STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065283	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIDGEVIEW POST ACUTE	5230 E 66TH WY COMMERCE CITY, CO 80022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure one resident (#2) out of three residents was free from neglect. Specifically: Resident #2, resided on the secured unit, and was cognitively impaired. The facility failed to ensure had had adequate supervision while outside and according to the National Weather Service historical weather records at https://w2.weather.gov/climate/index.php?wfo=bou, the official high temperature for 6/12/2020 was 91 degrees Fahrenheit and was recorded at 1:00 p.m. The resident was not provided adequate hydration for the over five hours of sitting outside. As a result, the resident had [MEDICAL CONDITION] type activity, and he was found unresponsive by staff, he was transferred emergently to the hospital and found to have a [DIAGNOSES REDACTED]. Cross reference F610: Failure to investigate neglect. Findings included: A. Facility policy and procedure The Incident accident Reporting policy and procedure proved by the director of nursing (DON) on 6/30/2020 at 8:45 p.m., revised May 2020, documented in pertinent part: -An Incident/Accident Report will be completed for incidents or accidents involving residents. -The administrator will coordinate an investigation of the event as needed. This investigation would be separate from the Incident/Accident Report Investigation. B. Resident status Resident #2, under the age of [AGE] years old, was admitted to the facility on [DATE] and discharged on [DATE]. According to the June computerized physician's orders [REDACTED]. The resident did not have a [DIAGNOSES REDACTED]. The resident required assistance with activities of daily living (ADL) but was independent with eating and ambulation. The MDS coded the resident as receiving both an antipsychotic and anti depressant medication. The resident was 73 tall and weighed 174 pounds. The resident resided on the secured unit. C. Paramedic Interview On 6/26/2020 at 1:17 p.m. the paramedic who had been dispatched to the facility and picked up Resident #2 was interviewed. She said that when she arrived at the facility none of the staff at the front door were aware of why she was there. After she informed them that she had been dispatched about a resident on the secure unit they escorted her back to the secure unit. She said she, with her coworkers, entered the secure unit and then were sent to the shower room. In the shower room she observed the resident sitting in a wheelchair, in his clothes, receiving a shower. She said the resident was red in appearance, felt hot to the touch and was unresponsive. She said his heart rate was 182 beats per minute. She said facility staff who were in the shower room were unable to say exactly how long the resident had been outside. She said one nurse said five hours and another employee said thirty minutes. She said the resident was transported to the hospital. She said when they got to the hospital the emergency room physician said that the resident had suffered hyperthermia and heat stroke. D. Surveillance Video The secured unit had a fenced in courtyard. On 6/30/2020 at 7:03 p.m. the surveillance video was reviewed with the nursing home administrator (NHA) and the regional vice president (RVP). The video revealed the following: -10:39 a.m. until 1:30 p.m. Resident #2 was in the courtyard, and staff were intermittently going outside; it was unknown what staff did because once staff were seen going outside, there was no video surveillance. According to the assistant director of nursing (ADON) (see interview below) he was sitting under the gazebo, towards the edge closest to the walkway and facility, the area was partially shaded during the time of observation (6/26/2020 at approximately 3:00 p.m.) -1:30 p.m. Resident #2 was escorted by staff inside to be weighed. -1:50 p.m. until 2:25 p.m., at 1:50 p.m. Resident #2 went back outside. Two certified nurse aides (CNA) went outside for approximately one to three minutes. It was unknown what the CNAs did when outside. -2:25 p.m. until 3:06 p.m. one CNA glanced out the window toward the courtyard, the resident remained outside. -3:13 p.m., the activity assistant (AA) went outside for 10-15 seconds; it was unknown what she did. -3:13 p.m. until 3:38 p.m. a CNA looked out the window twice. At 3:19 p.m. the activity director (AD) was outside briefly (see AD interview below). -3:38 p.m. until 4:04 p.m. a CNA briefly went outside (less than two minutes) then came back inside; it was unknown what they did. -4:04 p.m. three CNAs go outside, and immediately came inside and gets a nurse. -4:06 p.m., LPN #1 was observed to go outside -4:11 p.m., CNA brought Resident #2 inside the facility by using a wheelchair and immediately went into shower room with Resident #2. LPN #1 was observed on the video to bring a vital machine cart into shower room. -4:20 p.m., the ambulance arrived -4:51 p.m., EMS was observed to take the resident off of the secured unit on gurney. Although, CNAs, AA, AD and LPN #1 went to the courtyard, it was unknown whether they spoke to the resident to determine if he wanted to come inside (his BIMS was three out of 15) or offer hydration. Additionally, from 2:25 p.m. to 3:13 p.m. the resident was outside without any staff contact, a total of 48 minutes. The NHA and the RVP were interviewed on 6/30/2020 at 7:03 p.m., while reviewing the surveillance video. The NHA and the RVP agreed that there was no evidence to indicate when staff went outside that Resident #2 was offered hydration or was offered to come inside based on the surveillance video. E. Record review 1. Care plan The resident had a [DIAGNOSES REDACTED]. The care plan also failed to include the resident ' s history of [MEDICAL CONDITION] activity. 