STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY HEIGHTS REHAB AND CARE COMMUNITY	656 DILLON WY AURORA, CO 80011

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 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to treat one Resident (#16) of three residents out of 27 sample residents with dignity and respect. Specifically the facility failed to ensure personal medical information for Resident #16 was not overheard by others. Resident #16's privacy was not maintained. I. Resident #16's status Resident #16, age 57, was admitted on [DATE]. According to the September 2020 CPO, [DIAGNOSES REDACTED]. The 8/28/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a BIMS score of 13 out of 15. The resident required extensive assistance of two people with her ADLs. II. Observations The medical records / transportation person (MR/TP) was observed on 9/17/2020 at 10:35 a.m. to speak very loud across the day room to Resident #16. There was an activity being held with five residents in the same room, and while the MR/TP spoke loudly across the room to Resident #16, the activity had to stop because of the noise from the conversation. The MR/TP told Resident #16 what day her appointment was and it was a telehealth appointment. He said he took a picture of her body part to send to the specialist at the physician's office prior to the telehealth appointment. He failed to keep Resident #16's medical information private. III. Record review The cognition care plan for Resident #16 revised on 11/13/2017 read in pertinent part; Resident had a potential for cognitive deficit related to [MEDICAL CONDITION] attack [MEDICAL CONDITION] and borderline personality disorder. She was alert and oriented to self, place, and time. The goal was to allow adequate time to respond, repeat communication as necessary, do not rush her to communicate, and request clarification from Resident #16 to ensure her understanding. Face the resident when speaking to her and make eye contact. Turn off the television and radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues and use alternative communication tools as needed. The resident understands consistent, simple and directive sentences. Provide the resident with cues and stop if the resident was agitated. IV. Resident and staff interview Resident #16 was interviewed on 9/17/2020 at 11:04 a.m. She said it upset her and made her mad when the MR/TP yelled her private information across the room in front of other residents. She said it was not anyone else's business, just like their personal information was none of her business. Activities assistant (AA) was interviewed on 9/17/2020 at 1:30 p.m. She said she talked to the residents in private when discussing anything about their care and activities. She said she did have to stop the activity earlier today because the conversation with Resident #16 and the MD/TP was too loud for her to continue with the other residents.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to respond to grievances for two (#1 and #16) of three out of 27 sample residents. Specifically, the facility failed to follow-up with Resident #1 and #16 regarding their grievances. Findings include: I. Facility policy and procedure The Grievances policy, updated 10/10/19, was received from the corporate consultant (CC) on 9/18/2020 at 9:57 a.m. It read in pertinent part, To provide residents and responsible party with information on the facility grievance procedure. To ensure that residents are afforded their right to file a grievance without discrimination or reprisal and that such grievance shall be responded promptly and in written form. II. Resident #1 A. Resident status Resident #1, age 59, was admitted [DATE], discharged to the hospital on [DATE], and readmitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 9/7/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision with set up or one-person assistance for all activities of daily living (ADL)s, including bed mobility, transfers, locomotion on and off the unit, dressing and eating. She required limited assistance of one person for toileting and bathing. B. Resident interview Resident #1 was interviewed on 9/1/2020 at 10:32 a.m. She said she had filed multiple grievances about multiple incidents. She said she filed grievances about a maintenance person giving her attitude, the administrator, staff members and missing appointments. She said she had the direct numbers for the nursing home administrator (NHA), the director of nursing (DON), and the corporate consultant (CC). She said she text messaged management about three different incidents with homeless men outside her window, residents calling her names and chasing her away from the outside patio area. She said the nursing home administrator (NHA) had begun meeting with her weekly on Tuesday or Thursday. She said they had been meeting weekly for a month. She said she felt she was heard in these meetings but had not seen any follow-up to her filed grievances. C. Record review The resident's grievances were provided by the NHA on 9/18/2020 at 9:30 a.m. - The grievance filed on 6/21/2020 described when the maintenance staff came into her room to fix her sink which was draining slowly. She claimed the sink was not unclogged despite multiple visits from maintenance staff. She claims the maintenance staff raised his voice to her and called her crazy. The follow-up from the facility had no date, documented sink drain cap removed and the sink drains. -There was no information included on the follow-up documenting if the resident concern was resolved, any further action taken by the facility, reviewed by the NHA, or any recommendations for the resident. The NHA did not sign and date the grievance form. - The grievance filed on 6/25/2020 documented the concern was reported to the corporate consultant. The grievance concerned the facility transportation company not being careful during transport and her missing or arriving late to appointments. The facility documented the follow-up and the resident signed the grievance and accepted the solution. -The NHA signed the grievance but did not date it. - The grievance filed 7/12/2020 documented complaints regarding the NHA not having [MEDICATION NAME] or caring about the facility. -There was no follow-up or resolution from the facility documented on the grievance form and the NHA or resident did not sign the grievance as resolved. - A second grievance was filed on 7/12/2020. It documented that some of the floor staff were nosey and never stayed out of people's business and were always gossiping with each other. -There was no follow-up or resolution from the facility documented on the grievance form and the NHA or resident did not sign the grievance as resolved. - An undated grievance was filed concerning how her friend was treated when dropping something off for her. The resident claimed the receptionist at the front was rude to her friend who dropped off a drink for her. The staff could not find her and when she got her drink it was melted. -There was no follow-up or resolution from the facility documented on the grievance form and the NHA or resident did not sign the grievance as resolved. There was no documentation of the grievances or follow-up from the incidents with the homeless men outside her window, the male resident calling her names, or being chased away from the outside patio area. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 9/17/2020 at 5:20 p.m. She said when a resident had a complaint, the facility had pink grievance forms and the staff helped fill them out if a resident needed it. She said if the nursing staff could address the grievance

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

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) before it went to management it would be addressed, documented, and turned into management for any additional follow-up. She said Resident #1 complained a lot and it was a part of her behavior. She said she provided the resident with the grievance forms and passed them onto management when they were completed by the resident and turned into her. The NHA was interviewed on 9/17/2020 at 11:39 a.m. He said he or a member of management had been meeting with Resident #1 weekly for several weeks. He said the meetings were for the resident to express her concerns to management and to build rapport with the resident. He said he had not been taking notes during his meetings with her. The NHA and CC were interviewed on 9/17/2020 at 12:00 p.m. The NHA said he had received multiple emails from the resident and several more forwarded to him from the owner of the facility. He said that after the homeless incidents occurred the resident was offered a different room at the front of the building or by the courtyard, as her room was currently at the back of the building in the alleyway. He said she declined as she did not feel like that would solve the problem. He said management offered to help her find another facility and she continually goes back and forth on the issue. He said the facility was working with the city agencies on the homeless problem around the building but the process was slow-moving. He said the most recent issue with the homeless man at her window happened several weeks earlier. He said the incident was addressed by removing the old beds they had put in the alley-way and installing a motion-activated floodlight on the corner of the building next to her window. He said these interventions had been working. He said a local police officer had also been making weekly rounds to the facility to check the property. He said he addressed the issue of the male resident calling her names and being chased out of the patio area. He said when he went to talk with the male resident he did not recall the incident and did not know who to talk to about her being chased off the patio because she did not give the names and descriptions of the residents who had called her names. He said she used to spend most of her time outside in the sun and since COVID-19 she had not been able to go outside. He said a solution was reached and that she could go outside and use the chapel patio. The CC said Resident #1 had contacted her with several complaints. She said she had been establishing a rapport with the resident, who seemed comfortable talking to her. She said the facility had been working with her to feel empowered and in control of some aspects of her life inside the facility. She said the resident had made allegations to feel in control during a time when her choices seemed out of her control. She said her allegations were taken seriously and addressed. She said the goal of the weekly meeting with the resident was to establish rapport and give the resident an opportunity to voice her concerns and complaints. She said concerns should be reported outside of the meeting times as well. She said documentation should accompany the complaints. The DON and CC were interviewed on 9/18/2020 at 4:55 p.m. They said grievances should be addressed within three days of receiving them. They said sometimes the grievance could take more than three days to address and solve. They said in this case, the resident is kept up to date on the steps taken by the facility to assist with their concern. They said if the resident was not satisfied with the outcome the CC would handle it from there and speak with the resident. The CC will explore other options with the resident that had not been attempted by the facility. They said all follow-up and resolutions for grievances should be documented. The CC said the NHA should have documented all actions and meetings taken to address grievances. III. Resident #16 A. Resident status Resident #16, age 59, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 8/28/2020 MDS assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive assistance of two staff with her activities of daily living (ADLs). B. Resident interview Resident #16 was interviewed on 9/15/2020 at 11:25 a.m. She said she has had several problems related to the social services department lately (cross-reference F745 for provision of social services). She said her reading glasses were stolen last month. She said she told the social worker but that person got fired and the facility did not have a social worker at this time. She said the nursing home administrator (NHA) told her they would have a new social worker in a couple of weeks. She said, It's been a couple of weeks, and we still don't have anyone. C. Record review Grievances filed by the resident or on behalf of the resident were requested from the facility on 9/17/2020. The facility reported they had no grievances from the resident. The facility had no report of the resident reporting her stolen reading glasses. D. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 9/16/2020 at 2:42 p.m. She said Resident #16 had told the social service director that was here before that her reading glasses were missing but that person was no longer here so she did not know if the other managers had done anything about it or not. The director of nursing (DON) and corporate consultant (CC) were interviewed on 9/18/2020 at 4:18 p.m. The DON said she was not aware Resident #16's reading glasses were missing but would get them replaced right away.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to keep residents safe from abuse for two (#7 and #24) of three residents out of the 27 sample residents. Specifically, the facility failed to prevent resident-to-resident abuse perpetrated by Resident #24. Findings include: I. Facility policy and procedure The Abuse policy, revised 11/15/19, was received from the corporate consultant (CC) on 9/18/2020 at 9:57 a.m. It read in pertinent part, The facility does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, and staff of other agencies serving the resident, family members, legal guardians, resident representative, sponsors, friends, or any other individuals. Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. II. Resident #7 A. Resident status Resident #7, aged 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 9/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental score (BIMS) of zero of 15. The resident required extensive two-person physical assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. The resident displayed behavioral symptoms not directed towards others (screaming/yelling out, disruptive sounds) daily and rejected care one to three days during the lookback period. B. Care plan The updated care plan dated 6/25/2020 documented the resident had behavior challenges related to dementia. She could become easily agitated due to overstimulation in a group environment and begin yelling and being disruptive to others. Interventions included going outside for short walks (12/8/19), offer favorite snacks or beverages (12/8/19), anticipate the resident ' s needs (11/27/19), provide opportunities for positive interactions (6/25/2020), and minimize her potential for disruptive behaviors such as yelling, by monitoring for signs that the resident was overstimulated by noise, light, activity, and offer to move her to an area with less stimulation (11/27/2020). III. Resident #24 A. Resident status Resident #24, aged 87, was admitted to the facility on [DATE] and readmitted on [DATE]. The September 2020 CPO revealed a [DIAGNOSES REDACTED]. The 8/16/2020 MDS revealed the resident had moderate cognitive impairment with a BIMS of 11 of 15. The resident displayed no behaviors during the lookback period. B. Care plan The revised care plan updated 1/30/2020 revealed the resident had behavioral challenges related to his cognitive status, which led him to make false allegations against other residents. Interventions included behavior monitoring (2/3/2020), walks outside (9/19/19), utilized social service team members who have good rapport (9/19/19), watch old war films (9/19/19), talk with him about sports (9/19/19), anticipate needs (9/19/19), assist the resident to develop more coping strategies (5/5/2020), provide positive interaction (9/19/19), encourage the resident to express his feelings (9/19/19), monitor behavior episodes and attempt to determine the cause (9/19/19), and when behaviors occur intervene as necessary to protect the rights of other residents (9/19/19). IV. Altercation 6/15/2020 A 6/15/2020 nursing note documented resident-to-resident abuse occurred at 12:32 p.m. Documentation revealed Resident #7 was sitting at the common area at the north station watching television and yelling to herself, using a lot of profanities, when Resident #24 got up and poured a cup of water on her. No physical contact was seen. No injuries noted. V. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 9/18/2020 at 9:55 a.m. She said she received abuse training a week ago that covered what constitutes abuse and who to report it to. She said if she witnessed abuse she separated the residents involved and made sure they were safe. She said she reported abuse to the director of nursing (DON) or the administrator. She said she witnessed the incident between Resident #7 and #24. She said Resident #7 was yelling and cursing in the common area in front of the television and Resident #24 poured a glass of water on her to get her to be quiet. She said she told management about the incident and followed their instructions (cross-reference F609 for failure to report abuse and F610 for failure to investigate abuse). Resident #24 went back to his room after pouring water on Resident #7 so they were separated. She said she moved Resident #7 to a quieter area and gave her some picture

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) books. She said Resident #24 came up to her after the incident with Resident #7 and apologized for pouring water on her. She said he said he hoped the nursing staff was not mad at him for pouring water on her, he just wanted her to be quiet. The director of nursing (DON) was interviewed on 9/18/2020 at 4:55 p.m. She said in the event of resident to resident abuse the residents should be separated for safety, then assessed for injuries. She said she was not aware that the incident between Resident #7 and Resident #24 was considered abuse. She said when she read the initial progress note it did not seem like abuse and was not investigated.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to report alleged abuse for two (#7 and #24) of three residents out of the 27 sample residents. Specifically, the facility failed to report resident to resident abuse between Resident #7 and Resident #24 to the State Agency (SA) timely. Findings include: I. Facility policy and procedure The Abuse policy, revised 11/15/19, was received from the corporate consultant (CC) on 9/18/2020 at 9:57 a.m. It read in pertinent part, The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. All employees of this facility must immediately report any suspected, observed or reported incident of resident neglect, abuse, or misappropriation of resident property, whether by staff members, family members, or any other persons to the facility Administrator. II. Resident #7 Resident #7, aged 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 9/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental score (BIMS) of zero of 15. The resident required extensive two-person physical assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. The resident displayed behavioral symptoms not directed towards others (screaming/yelling out, disruptive sounds) daily and rejected care one to three days during the lookback period. III. Resident #24 Resident #24, aged 87, was admitted to the facility on [DATE] and readmitted on [DATE]. The September 2020 CPO revealed a [DIAGNOSES REDACTED]. The 8/16/2020 MDS revealed the resident had moderate cognitive impairment with a BIMS of 11 of 15. The resident displayed no behaviors during the lookback period. IV. Altercation 6/15/2020 A 6/15/2020 nursing note documented resident-to-resident abuse occurred at 12:32 p.m. Documentation revealed Resident #7 was sitting at the common area at the north station watching television and yelling to herself using a lot of profanities when Resident #24 got up and poured a cup of water on her. No physical contact was seen. No injuries noted. Cross-reference F600 for resident-to-resident abuse. The abuse investigation was received from the nursing home administrator (NHA) on 9/18/2020 at 9:30 a.m. It documented the incident occurred on 6/15/2020 but the facility was informed of the incident on 9/16/2020 (during the survey). -However, interviews revealed that management was notified at the time of the incident. The investigation documented that the NHA reported the incident to the state agency (SA) on 9/17/2020 at 5:05 a.m., which was not timely. V. Staff Interviews Licensed practical nurse (LPN) #4 was interviewed on 9/18/2020 at 9:55 a.m. She said she received abuse training a week ago that covered what constituted abuse and who to report it to. She said if she witnessed abuse she separated the residents involved and made sure they were safe. She said she reported abuse to the director of nursing (DON) or the administrator. She said she witnessed the incident between Resident #7 and #24. She said Resident #24 came up to her after the incident with Resident #7 and apologized for pouring water on her. She said he said he hoped the nursing staff was not mad at him for pouring water on her, he just wanted her to be quiet. She said she told management about the incident and followed their instructions. LPN #1 was interviewed on 9/18/2020 at 2:37 p.m. She said she received an abuse training in-service within the last two weeks. The training covered when reporting needed to be done, who to report to, and what constituted abuse. She said all abuse allegations were reported to management. The director of nursing (DON) was interviewed on 9/18/2020 at 4:55 p.m. She said in the event of resident to resident abuse the residents should be separated for safety, then assessed for injuries. She said she was not aware that the incident between Resident #7 and Resident #24 was considered abuse. She said when she read the initial progress note it did not seem like abuse and was not investigated (cross-reference F610 for failure to investigate abuse).
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to investigate an allegation of abuse for two (#7 and #24) of three residents out of the 27 sample residents. Specifically, the facility failed to thoroughly investigate an incident of resident-to-resident abuse that occurred between Resident #7 and Resident #24. Findings include: I. Facility policy and procedure The Abuse policy, revised 11/15/19, was received from the corporate consultant (CC) on 9/18/2020 at 9:57 a.m. It read in pertinent part, In addition to an investigation by the Police Department, the facility conducts an internal investigation. That investigation includes interviewing any staff members, residents, or family members who may have knowledge of the incident. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. II. Resident #7 Resident #7, aged 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 9/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental score (BIMS) of zero of 15. The resident required extensive two-person physical assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. The resident displayed behavioral symptoms not directed towards others (screaming/yelling out, disruptive sounds) daily and rejected care one to three days during the lookback period. III. Resident #24 Resident #24, aged 87, was admitted to the facility on [DATE] and readmitted on [DATE]. The September 2020 CPO revealed a [DIAGNOSES REDACTED]. The 8/16/2020 MDS revealed the resident had moderate cognitive impairment with a BIMS of 11 of 15. The resident displayed no behaviors during the lookback period. IV. Record review A 6/15/2020 nursing note documented resident-to-resident abuse at occurred at 12:32 p.m. Documentation revealed Resident #7 was sitting at the common area at the north station watching television and yelling to herself using a lot of profanities when Resident #24 got up and poured a cup of water on her. No physical contact was seen. No injuries noted. Cross-reference F600 for resident-to-resident abuse. The abuse investigation was received from the nursing home administrator (NHA) on 9/18/2020 at 9:30 a.m. It documented the incident occurred on 6/15/2020 but the facility was informed of the incident on 9/16/2020 (during survey). However, interviews revealed that management was notified at the time of the incident (see below). The report documented that physical abuse did occur between Resident #24 and Resident #7. The facility did not substantiate the abuse as no intent, injury, or fear was reported from either resident. -However, Resident #7 did report fear to the assistant director of nursing (ADON) when interviewed on 9/16/2020 (see below). The facility follow-up to prevent further abuse documented that Resident #7 had been accepted to another facility and was awaiting transfer and that her pain medications were being adjusted to address possible back pain. The nurse practitioner was notified by the licensed practical nurse who witnessed the incident on 6/15/2020. The family was notified by the nurse practitioner on 6/15/2020. Resident #7 was interviewed by the assistant director of nursing (ADON) on 9/16/2020 at 5:52 p.m. The resident remembered the water being poured onto her head. The resident reported not feeling safe to the ADON and asked to be taken from the facility. The resident was cursing in between statements during the interview. -No follow-up was documented about the resident's statements of fear or wanting to leave the facility in the investigation. Resident #24 was interviewed by the ADON on 9/16/2020 at 5:48 p.m. He did not recall the incident. The LPN who witnessed the incident was interviewed by the NHA on 9/17/2020 at 5:00 a.m. She said Resident #7 was hollering in the north television room and Resident #24 walked behind Resident #7 poured his cup of water on her. Resident #24 then went to his room. The investigation did not mention that the LPN had reported the incident to the management. Six additional residents were interviewed, after being identified during the survey, and they did not report fear, witnessing abuse, or witnessing mistreatment of [REDACTED]. III. Staff interviews Licensed practical nurse (LPN) #4 was interviewed on 9/18/2020 at 9:55 a.m. She said she received abuse training

