STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065405	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUITES PARKER, THE	**9398 CROWN CREST BLVD PARKER, CO 80138**

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F 0558 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to accommodate the needs of three (#6, #5, and #3) residents out of eight sample residents. Specifically, the facility failed to ensure the call light was within reach of these three residents when in their rooms. Findings include: A.Observations and interviews On 8/18/2020 at 1:28 p.m. Resident #3 was lying in her bed with the head of the bed up 90 degrees. The resident ' s flat plate call light was clipped to the mattress at the head of the bed, out of reach of the resident. On 8/18/2020 at 1:48 p.m. Resident #5 was sitting up in a chair next to the bed in her room with her head leaned back and her feet elevated. Her soft bulb call light was lying on the bed out of reach of the resident. On 8/18/2020 at 2:20 p.m. Resident #6 was lying on her bed in her room. She was attempting to put her legs off the side of the bed and transfer herself from the bed to her wheelchair. She said she was unable to find her call light to ask for assistance to go to the bathroom. Her call light was behind the bed against the wall. On the wall next to the call light plug in was a sign that read, Please call for help. On 8/20/2020 at 11:15 a.m., the call light for Resident #6 was clipped to the cord against the wall on the other side of the bed out of reach of the resident. The resident said she was not able to reach over the bed to unclip the call light to use it. Certified nurse aide (CNA) #8 came was informed of the residents need for assistance. CNA #8 went into Resident #6 room and asked the resident if she needed to use the restroom. Resident #6 told CNA #8 she needed her call light where she could reach it in case she did need to go to the bathroom. B. Record review 1. Resident #6 status Resident #6, age 86, was admitted [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/17/2020 minimum data set (MDS) assessment revealed the resident had severe cognitive function with a brief interview for mental status (BIMS) score of six out of 15. She required extensive assistance of two persons for her activities of daily living (ADLs). 2. Resident #5 status Resident #5, age under 60, was admitted [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. She required extensive assistance of two persons for her ADLs. 3. Resident #3 status Resident #3, age 91, was admitted [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 6/14/2020 MDS assessment revealed the resident had severely impaired cognitive functions. She required extensive assistance of one to two persons for her ADLs. C. Staff interviews CNA #5 was interviewed on 8/20/2020 at 2:44 p.m. She said Resident #3 was no longer able to use her call light but it should still be placed where she could reach it if needed. CNA #5 said Resident #5 was able to use her call light at times and should be kept within reach at all times. CNA #8 was interviewed on 8/20/2020 at 11:17 a.m. She said Resident #6 was capable of using her call light and was encouraged to use it to help prevent her from self-transferring and falling. The wound care nurse (WCN) was interviewed on 8/20/2020 at 12:53 p.m. She said all residents should have access to their call lights, even the cognitively impaired residents. The director of nursing (DON) and nursing home administrator (NHA) were interviewed on 8/20/2020 at 2:57 p.m. The DON said she was not sure if Resident #3 was capable of using her call light but Resident #5 and Resident #6 were able to use their call lights. They said call lights should be accessible to all residents despite their cognitive function.
F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** Based on interviews and record review, the facility failed to ensure three of three halls for resident council were provided prompt efforts by the facility to resolve any grievances. Specifically, the facility failed to ensure grievances brought up during resident council interviews were addressed and a resolution provided. I. Facility policy and procedure The Grievance Policy and Procedure, last revised 1/20/2017, provided by the facility on 8/20/2020, included in pertinent part, It is the policy of this facility to investigate all grievances registered by or on behalf of a resident . The facility administrator has been designated to receive all grievances. The administrator shall confer with persons involved in the incident and other relevant persons and within three days of receiving the grievance shall provide a written explanation of findings and proposed remedies to the complainant . II. Resident interviews Resident #8 was interviewed on 8/18/2020 at 1:00 p.m. She said she had submitted complaints frequently about the long call wait times of greater than 20 minutes at times. She said she writes everything down and emails it to someone in management to fix at least once a month. She said the long call light times continue to be a problem. She said she does not feel like the facility has resolved the issue. Resident #6 was interviewed on 8/20/2020 at 11:15 a.m. She said sometimes she had to wait a long time, up to 20 minutes, for the staff to answer her call light when she needed to use the bathroom. She said she told the staff but they did not do anything different. III. Record review The May 2020 Resident Council Meeting notes were reviewed on 8/19/2020 and it indicated no Resident Council Meeting was conducted due to COVID-19. The June 2020 Resident Council Meeting notes were reviewed on 8/19/2020 and revealed the following: -Resident council survey forms were distributed between 6/9-6/13/2020; -Resident council was conducted through one-on-one interviews with the residents who wanted to participate in resident council and activities staff members due to the COVID-19 restrictions on social gatherings; -Thirteen resident from all three floors were interviewed; -Many resident ' s reported that certified nurse aides (CNAs) were not responding to the resident ' s call lights in a timely manner specifically around bedtime and the night shift; -Residents on the second and third floors stated the housekeepers were not cleaning the rooms very well, especially on weekends and in the bathrooms; -Many residents stated the food had been excellent, other residents stated that their meals had been delivered very late and many meals were cold, portions small and dinner option repeated too frequently; and -Many residents were missing clothes in the laundry room. The 7/17/2020 Resident Council Meeting notes were reviewed on 8/19/2020 and revealed the following: -Resident council was conducted through one-on-one interviews with the residents who wanted to participate in resident council and activities staff members due to the COVID-19 restriction on social gatherings; -Ten residents from the second and third floors were interviewed; -Some residents stated they sometimes wait up to thirty minutes for a CNA to come help them and some of the CNA ' s did not always have a good attitude when they were with the residents. -Some resident stated they were not getting their medications delivered to them on time; -Some of the residents stated their rooms and bathrooms were not being cleaned as often or as well as they used to be; -Some residents said the food was getting better, other residents said the food was still cold when it was delivered to them; and -Some of the residents stated that they missed some of the food that used to be on the alternative menu, especially the tamales. The minutes did not include a response to the Resident Council grievances brought up in the June Resident Council interviews. Grievances related to the complaints made during the June and July Resident Council interviews were requested from the facility on 8/19/2020. None were provided. IV. Staff interviews The social service director (SSD) was interviewed on 8/20/2020 at 11:56 p.m. She said the nursing home administrator (NHA) was responsible for dealing with any grievances. She said any grievance she received she would put on a concern form and turn it into the NHA to distribute to the appropriate department head to address. She said the activity department wrote down any grievances made during the resident council and gave them to the