2. Hospital history and physical The hospital history and physical form, dated 6/12/2020 at 5:25 p.m. documented the resident's chief complaints was hyperthermia (abnormally high body temperature)/altered mental status. The document further read: This patient comes to the emergency department via EMS (emergency medical service). Resident is a [AGE] year old male with a PMHx (past medical history) of hypothermia, AMS (altered mental status), subarachnoid hemorrhage, aneurysm, anxiety, and recent pneumonia [DIAGNOSES REDACTED]. Per EMS, patient was outside in the sun between 2-5 hours, as nursing staff did not check on for several hours. Today is a very hot day. Temperatures are nearly 100 degrees F. Patient was found unconscious by nursing staff at his nursing home with no change after putting he patient in cold shower. Patient remained unconscious upon EMS arrival, with them noting some tonic or [MEDICAL CONDITION] activity in route to the ED (emergency department). EMS then administered 0.5 mg IV (intravenous) [MEDICATION NAME] and patient subsequently became more alert and responsive, with tremors ceasing. EMS then administered an additional 2 mg Versed. Upon arrival to the ED, patient is easily aroused to voice .He states he remembers being outside, and when I asked him if nursing staff forgot about him, he laughed. On physical examination the patient appeared in moderate to severe acute cardiorespiratory distress and was alert and answering questions appropriately. Initial vital signs are interpreted as febrile (having or showing symptoms of a fever), [MEDICAL CONDITION](rapid heartbeat), tachypnea (rapid breathing) and [MEDICAL CONDITION] (oxygen deprivation). Mucous membranes of the mouth are dry. Sunburn to bilateral thighs. Medical decision making and course in the ED with interpretation/review of diagnostic studies: After considering the history, physical exam, signs and presenting symptoms I believe that this patient has symptoms of hyperthermia. Differential [DIAGNOSES REDACTED]. Laboratory results interpreted: Renal function was found to be acute [MEDICAL CONDITION] with BUN (blood urea nitrogen) and Creatinine of 18 and 1.61 respectively. Final impressions/Diagnoses: [REDACTED]. Suspected [DIAGNOSES REDACTED], 3. Heat exposure, 4. Hyperthermia . 3. Change of condition 6/12/2020 The medical record was reviewed and revealed the resident experienced a change of condition on 6/12/2020 resulting in unresponsiveness. The 6/12/2020 Event/Change of Condition note documented: Possible [MEDICAL CONDITION] activity, 1625 (4:25 p.m.) resident was non-responsive, shaking, vital signs: 107/75, 98.0, p(ulse)111, r(espiratory) 21, Oxygen at 2 liters (72%). Physician and

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

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

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) family notified. Resident sent to hospital. 4. Medication Administration Record [REDACTED]. The facility did not monitor other fluid intake on the MAR. F. Facility investigation The facility investigation was provided by the NHA on 6/26/2020. The investigation was completed on 6/23/2020 (11 days after the resident went to the hospital and four days after the survey start date). The investigation included a summary of the video surveillance on 6/12/2020, the day of the event. The interviews from one CNA on the unit and LPN #1 were completed on 6/26/2020. The CNA interview documented that she had not seen the resident go outside because she was completing showers but was notified by the nurse that Resident #2 was outside. She said she offered him water and asked him if he wanted to come inside but he refused. She said she went to the nurse to tell her that he was red and warm to the touch and sunscreen was applied. She said she went to get another CNA to see if they could help her get the resident inside. She said an activities staff told her that the resident had thrown up. She said Resident #2 was not acting like himself and was transferred to a wheelchair and brought inside to the shower room. She said she, the nurse and the other CNA attempted to cool him then Resident #2 started screaming a female name. The LPN #1 interview documented that the resident went outside at approximately 12:30 p.m. after lunch with a CNA; she said the CNA sat with him initially. She said the Resident was weighed and then reweighed at approximately 2:00 p.m. then Resident #2 went back outside. She said the resident had a Boost Breeze while outside and the CNA took water to the resident. She said the resident remained outside until the CNA came and got her, they took the resident inside via wheelchair. The DON was notified and the Resident was taken to the shower room to be cooled, the resident's hands were shaking slightly and not at baseline. Oxygen saturations levels were checked and were low and Oxygen was administered and vitals were taken. The physician and family were contacted and the resident was sent out emergently. Reported to wife possible [MEDICAL CONDITION] activity. The DON provided How Hot Weather Affects Senior Citizens with Alzheimer ' s and Dementia. She said education was provided