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) a week ago that covered what constituted abuse and who to report it to. She said if she witnessed abuse she separated the residents involved and made sure they were safe. She said she reported abuse to the director of nursing (DON) or the administrator. She said she witnessed the incident between Resident #7 and #24. She said Resident #24 came up to her after the incident with Resident #7 and apologized for pouring water on her. She said he said he hoped the nursing staff was not mad at him for pouring water on her, he just wanted her to be quiet. She said she told management about the incident and followed their instructions and she was not told to start an investigation over the incident that occurred between Resident #24 and Resident #7. The director of nursing (DON) was interviewed on 9/18/2020 at 4:55 p.m. She said she was not aware that the incident between Resident #7 and Resident #24 was considered abuse. She said when she read the initial progress note it did not seem like abuse and was not investigated (cross-reference F609 failure to report abuse).
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 resident interview, record review and staff interviews, the facility failed to honor the resident's right to participate in the development and implementation of the person centered care plan for three (#16, #7 and #1) residents out of four reviewed out of the 27 sample residents. Specifically, the facility failed to: -Hold routine care conferences to allow Resident #16, #1 and #7 to participate in the development and implementation of the plan of care; and, -Update Resident #1's care plan with newly amputated fingers. Findings include: I. Resident #16 A. Resident status Resident #16, age 59, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 8/28/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive assistance of two staff with her activities of daily living (ADLs). B. Resident interview Resident #16 was interviewed on 9/15/2020 at 11:25 a.m. She said she could not even remember the last time she had a care conference at the facility. C. Record review Review of the record on 9/16/2020 revealed the resident's last care conference was 12/19/19 and the last social service progress note was dated 3/26/19. II. Resident #1 A. Resident status Resident #1, age 59, was admitted [DATE], discharged to the hospital on [DATE] and readmitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 9/7/2020 minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision with set up or one person assistance for all activities of daily living (ADL)s, including bed mobility, transfers, locomotion on and off the unit, dressing and eating. She required limited assistance of one person for toileting and bathing. The resident was at risk for developing pressure ulcers and currently had surgical wounds and was receiving surgical wound care. B. Record review 1. Amputated finger A 5/15/2020 nursing progress note revealed the resident was readmitted back to the facility with a left hand second finger amputation with the dressing intact. The May 2020 CPO revealed the resident had order for wound care to the left hand 2nd finger: cleanse with wound cleanser, pat dry, apply one layer of zero-form and wrap with kerlix gauze daily until seen by the wound team, ordered 5/15/2020. A 5/22/2020 physician progress notes [REDACTED]. It indicated the resident had sutures that were to be removed by the surgeon at her appointment. The residents care plan was not updated to include the newly amputated left 2nd finger or the surgical incision. A 7/9/2020 nursing progress note revealed the resident returned from an appointment where she had the end of her fourth left finger amputated and daily dressing was required to the surgical site starting 7/14/2020. According to the July 2020 CPOs, a new order was received for wound care to the fourth left digit to start on 7/14/2020 that included soaking the wound in 90% saline and 10% peroxide daily then covering it with a dry dressing, the previous wound order to apply honey with alginate and wrap with gauze was not discontinued until 7/14/2020. The resident's care plan was not updated to include the newly amputated end of the resident's left 4th finger. 2. Care conference A review of the record on 9/17/2020 revealed the resident's last care conference was 1/16/2020 and the last social service progress note was dated 7/23/2020. III. Resident #7 A. Resident status Resident #7, age 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 1/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment and a brief interview for mental status of zero of 15. The resident required extensive two-person assistance with bed mobility and transfers. The resident displayed screaming and disruptive sounds every day of the lookback period and rejected care 1 to 3 days of the lookback period. B. Record Review A review of the record on 9/17/2020 revealed the resident's last care conference was 11/19/19 and the last social service progress note was dated 9/15/2020. IV. Staff interviews The director of nursing (DON) and corporate consultant (CC) were interviewed on 9/18/2020 at 4:55 p.m The DON said care conferences should be held 72 hours after admission, quarterly, with a change of condition, prior to discharge and as needed. She said depending on what topic was being discussed during the meeting would determine what staff members were present for the meeting. The CC said care conferences should be held quarterly with the resident and the resident's representative to go over the care plan and make changes if necessary. The CC said the social service director had been gone since 8/27/2020 and they were bringing a person from a sister facility full time for the position starting next week on Wednesday. She said the NHA has been handling all the social service needs in the facility in the meantime along with support from social workers from three other sister buildings coming in to assist. Both the DON and the CC agreed that Resident #1's care plan needed to be updated each time the resident presented with a new skin issue.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to provide care that met professional standards for three (#9, #17 and #2) of five of the 27 sample residents. Specifically, the facility failed to: -Treat the resident timely after a fall that resulted in injury with a delay of care for Resident #9; -Have qualified staff conduct nursing assessments after Resident #9 and Resident #17 fell ; and, -Schedule Resident #2 medications appropriately. Findings include: I. Failure to treat the resident timely after a fall resulting in injury A. Facility policy and procedure The policy Fall Documentation, [DATE], was received from the director of nursing (DON) on [DATE] at 2:10 p.m. It read in pertinent part, To have complete, accurate, and timely documentation for residents who have sustained a fall and/or preventive measures taken to prevent a fall. II. Resident #9 A. Resident status Resident #9, age 87, was admitted to the facility on [DATE]. She expired at the facility on [DATE]. The [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of eight out of 15. The resident required extensive one-person physical assistance with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. The resident was not steady and required staff assistance during transfers and locomotion. B. Record review The updated care plan, [DATE], documented the resident was at risk for falls related to gait/balance problems, history of falls, incontinence, and psychoactive drug use. Documented interventions included anticipate the needs of the resident ([DATE]), call light within reach and prompt use ([DATE]), hospice collaboration ([DATE]), non-slip cushion in her wheelchair ([DATE]), non-skid footwear ([DATE]), floor mat at the bedside ([DATE]), provide toileting and incontinence care as needed ([DATE]), physical therapy evaluation ([DATE]), frequent monitoring (discontinued [DATE]) and bed in lowest position at night with items in reach ([DATE]). Cross-referenced F689-failed to prevent falls for Resident #9 who sustained injuries A [DATE] nursing note documented an unwitnessed fall at 1:18 a.m. The resident reported falling to a certified nurse aide (CNA) and stated her hip hurt. The nurse assisted the resident to the restroom and back to bed and noted the resident was limping. The nurse asked the CNA if she usually limped and the CNA confirmed the resident does not usually limp. A licensed practical nurse (LPN) assessed the resident, neuro checks were initiated, the nurse practitioner (NP) was notified, pain medication was administered (pain level 5 with 10 being the worst pain), and an x-ray was ordered for the resident's right hip. However, a nursing note from [DATE] documented that the x-ray was not performed by third-party radiology services until [DATE]. A nursing note from [DATE] documented the results were received on [DATE] and forwarded to the physician. A nursing note from [DATE] documented the physician communicated his [DIAGNOSES REDACTED]. The x-ray results showed a new fracture to the resident's right hip. The [DATE] interdisciplinary team (IDT) meeting note for the resident's fall on [DATE] revealed the cause of the resident fall to be weakness. An intervention of a physical therapy evaluation was planned, but the resident refused. 3. Staff interviews LPN #1 was interviewed on [DATE] at 5:20 p.m. She said if the fall was serious and there was a possibility of injury the resident should be sent to the emergency department

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) via ambulance. She said Resident #9 had a couple of x-rays. She said she was not aware of the fracture resulting from one of the resident's fall on [DATE]. LPN #4 was interviewed on [DATE] at 9:55 a.m. She said if an x-ray was ordered it is usually done the same day. She said the results are typically available the same day as well. The nursing home administrator (NHA) was interviewed on [DATE] at 11:40 a.m. He said the facility was having issues getting the x-ray company into the facility in [DATE] due to the Coronavirus. He said the facility was dealing with an outbreak and the x-ray company was as well. He said he should have sent Resident #9 to the hospital after the fall on [DATE], but didn't think to do so at the time. The DON was interviewed on [DATE] at 4:19 p.m. She said unwitnessed falls should be accompanied by neurological checks. She said they were having some issues with the radiology company in May that resulted in a delay of care. She said they should have had a conversation with the resident about being sent to the hospital for acute care. She said interdisciplinary (IDT) meetings should be held within 24 hours of an incident so interventions can be put in place right away. She could not explain why the IDT meeting and interventions were not put in place for Resident #9 after each fall event. III. Failure to have qualified staff conduct assessments after Resident #9 and Resident #17 fell 1. Professional reference The 2019 Lippincott Nursing Procedures-Fall nursing Management read in pertinent part, Perform a post-fall assessment to determine the root cause of the fall. Gather assessment data from the patient, staff members, and any witnesses to the fall. Review the events that preceded the fall and any contributing factors.Assess the patient's environment, looking for possible causes of the fall. Review medications, such as sedative and opioids, that may have contributed to the fall. Assess for gait disturbances or improper use of a cane, crutches, or a walker. Retrieved [DATE] from https://online.statref.com/document/C8LAmyitWNkJ5FT4ykj_Fj!!?searchid= 8206&categoryType=All ,[DATE] 2. Facility policy and procedure The policy Fall Documentation, [DATE], was received from the director of nursing (DON) on [DATE] at 2:10 p.m. It read in pertinent part, The initial nursing note/assessment following a fall should contain the following and include a description of what was done. A. Resident #9 1. Record review The [DATE] nursing note documented an unwitnessed fall at 11:16 a.m. The resident was heard yelling for help and staff found her on the floor, lying on her left side. A small scratch was noted on the resident's left thigh and the resident reported right hip and knee pain (per LPN assessment). The [DATE] nursing note documented a fifth unwitnessed fall at 6:57 a.m. The resident was yelling for help and the night nurse walked into her room and found the resident sitting on the floor on her buttocks. An LPN assessed the resident and the resident reported mild pain in her buttocks. 2. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 5:20 p.m. She said if a resident falls the registered nurse (RN) was supposed to do the post-fall assessment. She said if there was no RN in the building she had to do the assessment. LPN #4 was interviewed on [DATE] at 9:55 a.m. She said if a resident fell the RN was called to assess the resident for injuries. The DON was interviewed on [DATE] at 4:19 p.m. She said an RN should be assessing residents after a fall, not an LPN. B. Resident #17 1. Resident status Resident #17, age 68, was admitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident required the supervision of one person for bed mobility, locomotion on the unit, eating and with toileting. She required limited assistance of one person for transfers, walking in her room, locomotion off the unit, dressing, personal hygiene and bathing. The resident had one fall with injury, not major, since the prior assessment. 2. Record review The care plan, last revised [DATE] (during survey), revealed the resident was a high fall risk secondary to impaired mobility, frequent inebriation and poor safety awareness. Interventions included: -Anticipate and meet the resident's needs, initiated [DATE]; -Call light within reach, initiated [DATE]; -Therapy services, initiated: [DATE]; -Transfers self with supervision and uses w/c for mobility, initiated [DATE]; -Encourage sobriety, initiated [DATE]; -The medical doctor and medical director to do a review of medications, initiated [DATE]; and -Medication reviewed and [MEDICATION NAME] was discontinued, initiated [DATE]. A [DATE] incident progress note revealed at 1:00 a.m. the resident reported she had fallen next to the bed while transferring herself from the wheelchair after losing her balance. It indicated neurological checks were initiated per the facility protocol. This note was written by LPN #6 and did not indicate an assessment was conducted by an RN. The [DATE] incident report, completed by LPN #6, revealed no RN assessment after the fall. 3. Interviews Licensed practical nurse (LPN) #8 was interviewed on [DATE] at 9:25 p.m. She said they did not have an RN on duty most of the time in the evenings so if a resident fell , she would assess them to determine if they needed further treatment. The DON was interviewed on [DATE] at 4:18 p.m. She said anytime a resident fell the resident was to be assessed by an RN. She said if there was not an RN available in the building, she was available to come in. IV. Failure to schedule medications appropriately A. Facility policy and procedure The police Medication Administration, [DATE], was received from the corporate consultant (CC) on [DATE] at 9:57 a.m It read in pertinent part, Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include: a. Enhancing optimal therapeutic effect of the medication; b. Preventing potential medication or food interactions; and c. Honoring resident choices and preferences, consistent with his or her care plan. B. Resident #2 status Resident #2, under the age of 65, was admitted to the facility on [DATE] and readmitted on [DATE]. The [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) revealed the resident had moderate cognitive impairment and a brief interview for mental status of 10 of 15. The resident required extensive two-person assistance for transfers, bed mobility, and toileting, as well as, a limited one-person assist with locomotion and eating. C. Resident interview Resident #2 was interviewed on [DATE] at 11:52 a.m. He said the nurse would wake him up in the middle of the night to give him medication. He said he asked for all of his medications to be given before he went to bed. He said he filed a grievance with the facility about the issue and had not heard anything from management. A grievance was not filed with the facility on this issue. D. Record review The [DATE] physician orders [REDACTED]. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 2:37 p.m. She said the hypnotic medication the resident was receiving was to aid with sleep. She said the medication takes effect 30 minutes after being taken. She said the medication could cause hallucinations and confusion if the individual was awoken after they had taken the hypnotic medication. She said residents taking a hypnotic medication were monitored for these side effects. She said if a medication was ordered to be given at 10:00 p.m. she would have to wake a sleeping resident to administer the medication. She said Resident #2 muscle relaxer was administered at 10:00 p.m. because the order was written for administration every eight hours. She said the hypnotic and muscle relaxing medications could be given together if there was an order from the physician to change the administration time. The director of nursing (DON) and corporate consultant (CC) were interviewed on [DATE] at 4:58 p.m. They said the resident's input to medication administration times was important and was working with the physician to change the administration time so the resident would not be woken in the night unnecessarily.
F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and implement an effective discharge planning process for four (#8, #11, #15 and #12) of four residents out of 27 total sample residents. Specifically, the facility failed to: -Develop and update a person-centered discharge plan and care plan for Residents #8, #11, and #15; and, -Ensure the discharge care plan for Resident #12 was thorough and complete. Findings include: I. Facility policy and procedures The Initial Discharge Plan policy, revised 5/15/19, was provided by the corporate social services consultant (CSSC) via email on 9/16/2020 at 11:48 a.m. It read in pertinent part, Policy: to honor resident choice related to placement and discharge planning to best suit their individual needs. Procedure: the initial discharge plan will be completed by the social services staff within seven days of admission. For residents admitted on Medicare A, the initial discharge plan will be documented by social services staff or nursing staff on the baseline care plan or resident profile within 48 hours of admission. The Discharge Summary and Plan policy, revised December 2016, was provided by the corporate social services consultant (CSSC) via email on 9/16/2020 at 11:48 a.m. It read in pertinent part, Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan. The post-discharge plan will be developed by the Care Planning/Interdisciplinary Team with the assistance of the resident and his or her family and will include: where the individual plans to reside; arrangements that have been made for follow-up care and services; a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity and capability to perform required care; how the interdisciplinary team (IDT) will support the resident or representative in the transition to post-discharge care; what factors may make the resident vulnerable to preventable readmission; and how those factors will be addressed. The discharge plan will be re-evaluated based on changes in the resident's condition or needs prior to discharge. II. Failure to develop and update a person-centered discharge plan and care plan A. Resident #8 1. Resident