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) NHA. The activity director (AD) was interviewed on 8/20/2020 at 12:01 p.m. She said for the last couple of months, due to COVID-19, the activities staff did one-on-one interviews with the residents that wished to be included in Resident Council. She said they would go over items for each department. She said afterwards she would type up the meeting notes and email them to each of the department heads. She said any concerns should be followed up by the individual departments. The NHA and director of nursing (DON) were interviewed on 8/20/2020 at 2:57 p.m. The NHA said all of the grievances should come to him or the DON and then, depending on the grievance, it was given to the appropriate department to address and follow up on. The NHA said the last couple of months the activity department has been doing one-on-one interviews with the resident ' s for Resident Council. He said after the interviews were complete the AD would type up the minutes and distribute them electronically to all the department heads then each department head was responsible to respond. He said the meeting notes did not identify individuals that made specific complaints so the concerns were addressed broadly. The NHA said they run a call light report once a week because they have a system that will log actual time and their average call light time was eight to eight and a half minutes. He said the staff were educated to leave the light on until the need required by the resident had been met so this contributed to the longer call light wait times. V. Facility follow-up On 8/20/2020, the AD provided copies of emails sent to the department managers after Resident Council that revealed the following: -The June 2020 Resident council minutes were attached if the managers wanted to look it over; and -The July 2020 Resident Council minutes were attached to review at the managers convenience. Even though an email was sent to the managers with the minutes, there was no documented resolution to the complaints made by the residents during the Resident Council interviews. On 8/21/2020, the NHA said in an email that he informed the activity staff that in future Resident Council one-on-one interviews, grievance forms were to be completed for each resident with concerns. He said that would help them ensure there was a good paper trail for issues and their resolution.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and ensure the comprehensive care plans were revised with accurate resident care information for each resident that included the instructions needed to provide effective and person-centered care for two (#2 and #3) of three out of eight residents sampled for care plans. Specifically, the facility failed to: -Ensure Resident #2's comprehensive care plan was revised, updated and accurate to reflect the resident current care needs; and, -Ensure Resident #3's comprehensive care plan was revised and updated after a stage 2 pressure ulcer developed on the resident's right buttock. Findings include: I. Facility policy and procedure The Comprehensive Care Plan policy, revised third quarter in 2018, was provided by the nursing home administrator (NHA) on 8/21/2020 at 3:30 p.m It read, in pertinent part The comprehensive, person-centered care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect treatment goals, timetables and objectives in measurable outcomes, identify the professional services that are responsible for each element of care, aid in preventing or reducing decline in the resident's functional status and/or functional levels, reflect currently recognized standards of practice for problem areas and conditions. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change. The interdisciplinary team (IDT) must review and update the care plan when there has been a significant change in the resident's condition, at least quarterly, in conjunction with the required quarterly MDS (minimum data set) assessment. II. Resident #2 A. Resident status Resident #2, age 72, was admitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. According to the 2/18/2020 minimum data set (MDS) assessment, the resident had severely impaired cognitive function with a brief interview for mental status (BIMS) score of five out of 15. She required extensive assistance of one staff for personal hygiene and locomotion on and off the unit, two staff for bed mobility, transfers, toileting and bathing and supervision with set up for eating. She had a mechanically altered diet and no skin integrity issues. B. Record review 1. Antibiotic According to the March 2020 CPO, the resident received an order for [REDACTED]. Cross reference F757 for failure to prescribe unnecessary medication. Review of the resident's care plan revealed it was not updated with the new [DIAGNOSES REDACTED]. 2. [MEDICAL CONDITION] Medications According to the March 2020 CPO, orders included: -[MEDICATION NAME] 1 milligram (mg) give one mg by mouth at bedtime for [MEDICAL CONDITION], ordered 12/3/19; -[MEDICATION NAME] Sodium Tablet Delayed Release give 1,000 mg by mouth at bedtime for [MEDICAL CONDITION], ordered 12/3/19; -[MEDICATION NAME] disintegrating tablet 1 mg give 1 mg by mouth two times a day for [MEDICAL CONDITION], ordered 12/3/19; and -[MEDICATION NAME] dispersible tablet 0.125 mg give one tablet by mouth before meals for movement disorder, ordered 1/31/2020. Review of the resident's care plan revealed the resident did not have a care plan for her [MEDICAL CONDITION] [DIAGNOSES REDACTED]. 3. Skin According to 3/13/2020 skin and wound evaluations, the resident had an unstageable, in-house acquired deep tissue injury (DTI) to the left heel measuring 1.5 centimeters (cm) by 1.2 cm with slough (dead tissue) in the wound bed. The resident also had an in-house acquired DTI to the right heel measuring 3.7 cm by 2.6 cm with eschar (hardened dead tissue) to the wound bed. It indicated the physician was notified and new orders were received for skin prep twice a day and as needed and prevalon boots to bilateral lower extremities. According to the March 2020 CPO, orders included: -Skin prep to bilateral heels two times a day for [MEDICATION NAME] (prevention), ordered 3/11/2020 then changed to cleanse bilateral heel deep tissue injuries (DTI) with wound cleanser and apply skin prep twice a day, ordered 3/14/2020; and -Prevalon (pressure relieving) boots to bilateral lower extremities at all times, ordered 3/13/2020. The skin integrity care plan, last revised 11/18/19, was not updated with the resident's current skin conditions, new orders or interventions. 4. Diet Review of the resident's physician orders [REDACTED]. The residents dietary care plan, last updated 1/19/2020, revealed the resident was on a regular diet, regular texture with thin liquids. The care plan was not updated with the current order for the texture of the food or liquids or the adaptive equipment needed. 5. Eating assistance The ADL care plan, last revised 11/18/19, revealed the resident required set up supervision with eating. According to the 2/28/2020 occupational therapy discharge summary, the resident was not able to meet all her short and long term goals due to upper extremity tremors impacting the resident's ability to complete self-feeding independently. It indicated she fluctuated between stand by assist to maximum assist secondary to the severity of her tremors on that day and recommendations were made for 24 hour care with assistance in self-feeding. Review of the resident's record on 8/19/2020 revealed the care plan was not updated with the increased assistance the resident required for eating. C. Staff interviews The wound care nurse (WCN) was interviewed on 8/20/2020 at 12:53 p.m. She said the care plans were updated by the person doing the MDS assessments but they were also updated daily during the week by the clinical team that included therapy, social services and nursing. Licensed practical nurse (LPN) #2 was interviewed on 8/20/2020 at 2:18 p.m. She said the care plans could be updated by any of the nurses on the floor. She said any new medications, like antibiotics, or new skin integrity issues should be updated on the care plan. The regional MDS coordinator (RMDSC) was interviewed on 8/20/2020 at 12:20 p.m. She had been doing the facilities MDS assessments on and off since May 2020. She said the last MDS coordinator in the facility had been doing the assessments for close to a year and then left with no notice in May 2020. She said the facility hired another person in July 2020that worked two weeks and then also left without notice. She said the new MDS coordinator was to start on Monday. She said she updated the care plans whenever she did an MDS assessment but any acute changes or updates to the care plan needed to be done by the staff at the facility. She said each department should be responsible for updating the care plan with any changes that occur in their area. The director of nursing (DON) and nursing home administrator (NHA) were interviewed on 8/20/2020 at 2:57 p.m. The DON said the acute care plans should be updated by the nurses on the floor, the unit managers or the specific discipline, such as social services or activities. The DON said information regarding care of the resident, the residents ability and the resident's care needs should be documented on the care plan or kardex (utilized by certified nurse aides to know how to take care of the resident) and should be kept up to date as the resident's needs change. III. Resident #3 A. Resident status Resident #3, age 91, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 6/14/2020 MDS assessment, the resident was severely cognitively impaired due to poor short and long term memory deficits and a brief interview for mental status (BIMS) was unable to be completed. She required extensive two-person assistance for bed mobility, dressing, and toileting, total two-person assistance for transfers and extensive one-person assistance for eating and personal hygiene. The assessment indicated the resident did

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) not have a pressure ulcer. B. Record review The August 2020 CPO revealed an order dated 11/23/19 for Barrier cream to buttocks/ischiums every shift and PRN (as needed). Do not cover the coccyx wound with anything other than barrier cream. This order was updated on 8/18/2020 (during survey) to Right gluteal open wound: Cleanse with wound cleanser, apply skin prep to peri wound. Cover wound bed with fibercol (or similar product) and foam border dressing. Treat daily and PRN and Barrier cream to buttocks/ischiums every shift and PRN. The comprehensive care plan initiated on 8/12/19, was reviewed during the survey on 8/18/2020. The comprehensive care plan had not been revised since it was initiated on 8/12/19. The resident did not have a skin integrity plan regarding the stage 2 pressure ulcer to the resident's right buttock, discovered on 7/20/2020. -The comprehensive care plan was not revised with the active orders related to skin integrity.
