. He said, We review interventions such as falls. As a team we review falls and determine what interventions were put in place. We evaluate situations daily, not just one time. If what we did for a fall did not help we will change what we are doing and come up with a new plan. The restorative service director (RSD) was interviewed on 8/6/2020 at 4:30 p.m. She said Resident #3 came to the facility a few months ago and had poor safety skills. She said the resident had two falls, a fractured shoulder and high ammonia levels. She said the resident presented well and the resident thought she could do everything even though she had medical needs where she required assistance. She said it was hard to keep a resident safe when they seemed capable of doing ADL 's on their own. She said when someone is independent there is not much we can do, we can not watch them 24/7, and falls are unavoidable. She said Resident #3 returned from the hospital in May 2020 and additional interventions were not put in place because the resident had not been reviewed for her falls. She said she planned to evaluate the resident 's falls with the interdisciplinary team. She acknowledged the facility failed to identify the risk factors after the resident had fallen to prevent falls. She said she could not have prevented the resident from falling. The director of nursing (DON) was interviewed on 8/6/2020 at 6:00 p.m. She said Resident #3 came to the facility from California with her daughter but ended up in the hospital after the long drive. The resident had complex issues and it was a struggle to put things in place for her. The DON said the resident was independent with her activities of daily living. She stated the resident was younger than some other residents and had medical complications. She said after the last fall there on 5/27/2020, the resident had a change in condition. The interdisciplinary team planned to meet with the family the next day after the fall on 5/27/2020 to decide on a treatment plan with her being on hospice services previous to the hospitalization She said, There is a struggle with the population we care for and it is hard to get outside resources for interventions. There is a fall prevention committee/meeting once a month in the facility and they look at falls weekly. II. Resident #5 A. Resident status Resident #5, age 82, was admitted on [DATE]. According to the computerized physician orders [REDACTED]. The 5/19/2020 minimum data set (MDS) assessment revealed that the resident was cognitively intact with a brief interview for mental status score of three out of 15. He required one person assistance with a walker and wheelchair. He had an acute change in mental status with fluctuating behaviors present including; inattention, disorganized thinking and altered level of consciousness. He required extensive assistance of two persons with bed mobility, transfers and toileting. He required extensive assistance of one person with locomotion on the unit, eating and personal hygiene. He used a wheelchair as a mobility device. The resident had an unsteady balance moving from seated to standing positions, moving on and off toilet, and surface to surface transfers. The resident was coded to have fallen twice with injury and twice without injury since admission. The resident had received anti anxiety medications since admission. The resident received hospice services. B. Observations On 8/5/2020 at 9:00 a.m. Resident #5's roommate was observed in the hallway asking staff for assistance for his roommate. Resident #5 was observed in his room sitting in his wheelchair asking for assistance with his shoe in his lap. The call light was positioned on top of the bed. The resident moved himself in his wheelchair to the entrance way of the room but not to the hallway to get the attention of the staff. Resident #5 expressed the desire to be put to bed. On 8/6/2020 at 3:40 p.m. Resident #5 was sitting in his wheelchair that faced the television alone in his room. A plastic cup was crunched up and tipped over between his left leg and the wheelchair with water spilled from the cup onto the floor under his feet. Resident #5 leaned forward and was unable to reach for his shoes that were three feet in front of him. Resident #5 was asked how he asked for assistance from staff and where his call light was located. He used his right hand to touch the wheelchair brake on the right side of his wheelchair and used his thumb to press down on the brake handle while he said please three times. A touch call light was on the bed next to him within his arms reach however he did not acknowledge it was available. At 3:54 p.m. certified nurse aide (CNA) #1 entered Resident #5's room and said she would be right back and exited the room while the resident remained in his room alone. At 3:55 p.m. CNA #2 entered and then exited the resident's room while the resident remained in the room by himself a second time. At 3:56 p.m. CNA #2 exited the room with the resident in his wheelchair and took him to the television area across from the nurses station. C. Record review The care plan, last revised on 5/22/2020, revealed the resident had a personal history of falls and was at risk for further falls. Interventions included: -Limited to extensive two person assist with transferring; -Resident #5 was re-educated on the need to use the breaks before transferring in a wheelchair and/or to wait for staff to assist; -The resident started a check and change program for increased incontinence of bowel and bladder; -Non skid device was added to the wheelchair between the seat and the cushion; -A grab bar placed on the outside wall of the bathroom; -An additional grab bar was mounted inside the bathroom on the wall; -Staff was inserviced