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F 0660 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) status Resident #8, age 57, was admitted on [DATE] and discharged on [DATE] to the community. According to the August 2020 computerized physician orders [REDACTED]. The 8/11/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required assistance of one to two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. According to the MDS, he had an active plan to discharge to the community. 2. Record review The Discharge Planning for Post Acute Admissions assessment dated [DATE] was incomplete, but revealed that Resident #8 had previously lived with a friend in an apartment and his discharge goal was to live with a daughter or his brother. The assessment indicated that the resident's prior level of function was independent, and there were no obstacles to returning home. The assessment further revealed that the resident had no primary care provider (PCP) in the community and there was no community pharmacy documented. The previous home health agency, equipment at home, and assistance available at home sections were not completed on the assessment. Review of the comprehensive care plan revealed that there was no discharge care plan. Review of progress notes revealed the following notes regarding discharge: -On 8/4/2020 at 11:12 a.m., the nursing data collection note documented in the discharge plan section Discharge Plan: not applicable (NA). -On 8/25/2020 at 2:51 p.m., Resident #8 left the facility with his brother. Discussed that this discharge was against medical advice (AMA) as the resident is not ready for discharge and we have no orders. Brother will bring the resident back to sign this paperwork and they verbalize understanding that the resident left AMA. -On 8/26/2020 at 12:23 p.m., Spoke with Resident #8's brother on the phone. He reports that the resident is refusing to return to sign AMA paperwork. Resident #8 does not currently have a PCP in the community. When the resident does get one, his brother will let them know that the resident was here so that they can request any information needed regarding his stay. There were no other progress notes pertaining to discharge or discharge planning noted in Resident #8's medical record. B. Resident #11 1. Resident status Resident #11, age 68, was admitted on [DATE] and discharged on [DATE] to the community . According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/27/2020 MDS revealed the resident had severe cognitive impairment with a BIMS score of 5 out of 15. He required assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. According to the MDS, he had an active plan to discharge to the community. 2. Record review There was no Discharge Planning for Post Acute Admissions Assessment found in Resident #11's medical record. Review of the comprehensive care plan revealed that there was no discharge care plan. Review of progress notes revealed the following notes regarding discharge: -On 8/21/2020 at 4:06 p.m., the nursing data collection note documented in the discharge plan section Discharge Plan: Patient is alert and oriented times three, able to make needs known, vital signs (VS) stable, denies any pain and will continue to monitor. -On 9/2/2020 at 10:35 a.m., Met with resident to discuss discharging after skilled stay, resident stated that he wants to leave and go back to prior living situation on the streets. Resident signed Notice of Medicare Non-Coverage (NOMNC), facility will discuss with resident any resources needed in the community. -On 9/3/2020 at 9:37 a.m., Spoke with the medical provider about the resident requesting to leave the facility. Medical provider stated that if resident were to be going to an apartment or home, then a safe discharge will be initiated with home health services. If resident were to discharge with a plan of being homeless, AMA would need to be initiated. Resident educated on this information, and the resident was able to verbally confirm the information back to the writer. Resident stated that he was going back to the streets and understood that if that were his plan, he would be required to sign Against Medical Advice paperwork. -On 9/3/2020 at 10:18 a.m., Resident provided with a list of community resources. Resident is discharging to prior living situation on the streets per resident request. -On 9/3/2020 at 10:42 a.m., Resident signed AMA paperwork at approximately 10:32 a.m. and left the building with belongings at approximately 10:40 a.m. Resident alert and oriented times four, able to make needs known, denied pain, and gave verbal understanding of the risks associated with leaving against medical advice, including but not limited to, understanding that his physician has not cleared him for discharge and that he understands, and accepts, that risk. Resident was pleasant at time of discharge and showing gratitude towards facility staff. Resident being transported to shelter. There were no other progress notes pertaining to discharge or discharge planning noted in Resident #11's medical record. There was no Discharge Summary Assessment documented in the resident's electronic medical record. C. Resident #15 1. Resident status Resident #15, age 62, was admitted on [DATE] and discharged on [DATE] to the community. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/7/2020 MDS revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance for bed mobility, transfers, toilet use, and personal hygiene. She required limited assistance from one person for dressing. According to the MDS, she had an active discharge plan to return to the community. 2. Record review There was no Discharge Planning for Post Acute Admissions Assessment found in Resident #15's medical record. Review of the comprehensive care plan revealed that there was no discharge care plan. Review of progress notes revealed the following notes regarding discharge: -On 8/1/2020 at 12:50 p.m., the nursing data collection note documented in the discharge plan section Discharge Plan: Per facility protocol. -On 9/10/2020 at 4:29 p.m., Resident discharged home with family, took all belongings including her narcotic pain medication. Both this writer and DON witnessed 23 pills. Resident was also given discharge instructions and left at about 4:25 p.m. with her son. There were no other progress notes pertaining to discharge or discharge planning noted in Resident #15's medical record. The Discharge Summary assessment dated [DATE] was incomplete. Cross-reference F661 for discharge summary. III. Failure to ensure the discharge care plan for Resident #12 was thorough and complete 1. Resident status Resident #12, age 59, was admitted on [DATE] and discharged on [DATE] to the community. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/7/2020 MDS revealed the resident had moderate cognitive impairment with a BIMS score of 9 out of 15. He required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. According to the MDS, he had an active discharge plan to return to the community. 2. Record review The resident's discharge care plan was initiated on 8/25/2020 and revealed a goal of discharging home to his apartment with his wife and daughter. Interventions initiated on 8/25/2020 were to encourage the resident to verbalize his thoughts or plans about discharge, and to establish a pre-discharge plan with the resident and evaluate progress and revise plan quarterly. The care plan did not include: addressing the resident's goals for care and treatment preferences; documenting the resident's interest in, and any referrals made to the local contact agency; identifying post-discharge needs such as nursing and therapy services, medical equipment and ADL assistance; identifying needs that must be addressed before the resident could be discharged , such as resident education, rehabilitation, and caregiver support and education. IV. Interviews The CSSC was interviewed on 9/16/2020 at 10:30 a.m. She said she had only been helping out remotely at the facility for a couple of weeks. She said social services completes the initial discharge assessment with the residents. She said social services was responsible for initiating the discharge care plan with the information gathered from the assessment. She said social services was responsible for updating the discharge care plan with changes or when new information regarding discharge was discussed. She said the interdisciplinary team (IDT) held weekly meetings to discuss the rehabilitation residents (short term) and talk about the resident's progress with therapy and nursing, a discharge date , and any discharge needs such as medical equipment or home health services. She said the information should be documented on the care plan. She said that social services was generally responsible for setting up the recommended services, such as home health, for discharges. She said that a progress note should be written in the chart to document that information. The nursing home administrator (NHA) was interviewed on 9/16/2020 at 11:30 a.m. He said that they have been having some social services issues, but that a new social services director would be starting on 9/23/2020. He said that the discharge planning process would go much [MEDICATION NAME] once the social services director started. He said that a discharge plan should be included in the care plan. He said he would expect to see discharge goals, any equipment needed at home, home health services, activities of daily living (ADL) needs included on the discharge care plan. He said he would expect the discharge care plan to be updated anytime there were changes to the discharge plan.
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to have a complete discharge summary that included a recapitulation of the stay, a final summary of the resident's status, a reconciliation of all the resident's medications and the post-discharge plan of care for two (#12 and #15) of four residents out of 27 total sample residents. Specifically, the facility failed to ensure a discharge summary was completed in its entirety upon the residents discharge from the facility. Findings include: I. Facility policy The Discharge Summary and Plan policy, revised December 2016, was provided by the corporate social services consultant (CSSC) via email on 9/16/2020 at 11:48 a.m. It read in pertinent part, The

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F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) discharge summary will include a recapitulation of the resident's stay at this facility and a final summary of the resident's status at the time of the discharge in accordance with established regulations governing release of resident information and as permitted by the resident. The discharge summary shall include a description of the resident ' s: current diagnosis; medical history (including any history of mental disorders and intellectual disabilities); course of illness, treatment and/or therapy since entering the facility; current laboratory, radiology, consultation, and diagnostic test results; physical and mental functional status; ability to perform activities of daily living including: bathing, dressing and grooming, transferring and ambulation, toilet use, eating, and using speech, language, and other communication systems; the need for staff assistance and assistive devices or equipment to maintain or improve functional abilities; and the ability to form relationships, make decisions including health care decisions, and participate (to the extent physically able) in the day-to-day activities of the facility; sensory and physical impairments (neurological, or muscular deficits; for example, a decrease in vision and hearing, paralysis, and bladder incontinence); nutritional status and requirements: weight and height; nutritional intake; and eating habits, preferences and dietary restrictions; special treatments or procedures (treatments and procedures that are not part of basic services provided); mental and psychosocial status (ability to deal with life, interpersonal relationships and goals, make health care decisions, and indicators of resident behavior and mood); discharge potential (the expectation of discharging the resident from the facility within the next three months); dental condition (the condition of the teeth, gums, and other structures of the oral cavity that may affect a resident's nutritional status, communications abilities, quality of life, and the need for and use of dentures or other dental appliances); activities potential (the ability and desire to take part in activity pursuits which maintain or improve physical, mental, and psychosocial well-being); rehabilitation potential (the ability to improve independence in functional status through restorative care programs); cognitive status (the ability to problem solve, decide, remember, and be aware of and respond to safety hazards); and medication therapy (all prescription and over-the-counter medications taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). As part of the discharge summary, the nurse will reconcile all pre-discharge medication with the resident's post-discharge medications. The medication reconciliation will be documented. Every resident will be evaluated for his or her discharge needs and will have an individualized post-discharge plan. II. Resident #12 A. Resident status Resident #12, age 59, was admitted on [DATE] and discharged on [DATE] to the community. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/7/2020 MDS revealed the resident had moderate cognitive impairment with a BIMS score of 9 out of 15. He required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. According to the MDS, he had an active discharge plan to return to the community. B. Record review Review of Resident # 12's progress notes revealed that no progress note was documented regarding the resident's discharge from the facility. Cross-reference F660 for discharge planning process. The Discharge Summary assessment dated [DATE] revealed the assessment was not fully completed. The following sections on the assessment were not completed: marital status; diagnosis; therapy information; community services and resources, to include home health agency and any necessary medical equipment; and summary of facility stay. The Discharge Summary Assessment did not include a recapitulation of the resident's stay, a final summary of the resident's status at the time of the discharge, a reconciliation of all the resident's medications, or the post-discharge plan of care. III. Resident #15 A. Resident status Resident #15, age 62, was admitted on [DATE] and discharged on [DATE] to the community. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/7/2020 MDS revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required extensive assistance for bed mobility, transfers, toilet use, and personal hygiene. She required limited assistance from one person for dressing. According to the MDS, she had an active discharge plan to return to the community. B. Record review Review of Resident #15's progress notes revealed the following note documented on the day of discharge: -On 9/10/2020 at 4:29 p.m., Resident discharged home with family, took all belongings including her narcotic pain medication. Both this writer and DON witnessed 23 pills. Resident was also given discharge instructions and left at about 4:25 p.m. with her son. The Discharge Summary assessment dated [DATE] revealed a status of in progress and the assessment was never completed. The following sections on the assessment were not completed: marital status; insurance type; where resident was discharging to; emergency contact information; attending physician; diagnosis; scheduled follow-up appointments; therapy information; and community services and resources, to include home health agency and any necessary medical equipment. The summary of facility stay section of the assessment was partly filled out, but did not include the following required items regarding the resident's status: demographic information; customary routine; cognitive patterns; communication; vision; mood and behavior patterns; psychosocial well-being; physical functioning and structural problems; disease [DIAGNOSES REDACTED]. This refers to documentation of who participated in the assessment process. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care/direct access staff members on all shifts. The discharge progress note and the Discharge Summary Assessment did not include a recapitulation of the resident's stay, a final summary of the resident's status at the time of the discharge, a reconciliation of all the resident's medications, or the post-discharge plan of care. IV. Interviews The corporate social services consultant (CSSC) was interviewed on 9/16/2020 at 10:30 a.m. She said she had only been helping out remotely at the facility for a couple of weeks. She said the Discharge Summary Assessment was completed by the interdisciplinary team. She said each discipline was expected to document a note in the summary of the facility stay section of the assessment. She said the assessment allowed each discipline to document instructions for the resident or discuss referrals made so the resident had all of the information needed at the time of discharge. She said the nursing staff were to print off the assessment and give a copy to the resident at the time of discharge. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 9/16/2020 at 11:30 a.m. The DON said that the facility did not document a recapitulation of the resident's stay upon discharge. She said therapy usually completed a summary of what the resident's progress was with therapy. She said nurses should review medications and discharge instructions with the resident and she expected the information to be documented in a progress note. The NHA said the recapitulation of the stay was a team effort and each member of the interdisciplinary team (IDT) was expected to enter pertinent information for their discipline in the Discharge Summary Assessment. He said he expected the assessment to be filled out completely. He said the social services department ensured the completion of the form and the other disciplines were putting in their information. He said they had been having issues with the social services department, but a new social services director would be starting on 9/23/2020, so discharge issues should improve.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure four (#1, #9, #23 and #17) residents reviewed of 27 sample residents received medication management, treatment and services in accordance with professional standards. Specifically, the facility failed to: -Routinely monitor, document and provide treatment to Resident #1's surgical wounds; -Ensure nursing staff did not remove Resident #1's surgical sutures without a physician's orders [REDACTED].#9, #23 and #17 fell ; and -Ensure staff properly monitored and provide appropriate interventions when Resident #17 was intoxicated. Cross-reference F689 environment remianed free of accident hazards Findings include: I.Wounds for Resident #1 A.Resident status Resident #1, under age 65, was admitted [DATE], discharged to the hospital on [DATE] and readmitted on [DATE]. According to the [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision with set up or one person assistance for all activities of daily living (ADL)s, including bed mobility, transfers, locomotion on and off the unit, dressing and eating. She required limited assistance of one person for toileting and bathing. The resident was at risk for developing pressure ulcers and currently had surgical wounds and was receiving surgical wound care. B. Record review A [DATE] incident progress note revealed the resident had reported she slept with her phone on her left hand and the heat from the phone burned her left hand. It indicated the left hand was red, swollen, warm, and tender to touch. The physician was notified, the resident refused treatment however was educated not to sleep with her phone. A [DATE] nursing progress note revealed the resident had abnormal vital signs with an elevated temperature of 103.3 Fahrenheit (F), pulse of 127 beats per minutes, blood pressure ,[DATE] and oxygen saturation between ,[DATE]% on room air. It indicated pictures of the wound (it did not specify the location of the wound) were sent to the