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 observations, record review, and interviews, the facility failed to ensure activities of daily living care was provided in a timely manner for one (#3) of three dependent residents reviewed for incontinence care and repositioning out of eight sample residents Specifically, the facility failed to provide timely incontinence care and repositioning in the bed for Resident #3. Findings include: I. Facility policy The Urinary Incontinence -Clinical Protocol, revised third quarter 2018, was provided by the nursing home administrator (NHA) on 8/21/2020 at 3:30 p.m. The policy provided did not reference incontinence care and the timing in which incontinence care was to be provided by the facility as it related to a dependent resident. II. Resident #3 A. Resident status Resident #3, age 91, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 6/14/2020 minimum data set (MDS) assessment, the resident was severely cognitively impaired due to poor short and long term memory deficits and a brief interview for mental status (BIMS) was unable to be completed. She required extensive two-person assistance for bed mobility, dressing, and toileting, total two-person assistance for transfers, and extensive one-person assistance for eating and personal hygiene. The assessment indicated the resident was frequently incontinent of bladder and always incontinent of bowel. The assessment documented the resident was at risk for developing a pressure ulcer, but was not on a turning and repositioning program. B. Record review The care plan initiated on 8/2/18 and revised on 11/6/18 documented the resident was at risk for alteration in skin integrity or pressure ulcers secondary to urinary incontinence and impaired mobility. Interventions, last revised June 2019, July 2019, and October 2019, included air mattress on and functioning within normal limits (WNL) with proper weight setting at approximately 120 pounds (lbs) every shift, encourage and assist to change positions frequently at least every two to three hours on 10/28/19, keep skin clean and dry, pressure relieving cushion for wheelchair and mattress for bed. The resident was incontinent of bowel and bladder and was to be changed every two to three hours, skin checks daily with activities of daily living (ADL) care, barrier cream to buttocks to prevent skin breakdown, and turn resident every two hours offloading her buttocks. The care plan initiated on 8/6/18 and revised on 6/25/19 documented an ADL self care performance deficit and impaired mobility related to dementia, limited range of motion (ROM), activity tolerance, and disease process of arthritis. The resident was to remain free of complications related to immobility, including skin-breakdown. Interventions included extensive assistance, two staff participation for repositioning, turning in bed, and toilet use, staff to provide prompt peri care every shift and as needed. The care plan initiated on 8/12/19 documented impaired skin integrity deficit. Interventions included protecting the skin from contact with urine and feces and preventative care to include continence - keep clean and dry and positioning - turn every two hours and as needed. C. Continual observations and interviews The resident was observed continually on 8/18/2020 from 11:26 a.m. through 3:08 p.m. resulting in the following: -At 11:26 a.m., Resident #3 was lying in bed on her back. -At 11:51 a.m., the resident was in the same position as previously observed. -At 12:15 p.m., the resident was in the same position as previously observed. -At 12:40 p.m., certified nurse aide (CNA) #5 delivered the noon meal to the resident's room. CNA #5 did not offer the resident toileting or repositioning. -At 12:43 p.m., CNA #7 sat down with Resident #3 to assist her with eating in her room. The head of the bed (HOB) was up at 90 degrees. The noon meal consisted of fortified mashed potatoes with brown gravy, pureed turkey potpie, pureed squash and zucchini, lemon pudding, and a Boost supplement CNA #7 said the resident mostly drank Boost at and in between meals. She said when she placed food in the resident's mouth, she spat it out. -At 1:26 p.m., CNA #7 came out of the resident's room with the noon meal tray. The resident had eaten a few bites of each food and drank all of the Boost supplement. The resident continued to lie in bed on her back, the head of her bed up at 90 degrees. The covers were pulled up around her. A styrofoam cup with a straw was on the bedside table, but the table is not close enough to the bed for the resident to reach it. The call light was attached to the top of the bed, out of reach of the resident. -At 1:48 p.m., the resident was in the same position as previously observed. -At 2:10 p.m., no staff had been in the resident's room since she finished eating at lunch time. -At 2:37 p.m., CNA #5 entered Resident #3's room to fill the styrofoam cup with ice from the cooler and water from the bathroom sink for both the resident and her roommate. CNA #5 was interviewed at 2:44 p.m. She said the resident required two-person assistance for transfers. The CNA said the resident was incontinent of bowel and bladder and had skin issues on her bottom. The CNA said incontinence care was provided to the resident before lunch, but she could do it again until after she finished passing out the ice to the other residents. -At 3:08 p.m., CNA #5 and CNA #3 had provided incontinence care for Resident #3. The resident's brief was saturated with urine and had bowel present. CNA #5 had difficulty removing the stool, as it had dried on to the residents skin. It took approximately 10 or more wipes and multiple wipings by the CNA to clean the resident's skin. The resident had an open area to the coccyx approximately 2 c.m. (centimeter) in diameter and approximately 0.2 m.m. (millimeter) in depth. There was pink granulation tissue in the wound bed and the peri-wound was pink. The wound was caked with a pink cream on it. No drainage noted. Cross-reference F686 for failure to provide treatment and services to prevent pressure ulcers. The resident was on a regular mattress, although on her care plan documented an air mattress was supposed to be in place initiated 10/28/19. However, per the family's request the air mattress was removed 8/17/2020 (see director of nursing interview below) which put the resident at risk of redeveloping a pressure ulcer. The facility did not offer additional repositioning or more frequent incontinent care with the resident being at high risk for developing a pressure ulcer. D. Staff interviews CNA #6 was interviewed via telephone on 8/19/2020 at 4:22 p.m. She said the residents should be repositioned and/or assisted with incontinence care every two hours or as they express the need. She said if this was not done timely, the outcome could be skin breakdown, pressure ulcers, and/or a UTI (urinary tract infection). She said Resident #3 was incontinent of bowel and bladder and was not able to make her needs known. She said the resident required total care and required a hoyer lift for transfers. She said the resident's skin was assessed every time she was repositioned or was provided incontinence care. CNA #6 was not aware the resident had an open area on her buttocks. CNA #8 was interviewed via telephone on 8/19/2020 at 4:30 p.m. She said the residents should be repositioned and incontinence care provided every two hours, but it could depend if the resident used their call light to alert staff they needed assistance. She said if a resident was not repositioned timely or if incontinence care was not provided, it could result in skin breakdown to the back and bottom. She said Resident #3 was not able to use the call light because she did not understand how to use the call light. She said the resident was not able to express when she needed care, such as repositioning or incontinence care. CNA #8 said the resident was incontinent of both bowel and bladder and at times needed to be changed more frequently due to diarrhea. She said the resident currently had an open area on her bottom that reappeared and the nurses were aware of it. Licensed practical nurse (LPN) #1 was interviewed via telephone on 8/19/2020 at 5:07 p.m. He said the resident was incontinent of bowel and bladder and required total care for repositioning and incontinence care. He said the hoyer lift was used for her transfers. He said the resident had a touch call light, but was not consistent using it. He said the resident was unable to express her needs for repositioning and incontinence care. He said residents should be repositioned and provided with incontinence care every two hours; otherwise, the resident was at risk for skin breakdown. LPN #1 was notified of the continual observation from 8/18/2020 (see above), of the resident not being changed for over three, almost four hours. The resident's brief was saturated and there was dried stool on her bottom. He said this was unacceptable. The director of nursing (DON) and NHA were interviewed via telephone on 8/20/2020 at 2:57 p.m. The DON said the standard practice for repositioning was every two hours, but it depended on the resident. She said if a resident was incontinent, the resident should at least be checked and changed every two hours. She said if a resident was known to be incontinent with skin impairment, the resident should be checked and changed more frequently, less than every two hours. She said even if the resident did not have an incontinent episode, they should at least be checked every two hours. The DON said Resident #3 was incontinent of bowel and bladder and was not able

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) to make her needs known. She said the resident was totally dependent on staff and required two person assistance with all her ADL. The DON and the NHA were notified of the observation from 8/18/2020, where the resident went three, almost four hours before being assisted with repositioning or incontinence care. The resident's brief was saturated with urine and there was dried stool on her bottom. The DON acknowledged that the resident needed to be cleaned and dry, especially since she currently had a wound on her bottom. She said if the resident was not kept clean and dry, it would contribute to skin breakdown. The DON said the resident was malnourished and had poor nutritional status due to her disease progression. She said the family no longer wanted to have the air mattress as of 8/17/2020 and the resident would benefit from frequent repositioning and being on an up/down schedule, especially for meals. The DON and NHA said there was a video recording of who went in and out of the resident's room during the period of the continual observation. They said the video did not allow them to view what was being done inside the resident's room due to privacy, they were certain the resident was being checked on by staff. The DON and NHA provided a script of the recordings, indicating multiple people entering and exiting the resident's room. The timeline showed staff were not in the room long enough to provide assistance with repositioning or incontinence care. The resident required extensive two-person assistance and only one person entered the resident's room at any given time. It was not until 3:08 p.m. which was observed (see above), when CNA #5 and #3 entered the resident's room at the same time to provide incontinence care and assist with repositioning.

F 0686

Level of harm - Minimal harm or potential for 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 observations, record review, and interviews, the facility failed to provide proper assessment, interventions, and care of pressure ulcer for one (#3) of three out of eight sample residents. Specifically, Resident #3's pressure ulcer was not adequately identified and was not managed in a timely manner with assessments and proper interventions contributing to the resident experiencing recurrence of a pressure ulcer. Findings include: I. Facility policy The Prevention of Pressure Ulcer/Injuries policy, revised third quarter 2018, was provided by the nursing home administrator (NHA) on 8/21/2020 at 3:30 p.m. It read, in pertinent part Provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Evaluate the resident upon admission or existing pressure ulcer/injury risk factors. Repeat the risk evaluation as needed. Conduct a skin evaluation upon admission, including skin integrity, any evidence of existing or developing pressure ulcers. Use a screening tool to determine if a resident is at risk for under-nutrition or malnutrition. Inspect the skin routinely when performing or assisting with personal care of ADL (activities of daily living). Identify any signs of developing pressure injuries; for darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency. Inspect pressure points (sacrum, buttocks, coccyx). Wash the skin after any episodes of incontinence. Reposition resident as needed. Assist with keeping the skin clean and free of exposure to urine and fecal matter. Reposition based on the resident's mobility and skin condition. Reposition frequently as needed, based on the condition of the skin. Evaluate, report, and document potential changes in the skin. Review the interventions and strategies or effectiveness on an ongoing basis. II. Resident #3 A. Resident status Resident #3, age 91, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. -The CPO did not indicate an existing pressure ulcer as a [DIAGNOSES REDACTED]. According to the 8/1/18 admission minimum data set (MDS) assessment, the resident was admitted without the presence of a pressure ulcer, injury, wound or other skin problems. According to the 6/14/2020 MDS assessment, the resident was severely cognitively impaired due to poor short and long term memory deficits and a brief interview for mental status (BIMS) was unable to be completed. She required extensive two-person assistance for bed mobility, dressing, and toileting, total two-person assistance for transfers, and extensive one-person assistance for eating and personal hygiene. The assessment revealed the resident was frequently incontinent with seven or more episodes of urinary incontinence and was always incontinent of bowel. Additionally, the assessment documented the resident was not on a turning or repositioning program nor did the resident receive pressure ulcer care. II. Observations On 8/18/2020 at 3:08 p.m., CNA #5 and #3 were observed providing incontinence care for Resident #3. The resident's brief was saturated with the presence of bowel. CNA #5 had difficulty removing the stool, as it had dried on the resident's skin. It took approximately 10 or more wipes and multiple wipes by the CNA to clean the resident's skin. The resident had not been changed since before 11:26 a.m. which had been over three hours, cross-reference F677 ADL care for failure to provide timely incontinence care. The resident had an open area to the coccyx approximately 2cm (centimeter) in diameter and approximately 0.2 mm (millimeter) in depth. There was pink granulation tissue in the wound bed and the peri-wound was pink. The wound was caked with a pink cream. No drainage noted. The resident was on a regular mattress, although on her care plan documented an air mattress was supposed to be in place initiated 10/28/19. However, per the family's request (see skin/wound assessment on 8/19/2020) the air mattress was removed 8/17/2020 which put the resident at risk of redeveloping a pressure ulcer. The facility did not offer additional repositioning or more frequent incontinent care with the resident being at high risk for developing a pressure ulcer. III. Record review The care plan initiated on 8/2/18 and revised on 11/6/18 documented a risk for skin integrity or pressure ulcers secondary to urinary incontinence and impaired mobility. Interventions revised June 2019, July 2019, and October 2019, included air mattress added on 10/28/19, encourage and assist to change positions frequently, at least every two to three hours, keep skin clean and dry, notify PCP (primary care physician) and wound care nurse of any noted skin alteration, pressure relieving cushion for wheelchair and mattress for bed, resident was incontinent of bowel and bladder and was to be changed every two to three hours, skin checks daily