to not leave the resident's bed in a low position post fall; -The post fall assessment completed with implementations included the resident's wheelchair has an appropriate cushion, auto locking anti roll back breaks. Back of the chair has been positioned to lean back. Bilateral assist handle on bed, bed at transfer height, bolster mattress and touch call in place. -The resident utilizes bilateral assistive handles on wheelchair for mobility and transferring; -Restorative program updated to, Stand and transfer into stationary chair and back to wheelchair 5 times each in the common area, up to three times weekly for strengthening post fall. -Review and update fall risk assessment quarterly, post any fall and PRN. -Soft touch call light provided -Staff is serviced to keep call light placed on the left side of his body. -Rule out potential causes of fall such as infection, medication side effects, [DIAGNOSES REDACTED]. One-on-one person monitoring for the resident was not documented as an intervention on the care plan. The 4/11/2020 fall risk assessments revealed the resident was a high risk for falling with a score of 23 with concern of multiple falls. No other fall risk assessment was documented. The following post fall investigation reports and the Incident Audit Reports, included the incident status history, incident details, injuries, predisposing factors, witnesses, action/care plan revisions and notes. The audits reviewed from 3/31/2020 to 8/4/2020 revealed Resident #5 sustained 17 falls. The results of the audit revealed the following: On 3/31/2020 at 2:15 p.m. Resident #5 fell on his knees from his wheelchair onto the floor while eating lunch in the TV common area across from the nurses station. The resident was placed on alert charting every shift. The restorative service director (RSD) revised the incident document on 4/1/2020 at 9:39 a.m. It read that an in-service for the staff was to not let Resident #5 eat unattended in the TV room. On 4/11/2020 at 8:21 a.m. Resident #5 was found on the floor in his room trying to get into bed from his wheelchair. The post fall assessment dated [DATE] documented that the wheelchair had an appropriate cushion in place, locking anti-roll back breaks, the back of the chair had been tilted back, a grab bar was added outside of the bathroom, bilateral assist handles were installed onto his bed, the bed height was maintained at his transfer ability, a bolster mattress was in place, the bedside table was moved to the foot of his bed and the call light was replaced with a touch call light to reduce risk of

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 5) injuries from falls. On 4/28/2020 at 5:00 p.m. Resident #5 attempted to transfer in the common area in front of the nurses station. The CNA could not get to the resident before he fell on his buttocks. The RSD added new therapy to include stand and transfer into a stationary chair then back again to the wheelchair. This was to be done five times each and up to three times a week for strengthening. On 5/2/2020 at 3:03 p.m. Resident #5 was found on the floor sitting in front of his bed in his room. He had four small skin tears. The intervention put in place was removing the bed cane from the side of his bed. On 5/5/2020 at 10:25 a.m. Resident #5 was found on the floor without injury in his room. The intervention included putting the resident on hospice services on 5/6/2020 due to falls, weakness and weight loss. On 5/13/2020 at 1:02 p.m. Resident #5 was found on the floor in his room and no injuries. No interventions were implemented after the fall. On 5/16/2020 at 10:27 p.m. Resident #5 was found sitting on the floor soiled with an incontinent bowel movement on him and in his wheelchair. The staff started a check and change program because of the increased incontinent bowel and bladder episodes. On 5/21/2020 at 9:13 p.m. Resident #5 slid from his wheelchair to the floor. The RSD on 5/22/2020 implemented a non-skid seat pad placed under his wheelchair cushion. On 5/22/2020 at 6:26 p.m. Resident #5 was found on the floor sitting in front of his wheelchair in his room. It read that the resident was placed on hospice due to his advanced dementia and weight loss with further decline expected. It read that the fall preventive measures that were in place were reviewed and kept in place after the last fall. On 5/23/2020 at 9:30 a.m. Resident #5 was found sitting on the floor in his room near the bathroom. No interventions were implemented after the fall. On 6/2/2020 at 6:15 p.m.; 6/17/2020 at 12:02 p.m. and 6/23/2020 at 2:00 p.m. were documented that the resident fell without injury, however no information about the falls and/or post falls were included in the audit. On 6/28/2020 at 7:40 p.m. Resident #5 was given medications for pain and anxiety, provided snacks before bed and one-on-one visit then fell on [DATE] at 2:27 a.m. when he was found on the floor on his knees in front of his wheelchair in his room. No interventions were implemented after the fall. On 7/5/2020 at 1:38 p.m. Resident #5 fell to the floor in the bathroom when he grabbed the bar by the toilet to stand up while the CNA was putting on her gloves. No interventions were implemented after the fall. On 7/11/2020 at 7:30 p.m. Resident #5 reached out his arms and leaned forward in his wheelchair and fell to the floor on his knees. No interventions were implemented after the fall. On 7/27/2020 at 4:17 a.m. Resident #5 was found on the floor in his room. It read, It sounds as though an aid had been assisting with dinner and she stepped out, then the resident may have been trying to get into bed and fell to the floor. Roommate turned the light on for the resident. (The roommate was) Unable to tell us what happened but he