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A [DATE] nursing progress note revealed the resident agreed to a non-emergent transport to the hospital to have the wound to the left hand evaluated and return with recommendations. A [DATE] physician progress notes [REDACTED]. It indicated the resident had also been biting her fingernails due to anxiety over health and COVID-19 pandemic with positive cases in the facility. The note revealed the resident's hand was discolored, warm to touch and swollen from the back of the hand to the index finger and x-rays suggest osteo[DIAGNOSES REDACTED] of the finger. It indicated the resident refused hospitalization initially but agreed to a transfer to the ER for evaluation and treatment including possible amputation. A [DATE] nursing progress note revealed the resident returned from the ER with a new order for an antibiotic. A [DATE] nursing progress note revealed the resident [MEDICAL CONDITION] per the hospital and was seen for an infection to the right hand index finger (it was actually the left). It indicated the resident continued to chew on this finger as well as the ends of her other fingers. A [DATE] nursing progress notes revealed the resident had a tele-med appointment with the doctor, who informed the resident that surgical debridement of the hand and finger were required with possible amputation if the condition continued and advised the resident that immediate admission to the hospital for assessment and treatment of [REDACTED]. The note indicated the finger was necrotic (tissue death) looking in color and smell with a large pus filled blister on the palm of her left hand and red peeling skin on the back of her left hand. The resident was transported via ambulance to the hospital for admission and treatment of [REDACTED]. It did not clarify what these issues were. A [DATE] nursing progress note revealed the resident was readmitted back to the facility with a left hand second finger amputation with the dressing intact and the resident refused to allow the dressing to be removed. There is no mention of the resident's skin condition of her bilateral [MEDICAL CONDITION] (BBKA). Review of the record on [DATE] revealed no documentation what the resident's skin looked like under the dressing, including how long the surgical incision from the left hand second finger amputation was, how many sutures (if any) were in place, if it had any drainage, redness or warmth . The [DATE] CPO revealed the resident had the following orders: -Left BKA: clean with normal saline, dry, apply silver gel, alginate and cover with dressing, ordered [DATE]; -Right BKA: cleanse with wound cleanser, pat dry, pack with ioda-form gauze and silver gel. Irrigate with Dakin's 0.25% solution every other day, ordered [DATE]; and -Left hand, 2nd finger: cleanse with wound cleanser, pat dry, apply one layer of zero-form and wrap with kerlix gauze daily until seen by the wound team, ordered [DATE]. According to the [DATE] TAR, the treatments for the left hand second finger, the LBKA and the RBKA were blank on [DATE] indicating it was not done. These treatments were also coded 3 on [DATE] and [DATE] indicating the resident was away from the facility. A [DATE] orders-administration progress note revealed the treatments were not done because the resident was out at [MEDICAL TREATMENT]. There was no documentation the treatments were attempted after the resident returned from [MEDICAL TREATMENT] or the time of treatment adjusted to ensure it would not conflict with when the resident was out of the facility. A [DATE] physician progress notes [REDACTED]. It indicated the resident had sutures that were to be removed by the surgeon at her appointment. A [DATE] orders-administration progress note revealed the resident's weekly nursing skin check was not done because the resident was out of the facility at [MEDICAL TREATMENT]. The skin check was not done when the resident returned from [MEDICAL TREATMENT] and it was not rescheduled.The resident did not have a skin check done for the week of ,[DATE]-[DATE]. According to the [DATE] CPO, an order was received on [DATE] for an in-house wound consult for the left hand fourth digit. (This is the first mention of any concerns with the fourth digit). No consult for the left hand fourth digit was found in the resident's record. The [DATE] weekly skin evaluation revealed the resident had previous surgical wounds to bilateral lower extremities (BLE) that were healing well but had no new skin issues. The surgical wound to the resident's left hand was not included. The left fourth digit was not mentioned. A [DATE] skin/wound progress note revealed the sutures were removed from the left second digit and the wound was resolved. It indicated the finger was cleaned, dried and left open to air but it did not reveal how many sutures were removed. The note revealed the wound to the right stump was resolved and the wound to the left outer stump was 2 centimeters (cm) by 2 cm diamond shaped, with no drainage, redness, pain or signs or symptoms of [MEDICAL CONDITION]. It indicated the wound was cleaned and redressed. According to the [DATE] CPOs, the wound care to the RBKA and the left hand second finger was discontinued on [DATE]. Review of the resident's record on [DATE] revealed the facility did not have an order from the physician to remove the sutures from the resident's surgical wound on [DATE]. This was confirmed by the corporate consultant on [DATE] at 11:04 a.m. A [DATE] provider progress revealed the resident reported she asked the nurse over the weekend to remove the sutures to the second finger amputations, saying her finger is healed and the sutures have been in too long. It indicated the amputation site was clean, intact with mild redness, swelling and no drainage. There was no mention of the left 4th digit. A [DATE] nursing progress note revealed the resident was started on V [MEDICATION NAME] 500 milligrams (mg) twice a day for [MEDICAL CONDITION] however it does not specify where the [MEDICAL CONDITION] was. Another [DATE] nursing progress note revealed the wound care to the LBKA had been changed to collagen. According to the June CPO ' s, a new order for wound care to the LBKA was initiated on [DATE] to include: cleanse area with normal saline, apply collagen to the wound bed followed by a dry dressing daily. Review of the [DATE] TAR revealed the treatment ordered for the wounds to the resident's bilateral [MEDICAL CONDITION] was blank indicating it was not done on ,[DATE], ,[DATE] or [DATE] and the weekly nursing skin check scheduled for ,[DATE] and [DATE] was blank indicating it was not done. The weekly nursing skin evaluation for the week of ,[DATE]-[DATE] was not done. A [DATE] nursing progress note revealed the resident had an x-ray of the left hand with attention to the fourth digit. Review of the record revealed no documentation for the reason of the x-ray at that time and the x-ray results were not in the resident's record. A [DATE] physician progress notes [REDACTED]. It indicated the resident was placed on [MEDICATION NAME] coverage and the resident had multiple antibiotic allergies [REDACTED]. According to the [DATE] treatment administration record (TAR), the resident was scheduled for her weekly nursing skin check on [DATE] in the morning and refused. It was not rescheduled for a later time or day. A weekly nursing skin evaluation for the week of ,[DATE]-/[DATE] was not done. A [DATE] physician progress notes [REDACTED]. It indicated arrangements for an outpatient wound and surgery consult were being made. According to the [DATE] CPO, an order was received on [DATE] for wound care to the left hand fourth digit. It indicated the wound was to be cleansed with a wound cleanser, patted dry, honey gel applied and covered with alginate and wrapped with gauze daily and as needed. According to the [DATE] TAR, the weekly nursing skin check scheduled for [DATE] and the treatment ordered to the left hand fourth digit for [DATE] was blank, indicating it was not done. A weekly nursing skin evaluation for the week of ,[DATE]-[DATE] was not done. A [DATE] skin/wound progress note revealed the resident had mild drainage with no odor to the left fifth (possible typo) digit with 90% slough and 10% eschar. It indicated the left knee also had drainage with no odor and the wound bed had 95% slough. It did not indicate the size of the wounds or if the physician had been notified of the appearance of the wounds. A [DATE] physician progress notes [REDACTED]. It indicated the resident was to continue the [MEDICATION NAME]. The [DATE] TAR revealed the weekly nursing skin check scheduled for [DATE] was blank, indicating it was not done. A weekly nursing skin evaluation for the week of ,[DATE]-[DATE] was not done. A [DATE] physician progress notes [REDACTED]. It indicated the resident was to see a hand surgeon that day. The resident was to continue taking the [MEDICATION NAME] and added another antibiotic, [MEDICATION NAME]. A [DATE] nursing progress note revealed the resident returned from an appointment where she had the end of her fourth left finger amputated and daily dressing were required to the surgical site starting [DATE]. According to the [DATE] CPOs, a new order was received for wound care to the fourth left digit to start on [DATE] that included soaking the wound in 90% saline and 10% peroxide daily then covering it with a dry dressing, the previous wound order to apply honey with alginate and wrap with gauze was not discontinued until [DATE]. The [DATE] TAR revealed the new order received on [DATE] to soak the finger was scheduled to start on [DATE] instead of on [DATE] as ordered and was documented as being done from ,[DATE]-[DATE]. This treatment was documented as being done along with the previous order of honey and alginate on [DATE] The [DATE] weekly nursing skin evaluation revealed the resident had amputated bilateral knees and left fourth finger amputation with dressings intact. No description of the wounds was given. A [DATE] orders-administration progress note revealed the resident declined her skin assessment due to [MEDICAL TREATMENT]. There was no documentation that the assessment was scheduled for a later time or day. A weekly nursing skin evaluation for the week of ,[DATE]-[DATE] was not done. Review of the [DATE] TAR revealed blanks on the record for the ordered treatment of [REDACTED]. A weekly nursing skin evaluation for the week for ,[DATE]-[DATE] was not done. According to the [DATE] CPO, a new treatment order for the wound

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) to the left lower extremity amputation was received on [DATE] to include: Cleanse with wound cleanser, apply Dakin's 0.25% moistened gauze to area of slough only then cover with dry gauze twice daily and as needed. The order for wound care to the left fourth finger was discontinued. No weekly nursing skin evaluations were completed for the month of [DATE]. The [DATE] TAR revealed the resident refused her weekly nursing skin check on [DATE]. There was no documentation the assessment was scheduled for a later time or day. Review of the [DATE] TAR revealed the weekly nursing skin check for [DATE] was signed off as being complete, however, the weekly nursing skin evaluation could not be found in the record. The care plan, last revised [DATE], revealed the resident was a high risk for impairment to her skin integrity related to impaired mobility, diabetes, [MEDICAL CONDITIONS], self-inflicted injuries and non-compliance with recommendations. The resident had below the knee surgical incision sites that had dehisced and had necrotic tissue. The resident was non-compliant with routine dressing changes and assessments. Interventions included: -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short, revised [DATE]; -Encourage the resident to allow assessments and treatments as indicated, revised [DATE]; -Educate the resident and her friend consistently of the risks associated with her refusal of care and treatment, revised [DATE]; -Administer treatments as ordered and monitor for effectiveness, initiated [DATE]; -Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician, revised [DATE]; -Educate the resident/family/caregivers as to causes of skin breakdown, including: transfer/positioning requirements, importance of taking care during ambulation/mobility, good nutrition and frequent repositioning, initiated [DATE]; -Followed by wound care clinic, initiated [DATE]; -Inform the resident/family/caregivers of any new area of skin breakdown, initiated [DATE]; -Monitor nutritional status. Serve diet as ordered, monitor intake and record, initiated [DATE]; -Weekly skin check by licensed nurse, initiated [DATE]; -Monitor /document/report as needed any changes in skin status, initiated [DATE]; -Monitor pain level prior to and during treatment and treat pain as per order to ensure the resident's comfort as needed, initiated [DATE]; and -Has wound vac after surgical debridement and drain. The resident choses to empty drain independently, nursing to offer assistance and education, initiated [DATE]. (This intervention was no longer being done and should have been resolved and removed from the care plan). The resident did not have a care plan to address the skin issues with her left hand, the subsequent amputation of her left index finger and part of her left fourth finger with surgical wounds requiring wound care. II. Neurological assessments post fall for Residents #9, #23, and #17 A. Professional reference The Agency for Health Care Research and Quality article Fall Response, [DATE], read in pertinent part Residents should have increased monitoring for the first 72 hours after a fall. Each shift, the nurse should record in the medical record a review of systems, noting any worsening or improvement of symptoms as well as the treatment provided. Reference to the fall should be clearly documented in the nurse's note. Retrieved [DATE] from https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man2.html B. Facility policy and procedure The policy Fall Documentation, [DATE], was received from the director of nursing (DON) on [DATE] at 2:10 p.m. It read in pertinent part, To have complete, accurate, and timely documentation for residents who have sustained a fall and/or preventive measures taken to prevent a fall. The initial nursing note/assessment following a fall should contain the following and include a description of what was done. -Vital signs to include neurological assessment if indicated C. Resident #9 1. Resident status Resident #9, age 87, was admitted to the facility on [DATE]. She expired at the facility on [DATE]. The [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 8 out of 15. The resident required extensive one-person physical assistance with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. The resident was not steady and required staff assistance during transfers and locomotion. 2. Record review A [DATE] nursing note documented an unwitnessed fall at 1:18 a.m. There were no neurological checks conducted after this unwitnessed fall. A [DATE] a nursing note documented an unwitnessed fall at 6:44 a.m. Neurological checks were initiated, but not completed. The neurological checks began at 6:00 a.m. - The form documented the checks between 6:00 a.m. and 6:45 a.m. were fifteen minutes apart, - Checks between 6:45 a.m. and 9:45 a.m. were 30 minutes apart. - Checks between 9:45 a.m. and 1:45 p.m. were one hour apart, at 11:45 a.m. only the vital signs were documented. - Checks between 1:45 p.m. to 9:45 p.m. check were four hours apart, at 9:45 p.m. only vital signs were documented. - There were four un-dated documented shift checks for the night (NOC), day, evening (EVE), and NOC shift. For the undated day shift documentation, no information was documented The check form added up to a total of 48 hours. The [DATE] nursing note documented an unwitnessed fall at 11:16 a.m. Neurological checks were initiated but not completed. The [DATE]-[DATE] neurological check form contained no documentation for the checks on [DATE] 10:00 p.m.-6:00 a.m., [DATE] 10:00 p.m.-6:00 a.m., and [DATE] 6:00 a.m.-2:00 p.m. The [DATE] nursing note documented an unwitnessed fall at 7:12 a.m. There were no neurological checks completed for this fall. The [DATE] nursing note documented an unwitnessed fall at 3:56 a.m. Neurological checks were initiated but incomplete. The [DATE]-[DATE] neurological form contained no documentation for the checks on [DATE] at 11:15 a.m. thru [DATE] at 7:00 p.m. The [DATE] nursing note documented an unwitnessed fall at 7:00 p.m. Neurological checks were initiated but incomplete. The [DATE]-[DATE] neurological form contained no documentation for the checks on [DATE] at 10:00 a.m, 2:00 p.m., and 6:00 p.m. No documentation for the [DATE] day shift check. No documentation for the [DATE] evening shift check. No documentation for the [DATE] into [DATE] night shift check. 3. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 5:20 p.m She said if a resident fall is witnessed and the resident did not hit their head, vital signs are taken and a physical assessment is completed. She said if the resident experiences an unwitnessed fall or hits their head during an observed fall, vital signs, a physical assessment, and neurological checks are completed. She said neurological checks were completed for three days after an unwitnessed fall or fall with a head injury. She said the residents have the right to refuse neurological checks but nurses were to encourage them to complete them for their safety. She said refusals should be documented on the neurological check form and the physician should be notified. She said neurological checks were important to make sure the resident was at cognitive baseline and to monitor for mental changes. LPN #4 was interviewed on [DATE] at 9:55 a.m. She said neurological checks were initiated in the event of an unwitnessed fall or fall with a head injury. She said resident refusals should be documented. She did not know how long neurological checks should be carried out. She said neurological checks were important to monitor the resident cognitive status and reaction times. The DON and corporate consultant (CC) were interviewed on [DATE] at 4:19 p.m. They said neurological checks, vital sign monitoring, and physical assessments should accompany any unwitnessed falls or falls with a head injury. D. Resident #23 1. Resident status Resident #23, age 92, was admitted on [DATE]. According to the [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident was severely impaired cognitively with shorts and long term memory loss. He had no behaviors. He required extensive assistance with two person care for bed mobility, transfers, dressing, toileting and hygiene. He had one fall since admission with no injury. Record review Nurse progress note for Resident #23 was reviewed on [DATE] at 3:30 p.m. it revealed a nurse note dated [DATE] at 4:01 a.m. that read; Roommate witnessed the fall, resident fall with no injury noted upon assessment, assisted resident back to bed with two person assist. Medical director (MD) called with a message left with the answering service person regarding a fall with no injury. The note was written by the licensed practical nurse (LPN) #5 and another nurse progress note dated [DATE] at 12:34 a.m. read; Resident had unwitnessed fall in his room. Head to toe assessment performed by Registered nurse (RN), no apparent injury noted, no head injury involved. Denied complaints of pain. Resident assisted back to his bed. Bed in low position. MD on call notified, family notified and neuro checks initiated per facility protocol. The nurse progress note was written by LPN #6. There was no evidence of an RN progress note for the actual assessment of Resident #23 post fall. No MD notes in record for review. Documentation requested on [DATE] at 1:39 p.m. for all fall assessments and investigations related to any falls for the past three months to also include nurse progress note and MD notes for Resident #23. None provided. -There was no evidence of any neurological assessments for the [DATE] fall. -Additional Neurological assessment reviewed for a previous fall. The neurological assessment flow sheet for Resident #23 dated [DATE] was completed for [DATE], [DATE] and [DATE]. There was no signature to verify the documentation was correct on [DATE] at 10:00 p.m. and 10:15 p.m. and on [DATE] at 6:30 a.m. 2. Interview The director of nurses (DON) was interviewed on [DATE] at 5:30 p.m. She said when a fall occurred the fall assessment was completed. She said for a witnessed fall, an assessment was completed and included vital signs. She said for an unwitnessed fall an assessment was completed and a neurological checklist and vitals were included. She said an assessment should be completed by the RN. She said she lived six minutes away from the facility and she was available to complete the assessment when an RN was not in the building. She said the LPN cared for the resident right away and the RN did the assessment as soon as possible and she documented the finding in a progress note. She said a fall assessment was not completed for Resident #23 until the computer system