with ADL care, barrier cream to butocks to prevent skin breakdown, and turn resident every two hours offloading her buttocks. A weekly skin check and wound assessment was completed on 12/31/18. There were no other assessments documented. A Braden scale completed on 1/26/19 and 6/20/19 indicated the resident was at high risk for skin breakdown with a score of 12 on each assessment. Each assessment revealed the resident was constantly moist, was chairfast, very limited in her mobility, very poor nutrition, and a potential problem with friction and shearing. -A Braden scale assessment had not been completed since 6/20/19. The 6/15/2020 physician progress notes [REDACTED]. The 7/16/2020 physician progress notes [REDACTED]. The 8/11/2020 physician bi-annual evaluation of chronic conditions documented the integumentary system was reviewed and negative for any concerns. In addition, the skin abnormality grid documented the skin was assessed and found to be dry and intact. -The evaluation did not reveal any nursing concerns related to the recurring pressure ulcer wound to Resident #3's buttocks. The August 2020 CPO revealed the following orders: -10/28/19: Nursing to ensure the air mattress was on and functioning WNL (within normal limits). Ensure proper weight setting at approximately 120 pounds (lbs) every shift. The weight setting for the air mattress was no longer valid, as the resident had a substantial weight loss from 120.6 lbs on 6/1/2020 to 109.6 lbs on 7/7/2020 and only weighed 102.8 lbs on 8/8/2020. -11/23/19: Barrier cream to buttocks/ischiums every shift and as needed. Do not cover the coccyx wound with anything other than barrier cream. The order was not updated until 8/18/2020 with right gluteal open wound, cleanse with wound cleanser, apply skin prep to peri-wound. Cover wound bed with fibercol and foam border dressing. Treat daily and as needed. Wound measurements to the right buttock reviewed from 7/20/2020 to 8/20/2020 revealed: -7/20/2020: area 0.21 cm; 0.58 x 0.46 x 0.1 -7/31/2020: area <0.1 cm; 0.34 x 0.28, 0.1 -8/5/2020: area 3.29 cm; 3.26 x 1.14 x 0.1 -8/12/2020: area 1.5 cm; 1.63 x 1.31 x 0.1 -8/18/2020: area 0.76 cm; 1.03 x 0.8 x 0.1 Skin and wound evaluation reviewed on 8/18/2020 revealed: -8/12/2020: Stage 2 facility acquired pressure ulcer to the right buttocks. The pressure ulcer was noted to have been discovered on 7/20/2020. Interventions included cushion, heel suspension, incontinence management, mattress with pump, mobility aids, nutrition/dietary supplementation. Generic wound cleanser used. Noted that the wound was healing as evidenced by measurements. The physician was updated, but not new orders were received. The resident had a Broda chair. -8/18/2020: Stage 2 facility acquired pressure ulcer to the right buttocks. The pressure ulcer was noted to have been discovered on 7/20/2020. Interventions included cushion, heel suspension, incontinence management, mattress with pump, moisture barrier, moisture control, and nutrition/dietary supplement. The wound was stable, the physician was notified and new orders were received for use of Fibercol (collagen wound dressing) and cover with a foam border dressing. Skin/wound progress notes reviewed on 8/18/2020 revealed: -7/22/2020: Late entry: IDT (interdisciplinary team) met and reviewed Resident #3. Resident has a new stage 2 pressure wound to her right buttocks. Resident has an air mattress that is on and functioning WNL. Resident is incontinent of bowel and bladder. Resident is turned frequently while in bed and check and change. IDT has no recommendations at this time. IDT will continue to monitor weekly. -8/18/2020: Late entry for 8/12/2020: IDT team met and reviewed residents wound. Wound healing. Resident has air mattress on and functioning WNL. Resident is incontinent of bowel and bladder and check and change. IDT has no recommendations at this time. IDT will continue to follow weekly. -8/19/2020: Resident's daughter said she wanted the air mattress discontinued (on 8/17/2020), as the cold air bothered the resident's [MEDICAL CONDITION] arthritis. Daughter was advised that the wound was stable at this time and would have the wound doctor assess when in the building. Risk versus benefit for not having the air mattress was explained to the daughter. Nursing spoke with the doctor, who approved the removal of the air mattress. The skin/wound progress notes did not document alternative interventions for care of the stage 2 pressure wound when the air mattress was discontinued on 8/19/2020. The facility failed to document progress notes between 7/22/2020 and 8/18/2020 with the status of the resident's right buttocks wound. The facility failed to document why the wound more than doubled in size between 7/31/2020 and 8/5/2020. Weekly head to toe skin checks reviewed on 8/19/2020 revealed: -7/20/2020: Resident with a stage 2 coccyx wound. The wound nurse and physician were notified. No new order, continue to apply barrier cream. -7/27/2020: Small open area to the coccyx, site cleaned. Barrier cream applied as ordered. -8/3/2020: Open wound on right buttocks that is healing without incident. Resident has air mattress on and functioning WNL. -8/10/2020: Resident has a small open wound to the right buttocks; cleaned and barrier cream applied. -8/17/2020: Resident has a resolving open area to the right buttocks; site cleaned, barrier cream applied. Resident repositioned frequently. IV. Staff interviews Certified nurse aide (CNA) #6 was interviewed via telephone on 8/19/2020 at 4:22 p.m. She said the resident should be repositioned and/or assisted with incontinence care every two hours. She said if the resident was not repositioned timely, it could result in skin breakdown, a pressure ulcer, or a urinary tract infection [MEDICAL CONDITION]. She said Resident #3 was incontinent of bowel and bladder and was not able to express her needs. She said the resident was total care and required a hoyer lift for transfers. She said the residents skin was assessed every time she was repositioned or incontinence care was provided. She said if there was a change in the residents skin, she would tell the nurse. She was not aware the resident had an open area on her buttocks. CNA #8 was interviewed via telephone on 8/19/2020 at 4:30 p.m. She said a resident should be repositioned and incontinence care provided every two hours, but it could also depend if the resident was able to use their call light to alert staff they needed assistance. She said a resident's skin was assessed every time care was provided. She said the CNAs looked for increased redness of the skin. She said this was done during showers and the nurse performed a weekly skin assessment. She said if repositioning and incontinence care was not done timely, it could result in skin breakdown to the back and bottom. She said Resident #3 was not able to use the call light due to her not understanding how to use the call light. She said the resident was not able to express when she needed care, such as repositioning or incontinence care. She said the resident was incontinent of both bowel and bladder and at times needed to be changed more frequently due to diarrhea. She said the resident currently had an open area on her bottom that reappeared and the nurses were aware of it. Licensed practical nurse (LPN) #1 was interviewed via telephone on 8/19/2020 at 5:07 p.m. He said residents should be repositioned and provided with incontinence care every two hours, otherwise the resident would be at risk for skin breakdown. He said Resident #3 was incontinent of bowel and bladder and required total care for repositioning and incontinence care and the hoyer lift was used for transfers. He said the resident had a touch pad call light, but she was not consistent using it. He said the resident was unable to express her needs for repositioning and incontinence care. LPN #1 was notified of the continual observation from 8/18/2020 (see above), of the resident not being changed for over three, almost four hours. The resident's brief was saturated and there was dried stool on her bottom. He said this was unacceptable. LPN #1 said the skin should be assessed weekly and