called. Even though interventions were put into place, the last intervention was dated 5/21/2020 of a non skid seat pad.The resident continued to fall seven more times after the last intervention was put into place. No new person centered interventions were added to prevent Resident #5 from falling. -In total Resident #5 fell 17 times within four months. D. Staff interviews The RSD was interviewed on 8/6/2020 at 4:20 p.m. She stated she led the fall interdisciplinary team (IDT) that consisted of the RSD, the unit managers and a staff member from each discipline including activities, dietary, nutrition, social services, the minimal data set coordinator (MDSC). She said the process for fall prevention included review in meetings with the fall IDT. Also, during stand up meetings every weekday morning involved information about falls in the last 24 hours, or over the weekend on Monday morning. The fall IDT meeting was held once a month to review falls, evaluate fall risk measures in place and update the care plan for the falls in the previous month that occurred. The electronic medical record system (EMR) contained the care plan with resident specific information that the CNA's did not have access to. The CNA's were notified of new or changed interventions by verbal education or given in verbal reports from the previous shift CNA's. The RSD said when Resident #5's falls increased due to the progression of his dementia and stated hospice care started on 5/6/2020. Fall risk prevention for the resident became challenging because of his poor solving and safety skills, as well as the COVID-19 pandemic because residents needed to stay in their rooms. Fall prevention interventions included one-on-one staff monitoring close to the nurses station, safety devices added to his wheelchair, and involved the activities department to implement the resident with new activities he enjoyed. Resident #5 did not have one-on-one monitoring because residents were to stay in their room due to COVID-19 mandates. The director of nursing (DON) was interviewed on 8/6/2020 at 5:30 p.m. She said fall intervention review was an ongoing process and is held once a month with the fall IDT. The pharmacy department was included in the fall IDT meetings held once a month as part of The Quality Assurance and Performance Improvement (QAPI) meetings. Resident safety became difficult because of the frequent infection control regulations updates mandated by The Center for Medicare and Medicaid Services (CMS) for the COVID-19 pandemic. The behavioral health population that the facility served was a challenge to provide for all the resident specific needs and supervision. She said fall prevention measures for Resident #5 was implemented by the facility that included equipment placed in his surroundings, outside family visits and other activities with the activities department. She said Resident #5 began hospice care because his problem solving skills and safety awareness worsened relating to [DIAGNOSES REDACTED]. However, according to the care plan and interviews the one-to-one did not happen and the resident continued to fall.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** Based on observations and interviews the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary environment, and help prevent the development and transmission of communicable diseases and infections such as COVID-19 in the facility for three out of three units. Specifically, the facility failed to ensure active screening was being done for staff entering the facility. A. Observations On 8/5/2020 at 8:05 a.m. the receptionist who is the facility health screener walked away from the front desk to escort people to the conference room on a separate wing of the facility. While she was away from the desk two staff members entered the front door, filled out their own COVID-19 screening paperwork. Both staff members reached around the plastic desk shield to put their papers on the front desk. One staff member came around the desk to answer the phone. Both members did not wait for the receptionist to do active screening or request anyone else to do an active screening. Both staff individuals continued and entered the building through the fire doors. B. Staff interviews The receptionist was interviewed on 8/5/2020 at 10:30 a.m. She said she was trained by the director of nursing (DON) and the staff development coordinator (SDC) to properly screen all staff and visitors. She was trained to take the temperature of anyone who enters the facility and read through the self-screening sheets after they are completed. She said staff do not do their own self screening. She said the two staff that entered should have waited for her at the front entry and not walked in the building without the proper screening. She said if the questionnaire has unanswered questions or areas of concern she gives the sheets to the SDC for follow-up immediately for her to review. The DON viewed on 8/6/2020 at 5:40 p.m. She said the receptionist was trained to be their active health screener for the facility. At the entry of the facility all staff and visitors are to stop at the front desk. The receptionist takes their temperatures. Individuals fill out a questionnaire about their health and give it to the receptionist who makes sure all questions have been answered and the temperature is recorded. The receptionist or a unit manager will take the temperature. She stated staff do not screen themselves. Staff have been trained to have an appropriate screener do the screening. Staff are not to begin work until they have been screened. She said if the questionnaire reveals any concerns or if any of the questions were not answered the receptionist is to get the SDC to follow up on concerns.