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) triggered a quarterly assessment which was due on [DATE]. The interdisciplinary team discussed any falls the next day and updated any new interventions needed with a care plan. E. Resident #17 1. Resident status Resident #17, age 68, was admitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident required the supervision of one person for bed mobility, locomotion on the unit, eating and with toileting. She required limited assistance of one person for transfers, walking in her room, locomotion off the unit, dressing, personal hygiene and bathing. The resident had one fall with injury, not major, since the prior assessment. 2. Record review The care plan, last revised [DATE] (during survey), revealed the resident was a high fall risk secondary to impaired mobility, frequent inebriation and poor safety awareness. Interventions included: -Anticipate and meet the resident's needs, initiated [DATE]; -Call light within reach, initiated [DATE]; -Therapy services, initiated [DATE]; -Transfers self with supervision and uses w/c for mobility, initiated [DATE]; -Encourage sobriety, initiated [DATE]; -The medical doctor and medical director to do a review of medications, initiated [DATE]; and -Medication reviewed and [MEDICATION NAME] was discontinued, initiated [DATE]. A [DATE] incident progress note revealed at 1:00 a.m. the resident reported she had fallen next to the bed after losing her balance while transferring herself from the wheelchair. It indicated neurological checks were initiated per the facility protocol. The [DATE] incident report revealed the resident had an unwitnessed fall and indicated neurological checks were initiated per the facility protocol. Review of the record on [DATE] revealed no neurological checks were completed. These were requested from the facility on [DATE] and were not received. III. Monitoring alcohol use Resident #17 A. Professional references According to www.drugs.com/food-interactions/[MEDICATION NAME].html?professional=1, ,[DATE], Do not use alcohol or medications that contain alcohol while receiving treatment with [MEDICATION NAME]. This may increase nervous system side effects such as drowsiness, dizziness, lightheadedness, difficulty concentrating, and impairment in thinking and judgment. According to www.drugs.com/food-interactions/pregabalin.html?professional=1, ,[DATE], Alcohol may potentiate some of the pharmacologic effects of central nervous central-active agents. Use in combination may result in additive central nervous system depression and/or impairment of judgment, thinking, and psychomotor skills. B. Record review A [DATE] behavior note at 11:41 p.m. revealed the resident acted inebriated being verbally abusive to the staff on the way to her room. It indicated the evening nurse reported the resident had been consuming alcohol on the smoking porch all evening. A [DATE] behavior note at 12:04 a.m. revealed the resident came inside the building from the patio and appeared to be inebriated. It indicated she screamed profanities while rolling in her wheelchair down the hallway. A [DATE] nursing progress note at 9:16 p.m. revealed the resident fell outside in the smoking area and was being assisted up by another resident. It indicated the resident appeared confused, intoxicated and had a strong smell of alcohol from her breath. The note indicated the resident was assisted in bed for safety and neurological checks were initiated per facility protocol. The [DATE] MAR indicated [REDACTED]. Review of the record on [DATE] revealed no documentation of the physician being notified of the resident's on-going intoxication over several days, from ,[DATE]-[DATE], to determine if the resident's medication needed to be held and receive further orders for treatment. A [DATE] nursing progress note revealed the found an empty bottle of liquor in the resident's trash can when she was administering the resident's medications that morning. It indicated she told the nurse manager. Review of the [DATE] Medication Administration Record [REDACTED]. According to the [MEDICATION NAME] narcotic count sheet, one tablet of [MEDICATION NAME] immediate release 5mg, was signed out at 10:45 a.m. on [DATE]. Review of the record on [DATE] revealed the facility did not notify the physician of the bottle of alcohol being found when medications, including narcotics, were being administered to determine if further action was warranted and there was no documentation the resident was monitored for adverse effects. The care plan was updated on [DATE], during the survey, to include the resident is inebriated with frequent falls. New interventions included: -Educate and remind the resident frequently of the consequences of drinking alcohol and increased fall risk; -Discontinue [MEDICATION NAME]; and -Refer to psychiatry for increased input and education. C. Interviews The DON was interviewed on [DATE] at 11:22 a.m. She said she talked to the nurses about the neurological checks for Resident #17 when she fell and they told her the resident refused to allow them to be done. She said she spoke with the resident prior to this interview about why she did not allow the nurses to do neurological checks when she fell . She said the resident did not remember falling but said, I think she is inebriated now so I don ' t know how reliable she is. The DON said she had not dealt with this type of community before and was not quite sure what to do. CNA #8 was interviewed on [DATE] at 2:42 p.m. She said s
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 interviews and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible, and residents received adequate supervision and assistive devices to prevent accidents. The facility failure affected two (#9 and #23) of four residents sample for falls and nine (#3, #4, #5, #6, #10, #16, #17, #25 and #26) of 25 residents sample for smoking hazards out of a total of 27 sample residents. Falls: The facility failed to take sufficient steps to prevent Resident #9 from falling repeatedly and sustaining injuries. Resident #9 experienced ten falls between April and August, 2020, sustaining a pelvic fracture as well as head injuries, a laceration, bruising and skin tears. Review of the resident's record revealed the facility failed to develop and implement effective measures to prevent falls with injury. Eight of the falls were unwitnessed, despite a plan for frequent checks. At least five of the falls were around toileting, yet care plan review revealed no toileting assessment or toileting schedule. There was insufficient evidence root causes were thoroughly considered in an effort to develop effective preventive measures. Smoking: The facility failed to address Residents #3, #4, #5, #6, #10, #16, #17, #25 and #26 unsafe smoking behaviors. Findings include: I. Falls A. Facility policy and procedure The Fall Documentation policy, dated [DATE], was provided by the director of nursing (DON) on [DATE] at 2:10 p.m. It read in pertinent part, To have complete, accurate, and timely documentation for residents who have sustained a fall and/or preventive measures taken to prevent a fall. B. Resident #9 1. Resident status Resident #9, age 87, was admitted to the facility on [DATE]. She expired at the facility on [DATE]. The [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 8 out of 15. The resident required extensive one-person physical assistance with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. The resident was not steady and required staff assistance during transfers and locomotion. The updated care plan, [DATE], documented the resident was at risk for falls related to gait/balance problems, history of falls, incontinence, and psychoactive drug use. Documented interventions included anticipate the needs of the resident ([DATE]), call light within reach and prompt use ([DATE]), hospice collaboration ([DATE]), non-slip cushion in wheelchair ([DATE]), non-skid footwear ([DATE]), floor mat at the bedside ([DATE]), provide toileting and incontinence care as needed ([DATE]), physical therapy evaluation ([DATE]), frequent monitoring (discontinued [DATE]) and bed in lowest position at night with items in reach ([DATE]). 2. Record review Record review revealed the resident fell ten times between April and August, 2020, sustaining a pelvic fracture as well as head injuries, a laceration, bruising and skin tears. Review of the resident's record revealed the facility failed to develop and implement effective measures to prevent falls with injury. Eight of the falls were unwitnessed, despite a plan for frequent checks. At least five of the falls were around toileting, yet care plan review revealed no toileting assessment or toileting schedule. There was insufficient evidence root causes were thoroughly considered in an effort to develop effective preventive measures. [DATE]: A [DATE] nursing note documented an unwitnessed fall. The resident was found on the floor by her bedside with an abrasion to her right elbow at 10:47 p.m The resident denied pain and was able to move limbs within normal limits. A registered nurse (RN) assessed the resident and neurological (neuro) checks were initiated and completed. The fall investigation for the [DATE] fall, received from the director of nursing (DON) on [DATE] at 11:00 p.m., revealed an abrasion to the right elbow, no pain, the resident was oriented to person and place, predisposing physiological factors of gait imbalance, high risk for falls, incontinence and poor safety awareness, predisposing situational factors included resident was on way to the restroom and was using her wheeled walker. Failure: There was no evidence the resident's predisposing risk factors (see above) were investigated or or new interventions considered to minimize them. No interventions were put in place after this unwitnessed fall to minimize her predisposing risk factors. [DATE]: A [DATE] nursing note documented an unwitnessed fall at 1:18 a.m The resident reported falling to a certified nurse aide (CNA) and stated her hip hurt. The nurse assisted the resident to the restroom and back to bed and noted the resident was limping. The nurse asked the CNA if she usually limped and the CNA confirmed the resident does not usually limp. A

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 10) licensed practical nurse (LPN) assessed the resident, neuro checks were initiated, the nurse practitioner (NP) was notified, pain medication was administered (pain level 5 with 10 being the worst pain), and an x-ray was ordered for the resident's right hip. However, the x-ray was not performed by third-party radiology services until [DATE]. Results were received on [DATE] and forwarded to the physician who returned his [DIAGNOSES REDACTED]. (Cross-reference F658) The [DATE] interdisciplinary team (IDT) meeting note for the resident's fall on [DATE] revealed the cause of the resident fall to be weakness. An intervention of a physical therapy evaluation was planned, but the resident refused. Failures: There was no evidence other interventions to minimize the safety risk posed by the resident's weakness were considered and documented, such as monitoring the resident to determine if there were periods of the day when she was weak, specific times when she was likely ambulating to the bathroom or increasing staff supervision. [DATE]: A [DATE], two days following her fall with fracture, a nursing note documented another unwitnessed fall at 6:44 a.m. The CNA on duty walked into the resident's room and found her on the floor between the bed and night stand with her legs facing the doorway. The resident was wearing her non-skid footwear. A physical assessment by the RN revealed several bruises on the resident's left elbow, and three on her right elbow (pain level of 2 per fall investigation), Neuro checks were initiated (but not completed). The resident was assisted back to bed and reminded to use her call light if she needed assistance. Frequent checks were initiated for safety. The family and physician were notified. The [DATE] IDT meeting note for the resident's fall on [DATE] revealed the cause of the fall as increased confusion of the resident after a room change. No treatment was required for this fall. Interventions initiated included frequent checks for safety and neurological checks. Failures: Although frequent checks were initiated for safety, the meaning of frequent checks was not defined, this intervention per care plan (see above) was discontinued on [DATE], and there was no documentation to show if frequent checks were done and/or done consistently. [DATE]: The [DATE] nursing note documented an unwitnessed fall at 11:16 a.m. The resident was heard yelling for help and staff found her on the floor, lying on her left side. The resident said she was trying to go to the bathroom. Her call light was not on. A small scratch was noted on the resident's left thigh and the resident reported right hip and knee pain (per LPN assessment). Neuro checks were initiated (but not completed). She was wearing non-skid footwear. Staff assisted her back to bed and re-educated her about using her call light and placed it with her reach. The fall investigation noted the resident was complaining of pain to her right knee and hip and had a fractured pelvis from a previous fall. No pain level was documented The resident was oriented to person. No predisposing factors were documented. Failures: Effective interventions were not initiated to keep the resident safe. Although on frequent checks (per IDT note following the resident's [DATE] fall, the resident experienced a fourth unwitnessed fall. As noted above, the meaning of frequent checks was not defined, the intervention was noted as discontinued on the care plan, and there was no documentation to show frequent checks were done and/or done consistently. Moreover, the resident was known to not use her call light, yet the facility continued to utilize this intervention (remind and re-educate to use the device), despite knowledge it was ineffective. Finally, there was no evidence the facility evaluated the resident's incontinence or attempted to develop a toileting schedule, even though a number of her falls referenced the resident was heading to the bathroom when she fell . [DATE]: The [DATE] nursing note documented a fifth unwitnessed fall at 6:57 a.m. The resident was yelling for help and the night nurse walked into her room and found the resident sitting on the floor on her buttocks. The resident reported trying to go to the restroom and hit her head on the side of her bed as she fell . An LPN assessed the resident and the resident reported mild pain in her buttocks. She also had an open skin injury. Neuro checks initiated, but incomplete. Failures: As above; effective interventions were not initiated that would keep the resident safe. Although on frequent checks per the IDT note after the [DATE] fall, the resident experienced a fifth unwitnessed fall. This intervention was discontinued on the care plan, and there was no documentation to show frequent checks were done and/or done consistently. Further, there was no evidence the facility evaluated the resident's incontinence or attempted to develop a toileting schedule, even though this was another fall while the resident was trying to go to the bathroom when she fell . [DATE]: The [DATE] nursing note documented an unwitnessed fall at 11:38 a.m. The resident was found sitting on the floor next to her wheelchair by the bathroom door. Resident said she was trying to use the restroom and fell out of her wheelchair. The resident's call light was not on. The resident denied hitting her head and no injuries were apparent. An RN assessed the resident and initiated neuro checks. The resident was assisted back to bed and re-educated about using her call light to call for assistance. The resident verbalized understanding. The [DATE] IDT meeting notes for the resident's fall on [DATE] revealed the cause of the fall was the resident attempting to use the restroom independently and slid out of her wheelchair. Interventions initiated included continued collaboration with hospice services, offer toileting before meals and place a no-slide cushion in her wheelchair. Failures: While interventions included to offer toileting before meals, there was no evidence this toileting plan was based on an assessment of the resident's toileting needs and no evidence this intervention was added to the care plan. Moreover, reminding the resident to use her call light, even if the resident indicated understanding, was known to be ineffective in keeping the resident from ambulating without assistance. [DATE]: The [DATE] nursing note documented a sixth unwitnessed fall at 7:12 a.m. The CNA on duty found the resident bleeding on the floor of her room. The resident was found sitting on the floor with blood on her face, hands, legs and gown. A fall assessment was completed by a RN; neuro and neurological and physical assessments were done immediately. The fall resulted in a laceration to the resident's forehead that was bleeding slowly and continuously. The resident reported a pain level of seven out of ten. Staff helped the resident into a new gown and back into her wheelchair. Her wound was cleaned, band-aid applied and an ice pack provided for pain. The [DATE] IDT meeting notes for the resident's fall on [DATE] revealed the cause of the fall as a history of falls, weakness, poor safety awareness and hospice care. Treatment included wound care. Interventions included a fall mat to be placed at bedside. Failures: Effective interventions to keep the resident from falling were not implemented as she continued to fall unwitnessed. There was no evidence the facility considered increasing supervision of the resident to keep her safe. Moreover, there was no evidence whether the resident fell from bed or fell during ambulation, a factor in developing an effective intervention. [DATE]: The [DATE] nursing note documented a seventh unwitnessed fall at 3:56 a.m. The resident was heard shouting from her room. The CNA went to check on her and reported to the nurse that the resident was on the floor. She was observed sitting on her buttocks by her bed and her wheelchair was 10 feet away from the bed. The resident was assessed by a RN; neuro checks were initiated (but incomplete) and two skin tears were noted to the resident's left elbow. The resident reported a pain level of five out of 10 on the back of her head. The resident was assisted to the restroom and then back to bed by staff. Her wounds were cleaned and bandaged. The resident was reminded to use her call light for assistance, the fall mat was on the floor next to bed and non-skid footwear was on. Frequent checks were initiated for safety. The [DATE] IDT meeting notes from the resident fall on [DATE] revealed the root cause of the fall as confusion. Treatment included first aid rendered to reopened abrasion. Interventions put into place included a fall mat, neurological checks and frequent checks. Failures: As above; the facility failed to ensure the resident received adequate supervision; frequent checks had been in place since the resident's fourth fall per IDT notes, yet she continued to fall, unwitnessed. Interventions continued to include reminders to use her call light, another intervention known to be ineffective. [DATE]: The [DATE] nursing note documented a witnessed fall at 6:05 a.m A CNA on duty called for help from another staff member. The first CNA responded to the resident's cries for help and when she opened the door, the CNA witnessed the resident fall on the floor and land on her buttocks. The CNA was too far from the resident to intervene in the fall. The resident complained of a pain level of five out of ten. The laceration on her forehead reopened, was cleaned and bandaged. The resident was assisted to bed and reminded to use her call light, fall mat at bedside, non-skid footwear on, and fluids offered. Frequent checks initiated for safety. Failures: The [DATE] IDT meeting notes from the resident's fall on [DATE] revealed no root cause of fall, no treatment and no new interventions. [DATE]: The [DATE] nursing note documented an eighth unwitnessed fall at 10:03 p.m. A staff member heard calls for help coming from the resident's room. The staff member went into her room and found the resident laying on her right side next to her bed on the floor mat. Blood was noted on the resident's face from the existing wound. A RN assessed the resident; neuro checks initiated (but incomplete) and the staff member assisted the resident back to bed and cleaned and bandaged her wound. . The [DATE] IDT meeting notes for the resident's fall on [DATE] revealed the fall was reviewed. No specifics were documented. Failure: No fall investigation was provided for this unwitnessed fall. No new interventions considered. [DATE]: An [DATE] nursing note documented the resident's passing. 3. Staff interviews LPN #1 was interviewed on [DATE] at 5:20 p.m. She said if a fall was witnessed, a skin check was done and the RN comes to assess the resident. If the fall is unwitnessed, neurological checks are initiated and vital signs and cognitive functions are monitored. She said an investigation and interventions were done after every fall. She said investigations and interventions were important to determine the cause and prevent future falls. She said if no injury is present, the resident is assessed and does not go out to the hospital.