documented if there were changes. If skin changes were discovered, a referral was sent to the wound nurse for an evaluation. He said there should be an assessment completed when the area to the right buttock of Resident #3 was initially discovered. Also documentation of progression and any changes that led up to the development of the current stage 2. He was unable to explain why there was a lapse in time from when the pressure ulcer to the resident's right buttocks was discovered, to the time the evaluation was completed. He said he would need to talk with the wound nurse. He said interventions included an air mattress for skin integrity. He said he was unaware the air mattress was discontinued by the family and he would expect the air mattress to remain in place until other interventions had been implemented. Wound care nurse (WCN) was interviewed via telephone on 8/19/2020 at 5:30 p.m. She said as a wound nurse, the first sign of a change in skin integrity would be increased redness with non-blanching. She said she would expect to be notified as soon as there was a change to the resident's skin. She said Resident #3 had a recurring wound to her bottom that healed and reopened She said the resident's daughter had requested that the facility stop using the air mattress, as the daughter felt the air that circulated throughout the mattress was too cold and contributed to the resident's increased discomfort due to her [MEDICAL CONDITION] arthritis. She said a referral had been sent to the wound doctor, who would be at the facility on

8/20/2020 to assess the resident. She felt this would be beneficial, especially since the resident will no longer be on an air mattress. She said the plan for wound care treatment was changed as of 8/18/2020 from barrier cream with no dressing to cleaning the wound with wound cleanser, applying skin prep, covering the wound bed with Fibercol and applying a foam border dressing. She said the treatment was to be done daily and as needed. The director of therapy (DOT) was interviewed via telephone on 8/19/2020 at 5:48 p.m. She said the facility was trialing a Broda chair to aid with positioning and prevent skin breakdown. She said the resident was previously in a high back wheelchair with a roho cushion. She said the Broda chair was designed to relieve pressure and did not require an additional cushion. The DOT confirmed that an air mattress would be best for when the resident lied down in bed, but said the daughter no longer wanted the air mattress to be used. She said alternative interventions to the air mattress would be repositioning in bed every two hours or initiating an up/down schedule, as both would limit the time the resident stayed in the same position. WCN was interviewed again via telephone on 8/20/2020 at 12:37 p.m. She said you may not necessarily see a wound go through the normal progression, such as increased redness, blanching, stage 1, and so on. She said it could depend on the resident's co-morbidities. She said Resident #3 had poor nutritional intake and was incontinent of bowel and bladder. She said she did not know about documentation leading up to the discovery of the stage 2 pressure ulcer and would have to defer this to the nurse practitioner (NP) or physician for their assessment. She was unable to explain why the wound doubled in size between 7/31/2020 and 8/5/2020. She said sometimes when the picture of the wound is taken and the wound is traced, it may be off just a little bit. The wound nurse acknowledged there was a discrepancy to say the wound increased in size was because the wound was not traced accurately. She said progress notes from dietary on 8/3/2020, documented the resident had a weight loss, that could have contributed to the increased size of the wound. She said she was unable to find documentation to account for why there was a change in the size of the wound and believed it was the resident's poor nutritional intake that was a contributing factor. She said the wound doctor had not been consulted and treatment for [REDACTED]. The director of nursing (DON) and NHA were interviewed via telephone on 8/20/2020 at 2:57 p.m. The DON said the standard practice for repositioning a resident was every two hours, but it depended on the resident. She said if a resident was incontinent, the resident should be checked at least every two hours and changed if found to be incontinent. She said if a resident was known to be incontinent with skin impairment, they should be checked and changed less than every two hours. The DON said the resident was incontinent and was not able to express her needs, she was totally dependent on staff for care and required two person assistance with all her ADL. The DON acknowledged that the resident needed to be clean and dry, especially since she currently had a wound on her bottom. She said if the resident was not kept clean and dry, it would contribute to skin breakdown. She said since the family no longer wanted to have the air mattress and the resident benefited from increased repositioning and an up/down schedule, especially at meal time.

F 0757

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure each resident's drug regimen must be free from unnecessary drugs.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on record review and interviews, the facility failed to ensure one (#2) of three residents reviewed out of eight sample residents, were not prescribed unnecessary medications. Specifically, the facility failed to: -Ensure Resident #2 was not prescribed an antibiotic without adequate indications for use; and -Adequately monitor Resident #2 during antibiotic use for the presence of adverse consequences and effectiveness. Findings include: A. Resident status Resident #2, age 72, was admitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. According to the 2/18/2020 minimum data set (MDS) assessment, the resident had severely impaired cognitive function with a brief interview for mental status (BIMS) score of five out of 15. She required extensive assistance of one staff for personal hygiene and locomotion on and off the unit, two staff for bed mobility, transfers, toileting and bathing and supervision with set up for eating. B. Family interview The resident's family member was interviewed on 8/21/2020 at 1:41 p.m. She said she called the provider on 2/27/2020 because she thought the resident had pink eye in her right eye because it was red and had gunk in it. She said she got a medication sent to the facility for the resident to start using. She said when she saw the resident again on 3/4/2020 it was cleared up. C. Record review According to the March 2020 CPO, the resident had an order for [REDACTED]. A 3/1/2020 nursing progress note revealed the resident continued on antibiotic treatment of [REDACTED]. It indicated there were no signs and symptoms of infection noted. Review of the record on 8/19/2020 revealed no documentation prior to the order for the antibiotic ointment for the indications for its use and very minimal monitoring of the

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	065405	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUITES PARKER, THE	9398 CROWN CREST BLVD PARKER, CO 80138

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 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) antibiotic after it was prescribed to indicate its effectiveness and any adverse reactions the resident may have had during the antibiotic therapy. The resident's care plan was not updated with the [DIAGNOSES REDACTED]. D. Staff interviews The staff development coordinator (SDC) was interviewed on 8/20/2020 at 1:45 p.m. She said she was also the facilities infection control nurse. She said the clinical team reviewed new orders every weekday morning to ensure any orders for antibiotics met the McGreers criteria. She said she did not know why Resident #2 was prescribed the antibiotic eye ointment when there was no indication for its use. The director of nursing (DON) was interviewed on 8/20/2020 at 2:57 p.m. She said she was not able to find documentation to indicate the use of the antibiotic ointment from either the nursing staff or the providers.