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 11) She said if the fall was serious and there was a possibility of injury the resident should be sent to the emergency department via ambulance. She said Resident #9 had multiple falls due to confusion, lack of safety awareness, and not recognizing her need for assistance. She said she had a sitter briefly after the fall resulting in the head wound, although see above, record review revealed no consideration or documentation regarding a sitter. She said staff would take her to the restroom and remind her to use her call light, then find her out of her room a few minutes later. She said Resident #9 had a couple of x-rays. She said she was not aware of the fracture resulting from one of the resident's fall on [DATE]. She said the resident used both a walker and a wheelchair. She said the staff would sit her next to the nurses' station for safety. She said the resident had a 24 hour sitter near the end of life. LPN #4 was interviewed on [DATE] at 9:55 a.m. She said if an x-ray was ordered it is usually done the same day. She said the results are typically available the same day as well. She said Resident #9 had many falls at night. She said nursing staff assessed her every shift, fall or not. The nursing home administrator (NHA) was interviewed on [DATE] at 11:40 a.m. He said the facility was having issues getting the x-ray company into the facility in May due to the Coronavirus. He said the facility was dealing with an outbreak and the x-ray company was as well. He said he should have sent Resident #9 to the hospital after the fall on [DATE], but didn't think to do so at the time. The DON was interviewed on [DATE] at 4:19 p.m. She said unwitnessed falls should be accompanied by neurological checks. She said they were having some issues with the radiology company in May that resulted in delay of care. She said they should have had a conversation with the resident about being sent to the hospital for acute care. She said IDT meetings should be held within 24 hours of an incident so interventions can be put in place right away. She could not explain why the IDT meeting and interventions were not put in place for Resident #9 after each fall event. C. Resident #23 1. Resident status Resident #23, age 92, was admitted to the facility on [DATE]. According to the [DATE] computerized physician orders [REDACTED]. The [DATE] minimum data set (MDS) assessment revealed the resident was severely impaired cognitively with short and long-term memory loss. He had no behaviors. He required extensive assistance with two-person care for bed mobility, transfers, dressing, toileting and hygiene. He had one fall since admission with no injury. 2. Record review Record review revealed sustained two falls which were not thoroughly investigated to determine cause in order to develop effective interventions. [DATE]: A nurse progress note, written by LPN #5 for Resident #23 was reviewed on [DATE] at 3:30 p.m. It revealed a nurse's note dated [DATE] at 4:01 a.m. that read: Roommate witnessed the fall, resident fall with no injury noted upon assessment, assisted resident back to bed with two-person assist. [DATE]: A nurse progress note written by LPN #6, dated [DATE] at 12:34 a.m., read: Resident had unwitnessed fall in his room. Head to toe assessment performed by registered nurse (RN), no apparent injury noted, no head injury involved. Denied complains of pain. Resident assisted back to his bed. Bed in low position. Neuro(logical) checks initiated per facility protocol. Documentation was requested on [DATE] at 1:39 p.m. for facility investigations related to Resident #23's falls on ,[DATE] and [DATE] in order to identify root causes and to develop effective interventions. No such documentation was provided. II. Smoking A. Facility policy and procedure The Traditional Tobacco and Electronic Cigarette Smoking Policy, last reviewed [DATE], provided by the facility on [DATE], included in pertinent part, All residents who smoke or desire to smoke will be appropriately assessed to determine if the resident requires supervision and protective equipment during smoking. Smoking assessment and potential restriction shall be made upon admission, quarterly, at the time of unsafe smoking behavior or suspicion of smoking in an undesignated area or upon any change of condition, which would impact the resident ' s ability to smoke and/or smoke safely. Should the incidence of unsafe smoking behavior occur, the community will attempt to: educate the resident on safe smoking practices, offer smoking cessation assistance, including pharmacological and behavioral support for smoking cessation and implementation of the behavior management plan. Unsafe smoking behaviors will also result in the resident immediately becoming a supervised smoker for a period of up to 30 days. After the supervised smoking period, the resident will be re-assessed for safety. If another offense occurs, the resident will be immediately placed on supervised smoking and may be subject to a 30 day or immediate involuntary discharge. Existing smoking care plans will be amended and updated to reflect any unsafe smoking incidents and any new interventions that the interdisciplinary team (IDT) has developed to keep the community and the resident safe and prevent reoccurrence of unsafe smoking. Supervised smokers will have their smoking supplies kept at the nursing station, secured. Staff will be responsible for distributing smoking materials during designated smoking times. Any resident, who has been classified as unsafe, shall not be permitted to smoke without direct supervision of a designated staff member, family member or volunteer. Direct supervision will be provided throughout the entire smoking period. At no time may residents who smoke share, trade or sell their supplies with their peers. B. Facility documents and resident record reviews On [DATE], the facility provided a list of residents that smoke as of [DATE] per the most recent smoking assessments in the electronic records. The first column was the resident ' s name, the second column documented if the resident was safe or unsafe, supervised or unsupervised and the third column documented needed smoking equipment. The DON said if a resident was marked as safe/supervised, it meant the resident was able to smoke safely but needed some type of assistance such as lighting their cigarette or putting it in the ashtray. Review of this document on [DATE] revealed it was not updated with the current resident information in the electronic record. 1. Resident #16 Resident #16, age 59, was admitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. Further review of the CPO revealed the resident was ordered to receive oxygen at 3 liters/minute per nasal cannula. The [DATE] MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 13 out of 15. The resident required extensive assistance of two people with her activities of daily living (ADLs). Tobacco use was not indicated. The [DATE] smoking risk assessment revealed the resident was an unsafe smoker who must be supervised at all times when smoking. The care plan, last revised [DATE] (during survey), revealed the resident was a supervised smoker and was at risk for smoking in her room. Interventions included: -Monitor for any unsafe smoking practices. Observe clothing and skin for signs of cigarette burns, initiated [DATE]; -Instruct resident about smoking risks and hazards and about smoking cessation aids that are available, revised [DATE]; -Notify charge nurse immediately if it is suspected the resident has violated the facility smoking policy, revised [DATE]; -The resident requires a smoking apron while smoking, revised [DATE]; -The resident ' s smoking supplies are stored in the designated smoking box located at the south nurse ' s station, revised [DATE]; -Instruct and inform the resident about the facility policy on smoking: locations, times, safety concerns, and any changes, revised [DATE]; -Re-evaluate the resident for safe smoking abilities on a quarterly and as needed basis, making changes as needed, revised [DATE]; -The resident requires SUPERVISION while smoking, revised [DATE]; and -Alarm attached to oxygen tank to assist in reminding the resident to remove oxygen prior to entering the smoking area, revised [DATE] (during survey). Observations and record review revealed the resident engaged in unsafe smoking behavior that had not been addressed. Specifically: -On [DATE] at 1:47 p.m. and [DATE] at 11:04 a.m., the resident was outside on the smoking patio, smoking a cigarette without a protective smoking apron on, contrary to her care plan. -A [DATE] nursing progress note revealed the resident had a strong odor of marijuana in her room with a suspicion of the resident smoking while in bed since the resident was a Hoyer lift and her purse was next to her in bed. -A [DATE] incident progress note revealed the resident was smoking cigarettes and it smelled very strongly of marijuana in her room even after the resident had sprayed an air freshener to conceal the odor. It indicated the resident had a pack of cigarettes on her chest and asked the CNA to discard her cigarette butt. The note indicated the resident was educated and reminded of the danger of smoking in her room with an oxygen tank; however, the resident denied smoking in her room and understanding the education provided. However, according to the [DATE] facility list of residents that smoke (see above), the resident was a safe smoker who needed supervision. It indicated she needed assistance but did not specify what type of assistance and it did not indicate the resident was to have a smoking apron on when she was smoking. Further review of her record on [DATE] revealed the resident ' s smoking risk assessment was not completed after unsafe smoking behaviors were documented, no interventions were put into place to prevent reoccurrence and the care plan was not updated timely. Observations revealed the resident was not wearing a smoking apron while smoking as care planned. 2. Resident #25 Resident #25, age 64, was admitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She required extensive assistance of one person for her ADLs. Tobacco use was not indicated. The [DATE] smoking risk assessment revealed the resident must wear a protective non-flammable vest/apron when smoking. The care plan, last revised [DATE], revealed the resident was a supervised smoker. Interventions included: -Instruct and inform the resident about the facility policy on smoking: locations, times, safety concerns, and any changes, revised [DATE]; -Monitor for any unsafe smoking practices. Observe clothing and skin for signs of cigarette burns, initiated [DATE]; -Notify charge nurse immediately if it is suspected the resident has violated the facility smoking policy, initiated [DATE]; -The resident ' s

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F 0689 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 12) smoking supplies are stored in the designated smoke box at the south nurse ' s station, revised [DATE]; -Re-evaluate the resident for safe smoking abilities on a quarterly and as needed basis, making changes as needed, revised [DATE]; -The resident is supervised with a smoking apron, revised [DATE]; and -She requires a cigarette extension when smoking, initiated [DATE] (during survey). According to the [DATE] facility list of residents that smoke, the resident was an unsafe, supervised smoker, and required the use of an apron and extension. Observations and record review revealed the resident engaged in unsafe smoking behavior that had not been addressed. Specifically: -On [DATE] at 4:00 p.m., the resident was outside on the smoking patio, smoking a cigarette unsupervised and without an apron or extender. On [DATE] at 9:15 a.m. and 5:00 p.m., the resident was outside on the smoking patio, smoking a cigarette without an apron on or an extender. -A [DATE] risk management review progress note revealed the resident burnt her finger on [DATE] while smoking. It indicated the resident was to be reviewed for a cigarette holder and verbal education was given to the CNA to stay close and help the resident with ashing her cigarette. -An [DATE] nursing progress note revealed a staff member reported Resident #5 gave Resident #25 marijuana to smoke. It indicated the DON was notified. Review of the record on [DATE] revealed the smoking risk assessment was not updated when unsafe smoking behavior occurred, new interventions were not initiated to prevent the behavior from reoccurring and the care plan was not updated with this behavior. Observations revealed the resident was not being provided supervision while smoking and the resident was smoking without the use of an apron or extender. 3. Resident #3 Resident #3, age 61, was admitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. Further review of the CPO revealed the resident was ordered to receive oxygen 6 liters/minute via nasal cannula. The [DATE] MDS assessment revealed the resident had no cognitive impairment with a BIMS score of 15 out of 15 and the resident used tobacco. The resident required supervision with all of her ADLs. The smoking care plan, initiated [DATE] and last revised [DATE] (during the survey), revealed the resident was a supervised smoker and had a history of [REDACTED]. Interventions included: -Instruct and inform the resident about the facility policy on smoking: locations, times, safety concerns, and any changes, initiated [DATE]; -Instruct resident about smoking risks and hazards and about smoking cessation aids that are available, initiated [DATE]; -Monitor for any unsafe smoking practices. Observe clothing and skin for signs of cigarette burns, initiated [DATE]; -Re-evaluate the resident for safe smoking abilities on a quarterly and as needed basis, making changes as needed, initiated [DATE]; -The resident requires SUPERVISION while smoking, revised [DATE]; -Notify charge nurse immediately if it is suspected the resident has violated the facility smoking policy, revised [DATE]; and -Alarm monitor on oxygen tank as a reminder to leave in building when smoking, initiated [DATE] (during the survey). The resident's most recent smoking risk assessment, dated [DATE], revealed the resident was a safe smoker and was capable of smoking without physical assistance but must be supervised per facility policy. Likewise, on the [DATE] facility list of residents that smoke, the resident was a safe smoker who needed supervision. Observations and record review revealed the resident engaged in unsafe smoking behavior that had not been addressed. Specifically: -On [DATE] at 4:00 p.m., the resident was outside on the smoking patio, smoking a cigarette, unsupervised. -A [DATE] nursing progress note revealed the resident was observed by staff smoking a cigarette in her room while her oxygen was on. It indicated the cigarette was removed, the resident was educated about safety and the DON and NHA were notified. -A [DATE] nursing progress note revealed the resident had oxygen on while smoking outside in the smoking area. It indicated the oxygen tank and tubing were removed and the resident was educated on safety measures for herself and other residents; however, the resident continued to repeat the non-safe behavior throughout t
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to provide dementia treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for one (#7) of two of the 27 sample residents. Specifically, the facility failed to consistently implement documented behavioral interventions for the resident. Findings include: I. Facility policy and procedure The Dementia-Clinical Protocol policy, revised November 2018, was received from the corporate consultant (CC) on 9/18/2020 at 9:57 a.m. It read in pertinent part, For the individual with confirmed dementia, the interdisciplinary team (IDT) will identify a resident-centered care plan to maximize remaining function and quality of life. The physician and staff will review the effectiveness and complications of medications used to try to enhance cognition and manage behavioral and psychiatric symptoms and will adjust, stop, or change such medications as indicated. II. Resident #7 Resident #7, aged 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 9/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment with a brief interview for mental score (BIMS) of zero of 15. The resident required extensive two-person physical assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. The resident displayed behavioral symptoms not directed towards others (screaming/yelling out, disruptive sounds) daily and rejected care one to three days during the lookback period. III.Observations The resident was observed on 9/16/2020 on the North unit. -At 4:29 p.m., Resident #7 was sitting by the nurses station in the common area. She was yelling and cursing to herself. Another resident yelled at her to shut the (expletive) up! Resident #7 then got louder as she began yelling at the resident who yelled at her. No staff came to intervene or redirect Resident #7. Resident #7 continued to yell in the common area. -Between 4:53 p.m. to 5:10 p.m., Resident #7 was ambulating the north hallway toward her room. She was shouting, cursing and yelling as she ambulated herself. Three nursing staff remained at the nurses station that was approximately 10 feet away and the resident could be heard. The nursing staff did not come to redirect the resident. -At 9:20 p.m., the resident was heard yelling and cursing to herself in her room from the nursing station. The four nursing staff members remained sitting at the nurses station which was approximately 100 feet away from the resident's room. The resident was observed on 9/17/2020 on the North unit. - At 11:31 a.m., the resident was lying in her room yelling to herself. She could be heard from outside her room into the hallway. - At 2:44 p.m., the resident was cursing and yelling loudly in her room. The nursing staff were distributing medications and sitting at the nurses station where the resident could be heard from her room that was approximately 100 feet away. No staff member went into check on the resident. Review of Resident #7's electronic medical record revealed the above observations were not documented. IV. Resident interviews Resident #2 was interviewed on 9/15/2020 at 11:52 a.m. He said Resident #7 yelled and cursed all day long just up the hallway from his room. He said the yelling has been bothersome. He said her yelling prevented him from wanting to be here at all. He said her constant cursing made the facility a worse place. He said he had not told any staff members about how much her yelling bothered him. Resident #18 was interviewed on 9/16/2020 at 4:02 p.m. She said Resident #7 yelled and cursed all day long. She said she does her best to ignore the cursing but it disturbed her while she was in her room. She said she can hear the yelling through both shut doors. She said the yelling was so loud sometimes that she could not hear her television with the door shut. She said the residents yelling was disturbing during meal times since everyone had to eat in their rooms. She said when other residents yell at Resident #7 it makes her cursing and yelling louder. She said hallway bingo had to stop one day because Resident #7 would not stop cursing and yelling in the hallway. She said no staff came to intervene with the resident that day. She said she did not know what staff did to help Resident #7 but it was not working. She said she went to the nursing home administrator (NHA) and told him that the yelling and cursing was getting out of control. The NHA told her they were seeking another facility for Resident #7. An unidentified resident was interviewed on 9/16/2020 at 4:19 p.m. He said the resident's yelling wakes him up in the middle of the night. He said the yelling and cursing needed to stop. He said the facility just moves Resident #7 from room to room in the facility without doing anything to manage her yelling and cursing. Resident #1 was interviewed on 9/16/2020 at 5:00 p.m. She said Resident #7 yells in the hallway and television room all day and the staff does not do anything about it. She said staff has no training on how to deal with her. She said Resident #7 could get beat up because she is so loud and mean. Resident #18 was re-interviewed on 9/17/2020 at 8:54 a.m. She said she had some sleep last night (9/16/2020) but was awoke by the yelling and cursing of Resident #7. V. Record review The updated care plan dated 6/25/2020 documented the resident had behavior challenges related to dementia. She could become easily agitated due to overstimulation in a group environment and begin yelling and being disruptive to others. Interventions included going outside for short walks (12/8/19), offer favorite snacks or beverages (12/8/19), anticipate the resident's needs (11/27/19), provide opportunities for positive interactions (6/25/2020), and minimize her potential for disruptive behaviors such as yelling, by monitoring for signs that the resident was overstimulated by noise, light, activity, and offer to move her to an area with less stimulation (11/27/2020). A 6/15/2020 nursing note from 12:32 p.m.