F 0770 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely, quality laboratory services/tests to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure physician ordered laboratory services were provided in a timely manner for three (#2, #3, and #4) of three residents reviewed out of eight sample residents. Specifically, the facility failed to ensure: -Laboratory tests ordered by the physician for Resident #2 and #3 were obtained and -Weekly scheduled laboratory tests for Resident #4 were obtained timely. Findings include: I. Facility policy The Lab and Diagnostic Test Results-Clinical Protocol, revised third quarter 2018, was provided by the nursing home administrator (NHA) on 8/21/2020 at 3:30 p.m. It read, in pertinent part The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. II. Resident #2 A. Resident status Resident #2, age 72, was admitted [DATE]. According to the March 2020 computerized physician orders [REDACTED]. She required extensive assistance of one staff for personal hygiene and locomotion on and off the unit, two staff for bed mobility, transfers, toileting and bathing and supervision with set up for eating. B. Record review The January 2020 CPO revealed the resident had an order for [REDACTED]. Review of the resident ' s record on 8/19/2020 revealed the first order on 1/13/2020 was never fulfilled or carried out by the staff. The resident never had a CBC and CMP done from the original order written on 1/13/2020, this prompted another order to be written as indicated above. C. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 8/19/2020 at 5:15 p.m. He said when an order for [REDACTED]. He said the laboratory came out Sunday through Thursday to draw labs. The wound care nurse (WCN) was interviewed on 8/20/2020 at 12:53 p.m. She said the nurse that took the order from the provider for labs or x-rays, should put the order into the computer, fill out the laboratory requisite then call the laboratory to come out and draw the specimen. She said the nurse managers pulled up all orders daily to ensure that any orders for labs were obtained and the results were received and communicated to the provider. The staff development coordinator (SDC) was interviewed on 8/20/2020 at 1:45 p.m. She said laboratory services were very confusing at that time due to COVID-19. She said the laboratory had refused to come out and draw labs for a while so the nurse would have to draw the labs and then have the laboratory come and pick them up but she thought the laboratory was now coming out and drawing the labs themselves now. She said labs should be collected as soon as possible after receiving the orders and if there was a delay, the physician needed to be notified. The director of nursing (DON) was interviewed on 8/20/2020 at 2:57 p.m. She said when a nurse received an order for [REDACTED]. III. Resident #3 A. Resident status Resident #3, age 91, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 6/14/2020 minimum data set (MDS) assessment, the resident was severely cognitively impaired due to poor short and long term memory deficits and a brief interview for mental status (BIMS) was unable to be completed. She required extensive two-person assistance for bed mobility, dressing, and toileting, total two-person assistance for transfers, and extensive one-person assistance for eating and personal hygiene. B. Record review Review of the June 2020 computerized physician orders [REDACTED]. However, according to the laboratory results, only the CXR and CBC were completed. Review of the June and July 2020 Medication Administration Record [REDACTED]. The nurse progress notes were reviewed on 8/20/2020 and revealed: -6/8/2020 at 1:11 a.m.: This nurse received report on this patient at 2220 (10:20 p.m.), pt (patient) had been running a temp, mild infiltrate in lungs, no new orders, no abx ordered, room cool, temp taken at 2245 (9:45 p.m.) 97.7 temperature, 62 pulse, 18 respirations, 134/79 blood pressure (bp), and 95% O2 (oxygen), pt appears comfortable and appears to be sleeping well, will continue to monitor during this night. -6/8/2020 at 2223 (10:23 p.m.).: Pt had CXR done, and COVID-19. waiting for the results. Physician updated about the CXR results. Pt on isolation r/t COVID-19 test done will the results come in. Physician ordered [MEDICATION NAME] liquid as needed for cough, no cough noted by the nurse at the moment. Pt's vitals have been stable, recorded in PCC (point click care; electronic medical record). Pt educated. Staff taking care of the pt educated about precautions to take while providing care. Pt denies pain at the moment. Call light in place and frequent monitor to pt to be done. Will continue. -6/9/2020 at 1:59 a.m.: Patient continues on isolation, has been sleeping, this nurse received report at 2300 (11:00 p.m.) on 6/8, VS (vital signs) at 2400 (12:00 p.m.): 129/54 bp, 97.5 temperature, 84 pulse, 18 respirations, 97% on O2 oxygen, will continue to monitor. -6/9/2020 at 4:00 a.m.: Temp 97.1 Fahrenheit (F) -6/11/2020 at 6:28 a.m.: Resident remained in bed the entire shift. She is monitored for COVID-19 and displayed no symptoms. She prefers to keep her covers up over her and subsequently will show temps of high 98's and low 99's. Meds (medications) were crushed and placed in apple sauce but she spat them out. She remains on droplet isolation and received frequent visual checks for safety as well as hygiene. The COVID-19 assessment dated [DATE], completed but nursing, revealed Resident #3 was positive for COVID-19, yet there was no confirmation or documentation that the testing for COVID-19 had been completed. The physician progress notes [REDACTED].#3 with COVID-19 infection as evidenced by positive swab on 6/8/2020 with associated pneumonia. Results were reported on 6/10/2020. However, again, there was no confirmation or documentation that the testing for COVID-19 had been completed by facility staff. The residents' chart failed to confirm the COVID-19 test was completed or that the facility received consent from the family, as the family previously denied testing in May 2020. Even though there were new orders dated 6/7/2020 for a stat CXR, CBC, [MEDICAL CONDITION] panel, and COVID-19, there was no further documentation after 6/11/2020 related to the [DIAGNOSES REDACTED]. The residents chart failed to provide documentation to clarify or provide an explanation of why the [MEDICAL CONDITION] panel and COVID-19 which were part of the stat labs ordered on [DATE] were not completed. C. Staff interview The director of nursing (DON) and NHA were interviewed via telephone on 8/20/2020 at 2:57 p.m. The DON said when the national guard was at the facility on 5/12/2020 performing COVID testing, the family did not consent to the testing for Resident #3. -The DON and NHA were unable to provide an explanation, documentation of family refusal, and/or lab results as to why the stat testing was not completed related to the order dated 6/7/2020. IV. Resident #4 A. Resident status Resident #4 was initially admitted to the facility on [DATE] and was readmitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score of 14 out of 15. He required extensive assistance with activities of daily living (ADLS). B. Record review A physician order [REDACTED]. The residents Lab(laboratory) Results Report dated 5/21/2020 revealed that the resident's CBC labs were collected on 5/21/2020 and reported on 5/22/2020. The laboratory sample was collected six days later than the date specified on the order (see above). C. Staff interviews The director of nursing (DON) was interviewed 8/20/2020 at 2:57 p.m. She said that laboratory tests are reviewed daily. She said that when laboratory results came back they would be entered in the electronic medical record and would be flagged as critical if there were abnormal results. She said that the facility had difficulties with their laboratory services provider in the last several months which caused delays in labs being collected.
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have a physician's order prior to laboratory services being obtained for one (#2) out of three resident's reviewed out of eight sample residents. Specifically, the facility failed to ensure staff had a documented physician order prior to obtaining laboratory services for Resident #2. Findings include: I. Resident status Resident #2, age 72, was admitted [DATE]. According to the March 2020 computerized physician orders (CPO), [DIAGNOSES REDACTED]. She required extensive assistance of one staff for personal hygiene and locomotion on and off the unit, two staff for bed mobility, transfers, toileting and bathing and supervision with set up for eating. II. Record

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F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) review A 3/13/2020 nursing progress note revealed the resident exhibited a low grade fever and productive cough with crackles heard on the base of bilateral lungs. The provider was notified and ordered STAT (immediately) chest x-ray, CBC (complete blood count), influenza panel and RSV (respiratory [MEDICAL CONDITION]). Review of the record on 8/19/2020 revealed lab and radiology result reports in the resident's record however no physician order was found in the resident's record for the STAT chest x-ray, CBC, influenza panel or RSV. III. Interviews Licensed practical nurse (LPN) #1 was interviewed on 8/19/2020 at 5:15 p.m. He said a physician order was required to obtain an x-ray or laboratory tests. He said when the order was received from the physician, either verbally or via telephone, the nurse taking the order should enter it into the computer right away, then call the laboratory to come out and draw it. The wound care nurse (WCN) was interviewed on 8/20/2020 at 12:53 p.m. She said physician order was required to obtain any tests such as x-rays or laboratory tests. The director of nursing (DON) was interviewed on 8/20/2020 at 2:57 p.m. She said whenever a nurse received an order for [REDACTED]. She was not able to locate a physician order in the resident's record for the chest x-ray or labs that were obtained in March 2020.
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 observation and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of Coronavirus disease (COVID-19) and infection. Specifically the facility failed to ensure: -Social distancing amongst residents; -Residents wore face coverings when outside of their rooms or were encouraged; -Resident #7 who attended [MEDICAL TREATMENT] wore a mask when outside of their room; and, -Screening which included a recorded temperature was completed for all visitors prior to entering the facility. Findings include: I. Improper resident social distancing A. Professional standards The Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last updated 4/15/2020, accessed on 8/25/2020 retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-strategies.html included the guidance that long term care facilities ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Additional measures included that facilities should cancel communal dining and all group activities. Residents should be reminded to practice social distancing. According to the CDC guidance Infection Prevention and Control (IPC) Guidance for Memory Care Units, last updated 5/12/2020, retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html Limit the number of residents or space residents at least six feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel. B. Facility policy and procedure The Covid-19 Pandemic Plan, undated, was provided by the director of nursing (DON) on 8/20/2020 at approximately 11:00 a.m. The plan read in pertinent part, Additional measures such as social distancing, elimination/modification of communal dining and group activities as well as visitor restrictions are implemented. For residents who attend routine medical procedures like [MEDICAL TREATMENT]; these residents must wear a mask any time of the room. C. Resident #7's status Resident #7 was admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/11/2020 minimum data set (MDS) assessment did not have a completed brief interview for mental status score (BIMS). He required supervision with eating and extensive assistance with other activities of daily living. The 5/22/2020 MDS revealed that the resident had a BIMS score of five out of 15 which indicated a severe cognitive impairment. According to the resident's care plan, last updated 3/10/2020, the resident attended [MEDICAL TREATMENT] outside of the building every Tuesday, Thursday and Saturday. D. Observations and staff interviews 8/18/2020 of the second floor dining room on the memory care unit: -At 11:42 a.m. there were eight breakfast trays sitting on a cart just outside the dining room, near the elevator. Breakfast on the unit was scheduled to be served between 7:30 a.m. to 8:00 a.m. Lunch on the unit was scheduled to be served between 12:00 p.m. to 12:30 p.m. -At 12:05 p.m. two female residents were seated across from each other at a small table together approximately three feet apart. Another female resident approached them in a wheelchair to join the table and situated herself approximately two feet from the table. The residents were not eating at this time. Two of the female residents were not wearing masks and one of the residents had her mask pulled down below her chin. At another table two female residents were seated next to each other approximately two feet apart. One of the residents was not wearing a mask while the other resident her her mask pulled down below her chin. When asked, one of the female residents said that that was their preferred table to dine and said we always sit here. -At 12:23 the wound care nurse (WCN) who was working as unit manager that day was interviewed in the dining room. She said that the residents in the dining room preferred to eat outside of their rooms. She gestured to two female residents that were sitting at a table together and said, these two ladies should be farther apart, however, she did not redirect the residents and walked out of the dining room. -At 12:33 p.m. there were eight residents in the dining room who were seated at four different tables: three female residents sat at a table together, two tables each had two female residents and another male resident sat by himself at another table. The residents who were seated at tables together were all less than six feet apart. None of the residents wore masks while not eating. -At 12:42 p.m. there were 12 residents seated in two dining areas on the second floor. Six out of the 12 residents were seated together at tables less than six feet away from each other. During observations of the dining room from 12:05 p.m. until 12:50 p.m., no staff were observed to redirect residents to maintain a social distance of six feet from one another, nor were residents prompted or encouraged to put on masks. 8/19/2020 observations of the second floor dining room on the memory care unit: -At 12:03 p.m., 11 residents were observed sitting in the 2nd floor dining area. Residents were seated with two or three people at a table and were all less than six feet apart from one another. The residents were either not wearing their masks or had their masks pulled down below their chins. None of the residents wore a mask that was properly positioned to provide the intended protection. No residents were eating at this time. -At 12:05 CNA #1 was interviewed in the dining room. She said that the residents seated in the dining room would eat there because they required additional supervision either due to falls or for behaviors. -At 12:16 p.m. RN #1, who was acting as the unit manager, was interviewed. She said that residents were encouraged by staff to eat in their rooms but that the residents in the dining area at that time had dementia and prefered to eat in the dining area. She said that staff tried to encourage residents to socially distance and to wear masks. At 12:20 p.m. RN #1 was observed to ask a resident whether she was hungry and then directed the resident to a seat at a table that was next to another resident already eating. She did not offer the resident a room tray or try to encourage her to distance from other residents. 12:30 p.m. Resident #7 was seated at a table with two other residents, less than six feet apart. Resident #7 was not observed to wear a mask throughout the time he was present in the common areas. During observations of the second floor dining room from 12:00 to 12:35 p.m., no staff were observed to redirect residents to maintain social distancing, nor were residents prompted to wear masks. E. Additional staff interviews The SDC was interviewed on 8/20/2020 at 1:47 p.m. She said that the facility tried to encourage residents to eat in their room and to maintain six feet apart from each other, but that they had had difficulty redirecting residents. She said that nursing staff were directed to provide ongoing education to the residents but that the facility did not document when education was provided to residents. She said the facility tried to keep the units clean and restrict residents to their units as much as possible. She said that signs were posted in the units to alert the residents that there was no communal dining or activities at that time. She said it was not the facility policy to allow for three residents to be seated at a table together, however, it was included on specific residents ' care plans if they had difficulty understanding social distancing or the need for wearing a mask. The DON and nursing home administrator (NHA) were interviewed on 8/20/2020 at 2:57 p.m. The DON said that the staff were instructed to encourage the residents to wear masks frequently and gently redirect residents who were not socially distancing. She said it was difficult for the residents on the second floor unit to understand or follow the precautions due to dementia or cognitive impairments. She said that the facility had tried to rearrange the tables in the second floor dining room but that the residents would move to sit together. She said that Resident #7 was tested weekly for COVID-19 as part of the facility's protocol for residents who attended [MEDICAL TREATMENT]. She said that due to the resident's cognitive impairment, it was difficult for him to understand the need to dine in his room or to wear a mask when outside of his room. II. Improper screening A. Professional standards Centers for Medicare and Medicaid Services (CMS) (4/2/2020) COVID-19 Long-Term Care Facility Guidance. Accessed on 8/25/2020 Retrieved from: https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf. It read in pertinent part, Long-term care facilities should immediately implement symptom screening for all. Facilities should limit access points and ensure that all accessible entrances have a screening station. All long-term care facility personnel should wear a facemask while they are in the facility. According to the CDC guidelines updated 4/15/2020, accessed on 8/25/2020 retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, included the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065405	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUITES PARKER, THE	**9398 CROWN CREST BLVD PARKER, CO 80138**

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) following recommendations: -Actively screen everyone for fever and symptoms of COVID-19 before they enter the healthcare facility. A. Record review Visitor and staff screening sheets were reviewed from 8/18/2020 and 8/19/2020 revealed that out of the 45 visitor screenings completed, six of them had no recorded temperature. B. Staff interviews The front desk receptionist (FDR) was interviewed on 8/20/2020 at 1:28 p.m. She said she had received education on how to complete the screening of visitors in accordance with CDC guidelines. She said visitors were asked the questions from the facility's screening questionnaire. She said she would take the temperature of each visitor and record their temperature on the top of the questionnaire. She said if the visitor had a fever or answered on the questionnaire that they had symptoms of COVID-19, she would not allow for them to enter the facility or have visitation with a resident. The SDC was interviewed on 8/20/2020 at 1:47 p.m. She said visitor screening questionnaires should be completed for every visitor prior to entering the building beyond the screening area or seeing a resident for outdoor visitation. She said each visitor should have their temperature checked and recorded on their visitor screening questionnaire. She said that the questionnaires that did not have temperatures recorded on them were not completed in accordance with the facility's screening protocol. She said additional education of staff would be done to ensure temperatures were recorded for each visitor. The DON was interviewed on 8/20/2020 at 2:57 p.m. She said that all staff and visitors should be screened and their temperatures taken and recorded. She said that she would reeducate staff who complete the screenings of visitors.