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	065337	A. BUILDING _____ B. WING _____	09/18/2020

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 13) revealed the resident had been cursing profanities in the north television area when Resident #24 poured water on her. Cross-reference F600 for failure to prevent resident-to-resident abuse. A 7/8/2020 weekly nursing note documented the resident had been continuously yelling, cursing and screaming to herself and denied any pain. A 7/20/2020 nursing note from 9:58 p.m. revealed the resident was yelling and screaming and talking loudly to herself all day shift. The resident was on an antipsychotic medication with no signs or symptoms of adverse reaction. The resident's behavior continued and the medication was not at a therapeutic level. An 8/7/2020 nursing note from 11:44 a.m. revealed the resident had been yelling in the hallway all morning. The resident was yelling about back pain and medication was ordered. The resident met with the physician and some medication changes were made. An 8/13/2020 nursing note from 1:58 p.m. revealed the resident had been yelling to herself and those around her all day (other residents and staff). Staff attempted to redirect her multiple times and were unsuccessful. A 9/9/2020 physician encounter note revealed the resident was seen in her room laying in bed. The resident has some dementia with [MEDICAL CONDITION] as she cursed all day long for no reason. She was lying in bed with no one in the room but could be heard down the hall. Review of the behaviors progress notes, the facility did not document any behavior interventions that were utilized by staff documented on the resident's comprehensive care plan (see above). The resident's behaviors were known by staff and were disruptive to other residents and her interventions were not modified or updated to manage her ongoing yelling and cursing. VI.Staff interview Licensed practical nurse (LPN) #1 was interviewed on 9/17/2020 at 5:20 p.m. She said she completed a computer training about dementia from the facility. She said the video training covered how to administer medications to demented residents and redirect residents when they were having behaviors. She said the computer training had to be completed every month. She said Resident #7 enjoyed snacks and beverages as a diversion when she was screaming and cursing. She said staff were to encourage video visits with her family, bird watching and talking with her. She said she learned the interventions were positive in helping her behaviors . She said she did not know to find the resident's behavior interventions on the care plan. LPN #4 was interviewed on 9/18/2020 at 9:55 a.m. She said the nursing staff were provided a training on behavior management with residents but could not remember when or who conducted the training. She said the training covered how to handle resident behaviors in the nursing home setting and how to limit those behaviors. She said Resident #7 would usually sit in the common area during the day. She said she yelled and cursed aggressively and inappropriately to herself often. She said Resident #7 was redirected to a quiet area, to the bird box, given picture books and activity books, and conversation about her children helped calm her down when she yelled. She said many of the interventions documented in her chart or verbally passed on from activity staff. She said she knew the specific interventions that worked for the resident based on providing her care and what she tried with other residents on the unit. She said she did not review the resident's care plan often. The activities director (AD) was interviewed on 9/18/2020 at 3:00 p.m. She said she educated the activity staff on the different programs for residents with dementia and told the activity staff to video trainings monthly. She said the training covered associated behaviors, sundowning, and programs tailored for the residents with dementia She said she kept a copy of some helpful tips on the activity cart that went around the facility. She said she encouraged her staff to be patient and [MEDICATION NAME] with residents with dementia She said she had smaller groups and one-to-one activities for the residents with dementia, that the residents often responded well. She said Resident #7 responded well to a tablet program designed to help memory retrieval that she was trying out at the facility. She said the resident could use the tablet for twenty minutes before her attention diverted elsewhere. She said her care planned interventions included sitting the resident where she could bird watch, family video visits, giving her a favorite snack or drink, coloring, and listening to country music. She said these interventions populated wha the nurses documented on automatically after being input. She said nursing staff had access to each resident's care plan and the interventions documented in their electronic chart. The director of nursing (DON) and (CC) were interviewed on 9/18/2020 at 4:55 p.m. They said dementia trainings were done monthly on an electronic training program and all staff had to complete the trainings. They said when Resident #7 was cursing and screaming in the common area, the staff should redirect her and offer interventions from her care plan or use what worked with her.They said if the resident was being yelled at by another resident the nursing staff should intervene immediately and remove the resident from the common area for safety due to the risk of her being involved in resident-to-resident altercations.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide medically-related social services, necessary to facilitate and promote the resident's highest practicable mental and psychosocial for a sample of 27 residents affecting one (#16) resident, although the lack of a social service direcetor impacted residents throughout the facility. Specifically, the facility failed to provide the following social services for Resident #16 regarding ancillary services, address grievances, update the smoking risk assessment and include her in the care planning process. Findings include: I. Resident status Resident #16, age 59, was admitted on [DATE]. According to the September 2020 computerized physician orders [REDACTED]. The 8/28/2020 minimum data assessment (MDS) assessment revealed the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required extensive assistance of two staff with her activities of daily living (ADLs). II. Resident interview and observation Resident #16 was interviewed on 9/15/2020 at 11:25 a.m. She said she has had several problems related to the social services department lately. She said her reading glasses were stolen last month. She said she told the social worker but that person got fired and the facility did not have a social worker at this time. She said the nursing home administrator (NHA) told her they would have a new social worker in a couple of weeks. She said, It's been a couple of weeks, and we still don't have anyone. She said she really needed to see a podiatrist and she said she could not even remember the last time she had a care conference at the facility. The resident's toenails were very long and jagged, some were curved into the surrounding skin causing the resident discomfort. III. Record review According to a 1/29/2020 podiatry consult progress note the resident was seen for at risk foot care and toenail pain. It indicated the resident had ten toenails debrided with sharp nail nippers to reduce discomfort and limit the chance of future complications. The plan was for the resident to follow up every two to three months or as needed. The resident's last smoking risk assessment was done 5/5/2020. This assessment should have been updated in August 2020. Cross-reference F689 for accident hazards. Review of the record on 9/16/2020 revealed the resident's last care conference was 12/19/19 and the last social service progress note was dated 3/26/19. Cross-reference F657 for care plan timing and revision. Grievances filed by the resident or on behalf of the resident were requested from the facility on 9/17/2020. The facility reported they had no grievances from the resident. The facility had no report of the resident reporting her stolen reading glasses. Cross-reference F585 for grievances. IV. Staff interviews Certified nurse aide (CNA) #8 was interviewed on 9/16/2020 at 2:42 p.m. She said Resident #16 had told the social service director that was here before that her reading glasses were missing but that person was no longer here so she did not know if the other managers had done anything about it or not. She said the resident was diabetic so she was not allowed to provide toenail care for the resident but the nurses should be doing it. Licensed practical nurse (LPN) #1 was interviewed on 9/18/2020 at 3:00 p.m. She said since the COVID-19 restrictions were put into place, the podiatrist no longer came to the building. She said the nurses should provide nail care if they were able. The director of nursing (DON) and corporate consultant (CC) were interviewed on 9/18/2020 at 4:18 p.m. The DON said she was not aware Resident #16's reading glasses were missing but would get them replaced right away. The CC said ancillary services had been on hold due to the COVID-19 restrictions but now that the physicians were starting to come back into the facilities, they would put Resident #16 on the list to be seen by podiatry as soon as possible but in the meantime, she said nursing should provide toenail care for the resident to the best of their ability . The CC said the social service director had been gone since 8/27/2020 and they were bringing a person from a sister facility full time for the position starting next week on Wednesday. She said the NHA has been handling all the social service needs in the facility in the meantime along with support from social workers from three other sister buildings coming in to assist. She said the corporate social worker was doing the preadmission screening and resident review (PASSRs) and assisting with the discharge planning.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is**

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 14) **necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to monitor [MEDICAL CONDITION] medications for two (#7 and #2) of four out of the 27 sample residents. Specifically, the facility failed to: - Review the resident's [MEDICAL CONDITION] medications for Resident #7 and track her behaviors; and, - Have signed consent from Resident #2 to administer [MEDICAL CONDITION] medications. I. Facility policy and procedure The Medication Administration policy, revised April 2019, was received from the corporate consultant on 9/18/2020 at 9:57 a.m. It read in pertinent part, If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns. I. Resident #2 A. Resident status Resident #2, under the age of 65, was admitted to the facility on [DATE] and readmitted on [DATE]. The September 2020 computerized physician orders [REDACTED]. The resident required extensive two-person assistance for transfers, bed mobility, and toileting, as well as, a limited one-person assist with locomotion and eating. B. Record review The September 2020 physician orders [REDACTED]. The physician notes dated 7/27/2020, 7/28/2020, 8/3/2020, 8/4/2020, 8/17/2020, and 9/14/2020 documented the resident had difficulty sleeping and was [MEDICATION NAME] aid with sleep. The medical record revealed the resident's sleep was being tracked every shift. Review of the medical record showed no review of the medication or side-effects was conducted with the resident. C. Staff interview The corporate consultant (CC) was interviewed on 9/18/2020 at 3:58 p.m. She said a hypnotic medication would be included in a psychiatric medication review. She said a quick medication review was done upon resident admission, with some medications triggering a full medication review monthly. She said they did not have a psychiatric medication review for Resident #2's hypnotic medication because he was a short-term resident. The CC said they did not have the signed consent form or a psychiatric medication review for Resident #2's hypnotic medication because he was a short-term resident. II. Resident #7 A. Resident status Resident #7, age 79, was admitted to the facility on [DATE]. The September 2020 computerized physician orders [REDACTED]. The 1/8/2020 minimum data set (MDS) revealed the resident had severe cognitive impairment and a brief interview for mental status of 0 of 15. The resident required extensive two-person assistance with bed mobility and transfers. The resident displayed screaming and disruptive sounds every day of the lookback period and rejected care 1 to 3 days of the lookback period. B. Record review The September 2020 physician orders [REDACTED]. -No behavior monitoring was included in the physician orders [REDACTED]. Cross-reference F744 for treatment and services for dementia care. C. Staff interviews The activities director (AD) was interviewed on 9/18/2020 at 3:00 p.m. She said certified nurse aides were to track behavior interventions they attempted on the electronic record. She said there was no behavior tracking for Resident #7. She said setting up the behavior tracking in the electronic medical record was a nursing task. The director of nursing and the corporate consultant (CC) were interviewed on 9/18/2020 at 4:19 p.m. They said behavior monitoring should be completed every shift and should be a part of the nursing note. They said some residents had specific behavior notes. They said certified nurse aides were to track behaviors in the resident's electronic chart. They said they were not able to find any behavior tracking for Resident #7.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure infection control processes were in place to ensure the prevention of infectious cross-contamination of Coronavirus (COVID-19) for two of two hallways. Specifically the facility failed to: -Quarantine newly admitted Residents #21 and #27, -Screen staff before starting their shift; -Complete the daily COVID-19 monitoring; -Ensure staff donned appropriate personal protectice equipment (PPE) before entering isolation rooms -Ensure social distancing was followed for residents; -Clean residents water pitchers, and; -Complete [MEDICAL CONDITION] (TB) testing for staff members. Findings include: I. Facility policy Infection prevention and control program policy revised October 2018 provided by the director of nurses (DON) on 9/18/2020 at 11:00 a.m. read in pertinent part; An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. II. Failure to Quarantine newly admitted Resident #21 and #27 A. Resident #21 1. Observations On 9/15/2020 at 11:45 a.m. Resident #21's door was wide open and he was sitting in his wheelchair right inside the door. Observations on 9/16/2020 revealed; -At 5:00 p.m. Resident #21 was sitting in his wheelchair in the doorway with a tray table in front of him. The door was wide open. -At 9:08 p.m. Resident #21 was sitting in the north common area. Licensed practical nurse (LPN) #1 was at the nurse's station and did not redirect the resident to his room. -At 9:25 p.m. to sit in the dayroom hallway outside his room without a facial mask on. Resident #2 a non isolation resident sat next to him in the dayroom. No staff tried to redirect him back into the isolation room nor attempted to offer a facial mask. -At 9:54 p.m. Resident #21 was sitting in the north common room socializing with another resident. The two residents were not six feet apart or wearing face coverings. Observations on 9/17/2020 revealed the resident's door was wide open at 8:35 a.m., 11:10 a.m., 2:30 p.m., and 5:15 p.m. 2. Resident #21 status Resident #21,[AGE], was admitted to the facility on [DATE]. The September 2020 computerized physician order [REDACTED]. The resident required extensive one person physical assistance with transfers and bed mobility and supervision with one person physical assistance with walking. He displayed no behaviors and rejected no care within the lookback period. 3. Record review The 9/11/2020 Care plan revealed no behavior care plan objectives or interventions. A 9/4/2020 admission note documented the resident was a new admission and was to be quarantined, on transmission-based precautions for 14 days. The resident's 9/3/2020 COVID 19 test, from the hospital, was negative. Physicians notes from 9/5/2020, 9/9/2020, 9/14/2020, and 9/17/2020 documented the resident was pleasant, cooperative, and displayed no behaviors. No nursing note between 9/4/2020-9/17/2020 documented refusal of care, behavior issues, or confrontational behavior. 4. Staff interviews LPN #1 was interviewed on 9/16/2020 at 9:30 p.m. She said Resident #21 had two more days left before his isolation and transmission-based precautions were lifted. She said he should be in his room. She said the resident did not listen to staff when they redirected him to his room. She says the resident refused to stay in his room when redirected. She said the staff continually encouraged him to stay in or return to his room. She said he does stay in his room during the day but comes out of his room at night to watch television. She said the resident refused to wear a face-covering or social distance from other residents. LPN #4 was interviewed on 9/18/2020 at 9:55 a.m. She said residents on isolation precautions should stay in their room until the precautions were discontinued. She said some residents refuse to stay in their rooms and came out anyway. She said she would educate the resident on the importance of staying in their room for the safety of the community. The director of nursing (DON) and corporate consultant (CC) was interviewed on 9/18/2020 at 4:20 p.m. They said isolation and droplet precautions should be active for the first 14 days of the resident's stay. Staff was to wear full personal protective equipment (PPE) when entering the indicated precaution rooms. The residents on 14-day precautions were to stay in their rooms. They said if the residents refused to stay in their rooms during the isolation time, the staff were to encourage them to return to their rooms. They said the residents did have the right to refuse to stay in their rooms. They said resident #21 had been encouraged to stay in his room and wear a mask outside of his room. They said his behavior interventions could be found in the care plan. B. Resident #27 1. Observation Resident #27 who was on droplet isolation as a new admit on 9/11/2020 to the facility was observed on 9/17/2020 at 2:15 p.m. to walk down the hallway outside of his room. He walked halfway down the hallway and said he forgot his mask so he walked back to his room to the mask. Several staff members walked past the residents room and did not redirect him to stay in the room. Resident #27 who was on droplet isolation as a new admit on 9/11/2020 to the facility was observed on 9/17/2020 at 2:15 p.m. to walk down the hallway outside of his room. He walked halfway down the hallway and said he forgot his mask so he walked back to his room to the mask. Several staff members walked past the residents room and did not redirect him to stay in the room. 2. Interviews CNA #10 was interviewed on 9/16/2020 at 9:27 p.m. She said new residents from the hospital were in isolation for 14 days. She said she wore a mask, goggles, gown and gloves in those rooms. She said she worked at the facility for two months and she was not sure if the residents in isolation were on droplet or airborne precautions. She said Resident #21 did not always cooperate to stay in his room. The assistant director of nursing (ADON) was interviewed on 9/16/2020 at 2:45 p.m. She said the facility currently had five residents on isolation precautions. She said four of them were because they were new admissions and the other was a resident that kept leaving the facility for personal reasons and would not listen to the facilities recommendations so they decided she needed to be

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 15) isolated when she came back to the facility yesterday to protect the other resident ' s. She said many residents in their population were not compliant with isolating in their rooms when needed and it was a challenge to get them to comply. The corporate consultant (CC) was interviewed on 9/17/2020 at 12:14 p.m. She said if a resident left the facility for a non-medical reason, the resident should be placed on transmission based precautions for 14 days. She said they have had a hard time getting some of their resident ' s to be compliant with this. LPN # 4 was interviewed on 9/17/2020 at 12:42 p.m. She said any new admit was in isolation and the facility treated them like they had COVID-19. She said all PPE gear includes a mask, gown, gloves and eye protection. She said some residents were non compliant with staying in their room so she tried to have them be six feet apart and encouraged them to wear a mask when needed. Corporate consultant (CC) was interviewed on 9/17/2020 at 12:30 p.m. She said new admits were put on droplet isolation for 14 days. She said full personal protective equipment (PPE) gear with a mask, gown, glove and eye protection were worn by all staff members with the isolation residents. She said Resident #21 and #27 were redirected back to their rooms and encouraged to wear surgical masks outside of their rooms. The director of nursing (DON) and the CC were interviewed on 9/18/2020 at 4:18 p.m. They said the water pitchers should be cleaned by the kitchen on a daily basis and did not realize this was not happening and said a schedule would be put together right away to get the resident ' s water pitchers cleaned. III. The facility failed to screen staff before they started a shift. A. Observations Observations on 9/16/2020 revealed that; -At 10:00 p.m. licensed practical nurse (LPN) #2 scanned her employee badge to enter the building. She proceeded to the unmanned reception desk, used the hand sanitizer, filled out the COVID 19 screening form, took her own temperature, donned a surgical mask, set her form on the opposite side of the reception desk, then proceeded into the building. -At 10:01 p.m. LPN #3 scanned her employee badge to enter the building. She proceeded to the unmanned reception desk, used the hand sanitizer, filled out the COVID 19 screening form, took her own temperature, donned a surgical mask, set her form on the opposite side of the reception desk, then proceeded into the building B. Staff interview LPN #2 and LPN #3 were interviewed on 9/16/2020 at 10:05 p.m. They said they received screener training when the outbreak started. They said they had always had to screen themselves in. They said there was never any staff member at the reception desk to screen in the night shift. The restorative certified nurse aide (RCNA) was interviewed on 9/17/2020 at 2:15 p.m. She said she received COVID 19 screening training a few months ago when she returned from sick leave. She said her training covered the signs and symptoms of COVID 19 and why testing was important. She said she lets people into the facility, have them use hand sanitizer, takes their temperature, and completes the screening form. She said if someone reported symptoms or had a high temperature she asked them to wait outside until management could come to assess them. She said she was at the reception desk from 7:00 a.m. until 3:30 p.m. She said everyone, staff, and visitors, now have to use the doorbell to be let in, as of 9/17/2020. She said it was important to actively screen visitors and staff before they enter the facility so their symptoms could be assessed and no sick people entered the building. She said if no staff member comes to the door at night then the staff had to screen themselves in and leave their forms on the desk to be reviewed in the morning. She said after she left there was no one at the reception desk to screen in staff. She said it was important to have someone else screen staff and visitors into the facility because someone could lie on their screening form or what their temperature was. The director of nursing (DON) and corporate consultant (CC) were interviewed on 4/18/2020 at 4:55 p.m. They said no staff were to screen themselves in before beginning their shift. They said as of 9/17/2020 the front doors would be locked and all staff had to be let into the building and screened before starting their shift. They said having someone else screen staff in could prevent a staff member from working ill or lying on the screen form. IV. The facility failed to complete the daily COVID 19 monitoring. A. Record review The vitals record for Resident #1 revealed a full set of vitals was not taken on 5/21/2020, 6/9/2020, 6/12/2020, 6/14/2020, 6/20/2020, 6/21/2020, 6/23/2020, 6/30/2020, 7/3/2020, 7/5/2020, 7/12/2020, 7/18/2020, 7/19/2020, 7/24/2020, 7/26/2020, 8/1/2020, 8/2/2020, 8/3/2020, 8/8/2020, 8/10/2020, 8/16/2020, 8/22/2020, 8/27/2020, 9/1/2020, 9/2/2020, 9/3/2020, 9/5/2020, 9/6/2020, 9/10/2020, 9/11/2020, 9/12/2020, and 9/13/2020. The vitals record for Resident #7 revealed a full set of vitals was not taken on 8/12/2020. The vitals record for Resident #21, admitted [DATE], revealed a full set of vitals was not taken on 9/11/2020. No COVID-19 monitoring forms were found in the resident's electronic chart for any of the residents. B. Staff interview Licensed practical nurse (LPN) #1 was interviewed on 9/17/2020 at 5:20 p.m. She said vital signs for COVID-19 monitoring were to be taken once a shift and logged in the resident's electronic chart. She said if they were short-staffed or very busy the vitals might not get done. She said monitoring vitals signs daily was important because they could show a change of conditions within the resident and that was how the nursing staff monitored the resident was at baseline. LPN #4 was interviewed on 9/18/2020 at 9:55 a.m. She said vital signs for COVID-19 monitoring were completed every shift or more often if the nursing staff was monitoring a resident's condition or the resident was on certain medications. She said daily vitals were important for COVID-19 monitoring because changes could be noticed from the vital signs. The DON and CC were interviewed on 9/18/2020 at 4:55 p.m. They said vital signs were to be taken each shift and a minimum of once a day to monitor for COVID-19. They said vitals monitoring was important because vital signs can show when a person was becoming ill. V. Failure to don appropriate PPE when entering non-isolation and isolation rooms. A. Observations of a certified nurse aide not donning PPE before entering isolation rooms 9/16/2020 att 3:55 p.m. certified nurse aide (CNA) #4 was providing care to Resident #16 with her mask under her nose and she was not wearing eye protection. She said her glasses fell off in someone ' s bed and that they were always falling off. -At 9:33 p.m. CNA #4 had her mask below her nose and was not wearing eye protection. Meal tray delivery observations were conducted on 9/18/2020 at 12:15 p.m. -At 12:15 p.m. certified nurse aide (CNA) #1 entered room [ROOM NUMBER], delivered the residents meal tray, exited the room, and used hand sanitizer. CNA #1 did not don PPE before entering this isolation room. -At 12:16 CNA #1 delivered meals to rooms [ROOM NUMBERS], delivered their meal trays, exited the rooms, and used hand sanitizer. rooms [ROOM NUMBERS] were not isolation rooms. -At 12:17 p.m. CNA #1 entered room [ROOM NUMBER], delivered the residents meal tray, exited the room, and used hand sanitizer. CNA #1 did not don PPE before entering this isolation room. -At 12:19 p.m. CNA #1 entered room [ROOM NUMBER], delivered the residents meal tray, exited the room, and used hand sanitizer. CNA #1 did not don PPE before entering this isolation room. -At 12:19 p.m. CNA #1 entered room [ROOM NUMBER], delivered the residents meal tray, exited the room, and used hand sanitizer. room [ROOM NUMBER] was not an isolation room. -At 12:21 p.m. CNA #1 entered rooms [ROOM NUMBERS], delivered the residents meal tray, exited the room, and used hand sanitizer. rooms [ROOM NUMBERS] were not isolation rooms. -At 12:22 p.m. CNA #1 entered room [ROOM NUMBER], rose the head of the resident's bed, washed her hand, delivered the residents meal tray, exited the room, and used hand sanitizer. room [ROOM NUMBER] was not an isolation room. -At 12:25 p.m. CNA #1 entered room [ROOM NUMBER], delivered the residents meal tray, exited the room, and used hand sanitizer. room [ROOM NUMBER] was not an isolation room. B. Staff interviews CNA #1 was interviewed on 9/18/2020 at 12:30 p.m. She said she received isolation precaution training when she went through orientation in early July. She said the staff was to wear full personal protective equipment (PPE) when doing direct care or providing bathing assistance. She said PPE should be worn any time she entered an isolation room. She said she completed PPE training on the facility's digital training program monthly. She said no member of management or nursing staff had observed or gone over donning and doffing PPE with her. She said it was important to always wear PPE into isolation rooms to prevent the spread of illness to other rooms. The DON and CC were interviewed on 4/18/2020 at 4:55 p.m. They said nursing staff should wear full personal protective equipment (PPE) before entering isolation rooms, no matter how brief or distant their entry. They said this was important to keep an infection or virus from spreading through the facility. VI. Failure to ensure social distancing and encourage residents to wear masks A.Observations 9/15/2020 -At 4:00 p.m. eight residents were outside on the smoking patio smoking at this time and were not distanced six feet apart. The area did not have any signage to remind the residents of social distancing and there were no markings on the ground to show the resident ' s where to sit in order to be six feet apart. 9/16/2020 -At 10:35 a.m. multiple residents were out on the smoking patio, sitting next to each other less than one to two feet apart and were not wearing masks. -At 4:30 p.m. Resident #18 was standing next to a male resident who was sitting in the hallway and they were not six feet apart and both had their masks under their chin. -At 8:45 p.m. eight residents were sitting next to each other, less than one to two feet apart, outside on the smoking patio and were not wearing masks. -At 9:45 p.m. the resident was sitting in the North side television area next to two other male residents. None of them were wearing masks and were not six feet apart. 9/17/2020 On 9/17/2020 at 11:04 a.m. multiple residents were out on the smoking patio without social distancing or wearing masks. B. Resident #5 1. Observations -At 10:35 a.m. Resident #5 went out to the smoking patio in his electric wheelchair. He was not wearing a mask and he was not six feet from other residents. -At 4:25 p.m. the resident was out in the smoking area without a mask on or social distancing from other residents. -At 8:55 p.m. the resident wheeled himself into room [ROOM NUMBER] without wearing a mask and sat in the room with another resident visiting for about 10 minutes. They were not six feet apart. 2.Resdient status Resident #5, age less

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065337	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY HEIGHTS REHAB AND CARE COMMUNITY	656 DILLON WY AURORA, CO 80011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 16) than 55, was admitted [DATE]. According to the September 2020 CPO, [DIAGNOSES REDACTED]. The 8/28/2020 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. The resident required extensive assistance of two people for bed mobility, transfers, personal care, dressing, toileting and bathing but was independent with locomotion on and off the unit. 3. Record review An 8/21/2020 nursing progress note revealed the resident got up that morning and was very warm to touch, sweating with a temperature of 99.8 degrees Fahrenheit (F). It indicated the physician spoke with the resident about his change of condition and the importance of the resident to stay in his room however the resident left the facility with his family and did not return to the facility until 8/22/2020 after midnight. An 8/22/2020 nursing progress note revealed the resident got up that morning sweating heavily but refused vital signs to be checked and told the facility he was leaving the facility again that day with his family. An 8/24/2020 nursing progress note revealed the resident left the facility to attend a funeral that day. An 8/25/2020 nursing progress note revealed the resident left during the day stating he was going to a funeral. It indicated he signed the book and left the building. An 8/27/2020 nursing progress note revealed the resident continued in isolation, with total personal protective equipment (PPE) being used during care. It indicated the resident was out of his room wearing a mask in the area. (This was the first mention of the resident being on isolation precautions). An 8/30/2020 nursing note revealed the resident returned to the facility at 11:55 p.m. There was no note indicating the resident had left the facility or where he went. A 9/3/2020 provider progress note revealed the resident had a low grade temperature of 99.2 degrees (F) with some mild chills, body aches and nausea. A 9/3/2020 nursing progress note revealed the resident was having sweating, chills, all over body aches and vomiting. The resident was placed on continued isolation while waiting on laboratory results. A 9/18/2020 nursing progress note revealed the resident was off 14 day isolation per facility protocol and he was encouraged to continue to wear a mask and keep six feet distance as per protocol to limit the spread of [MEDICAL CONDITION]. VII. Inappropriate cleaning of water pitches A. Observations On 9/15/2020 at 3:47 p.m. Resident #16's water pitcher in her room had a dried brown substance on the lid. B. Interviews Resident #16 was interviewed on 9/16/2020 at 3:47 p.m. She said she uses one of her water pitchers for her coffee and the other for water. She said the staff do not wash her pitchers so she makes sure they rinse it out in the sink every morning. Resident #18 was interviewed on 9/16/2020 at 4:30 p.m. She said the facility used to pick up the water pitcher in her room and wash it every evening but they had not done it in months. Resident #17 was interviewed on 9/17/2020 at 11:00 a.m. She said the facility never washes her water pitcher that she rinses it out herself. CNA #4 was interviewed on 9/17/2020 at 3:30 p.m. She said she was not sure when the water pitchers for the residents got washed. She said she did not think they were changed out with new ones in a while. CNA #9 was interviewed on 9/17/2020 at 3:35 p.m. She said the kitchen changed out the water pitchers. She said in her [AGE] years she had worked at the facility they used to change them regularly but she had not seen them do that in a while now. Dietary manager (DM) was interviewed on 9/18/2020 at 1:30 p.m She said the kitchen crew changed out the resident water pitchers two times a day. Once in the morning and once in the evening. The director of nursing (DON) and the CC were interviewed on 9/18/2020 at 4:18 p.m. They said the water pitchers should be cleaned by the kitchen on a daily basis and did not realize this was not happening and said a schedule would be put together right away to get the resident ' s water pitchers cleaned. CC was interviewed on 9/18/2020 at 5:35 p.m. She said the resident water pitchers were washed daily by the kitchen staff. She said the facility would get a system in place moving forward to ensure the water pitchers were cleaned. VIII. [MEDICAL CONDITION] (TB) testing Record review and interview General orientation documentation for new hires was requested on 9/17/2020 at 6:10 p.m. No documentation was given as of 9/21/2020 at 5:00 p.m. for the deadline to submit any additional information after the exit date of 9/18/2020. TB documentation requested from corporate consultant (CC) on 9/18/2020 at 11:00 a.m. for seven employees, licensed practical nurse (LPN) #8, certified nurse aide (CNA) #2, #3, #4, #5, #6 and #7. At 2:20 p.m. CC said she had no documentation to show the employees had a TB test on hire and yearly.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on record review and interviews the facility failed to ensure one certified nurse aide (CNA #4) of four CNAs received 12 hours of education to include abuse, neglect and dementia training yearly. Specifically the facility failed to have a system in place to ensure CNA #4 had abuse, neglect and dementia training yearly. Findings include: Record review Record review of four CNA training logs on 9/18/2020 at 2:00 p.m. provided by the director of nurses (DON) at 1:55 p.m. revealed one CNA #4's training log list to be blank. No documentation was given as of 9/21/2020 at 5:00 p.m. for the deadline to submit any additional information after the exit date of 9/18/2020. Interviews CNA #4 was interviewed on 9/18/2020 at 1:45 p.m. She said she was trained on the computer system at the facility. She said she had abuse training when she started, a few years ago, but no training recently. The DON was interviewed on 9/18/2020 at 4:25 p.m. She said when the training log list was completed a date was listed and what percentage of the training was completed. When the training log list was empty then the training was not complete.