after 6/19/2020 and included information related to this article and to place residents on 15 minute checks. There was no further information. Sign in sheets were provided and documented the 6/21/2020 sign in sheet documented 15 CNAs and one nurse were educated and one nurse. The 6/22/2020 sign in sheet documented seven CNAs were educated and the 6/23/2020 sign in sheet documented six CNAs and one nurse were educated. G. Interviews Licensed practical nurse (LPN) #1 was interviewed on 6/19/2020 at 2:18 p.m. LPN #1 said Resident #2 was transferred to the secured unit, because he had multiple elopement attempts. She said he had behaviors and was ambulatory. She said he would go outside on occasion with assistance, and staff from the activities department would go out frequently and take residents. She said on 6/12/2020 the resident had gone outside sometime between 12:30 p.m. - 1:00 p.m. She said at approximately 1:50 p.m., he was assisted back inside at .to reweigh him as his earlier weight had not looked correct. She said after he was reweighed he was assisted back outside. She said she knew the CNA had given the resident a Boost breeze (dietary supplement juice) while he was outside. She said Resident #2 had been outside from approximately 2:00 p.m. to 4:00 p.m. She said around 4:00 p.m., a CNA took him water and found him shaking, maybe he had a [MEDICAL CONDITION]. She said the CNA went and got her and then went and brought him inside. She said they took him straight to the shower room, they took vitals twice. He felt warm so they put the shower on and soaked him down pretty good. The LPN #1 said the resident remained clothed when they wet him in the shower. She said the director of nursing (DON) was notified and called EMS and sent him to the hospital. The assistant director of nursing (ADON) was interviewed on 6/19/20 at 2:25 p.m. She said she remembered seeing Resident #2 sitting outside under the awning and had a Boost drink. She said she did not know how long he had been outside but he was sent to the hospital because he had a change in vitals and was unresponsive when he came inside. The NHA and DON were interviewed on 6/19/20 at 3:20 p.m. The DON said that when Resident #2 had gone to the hospital he wasn't looking too good, he had thrown up, we thought he might have had a [MEDICAL CONDITION]. The DON confirmed the resident did not have a history of [MEDICAL CONDITION]. The DON and the NHA both confirmed after the resident went to the hospital they did not complete a timeline or review why the resident went to the hospital. The DON said moving forward they will make sure resident that are out there (in the courtyard) are supervised and make sure they aren't there for long periods of time - I honestly don't know what we could have done different he was offered drinks, LPN #1 was by the door. The NHA, DON, ADON, director of clinical services (DCS) and clinical resource (CR) were interviewed on 6/26/20 at 5:12 p.m. The NHA said their investigation related to Resident #2 was completed on 6/23/2020. He said he had talked to the CNA who was working on the secure unit at the time and LPN #1. He said the surveillance video had been reviewed and it was clear the resident had never been left outside alone. The activity assistant (AA) was interviewed on 6/26/20 at 3:40 p.m. She said she was working the day Resident #2 was outside. She said when she saw him, he was sitting outside throwing up and she told the CNA. She said she saw staff go outside to assist him and bring him inside. She said when he came inside he continued to throw up, and was visibly tired and his eyes were squinted. CNA #6 was interviewed on 6/26/2020 at 4:10 p.m. He said if a resident goes out into the courtyard he will sit with them the entire time they are outside. CNA #5 was interviewed on 6/26/2020 at 4:20 p.m. He said that someone should always be with residents when they go outside. The activity director (AD) was interviewed on 6/30/2020 at 4:58 p.m. She said she passed through the courtyard on 6/12/2020 in the afternoon at approximately 3:00 p.m. because she said she had a phone call at 3:15 .m. She said she would pass through the courtyard instead of going through the building occasionally. She said she had seen Resident #2 sitting with another resident outside in the courtyard. She said he waved and said hello. She said at that time there was no other staff in the courtyard and she did not remember specifically about whether there was anything to drink for the resident.
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and record review the facility failed to ensure six (#7, #8, #9, #10, #11 and #12) of six sampled residents had the least restrictive alternative for the least amount of time and documented ongoing re-evaluation of the need for the restraint. Specifically the facility failed to ensure: -Resident #9 had a signed consent, physician's orders [REDACTED].#11 had a signed consent, a physician's orders [REDACTED].#12 had a signed consent, physician's orders [REDACTED]. -Resident #10 had a physician's orders [REDACTED].#8 had a physician's orders [REDACTED].#7 had a signed consent for the wanderguard, an order to monitor wandering behaviors or an accurate minimum data set (MDS) assessment indicating she had a wander/elopement alarm. Findings include: I.Policy and procedure A. Restraint policy The restraint policy, revised May 2020, was provided by the social services director (SSD) on 6/30/2020 at 5:55 p.m. The policy read in pertinent part: -It is the policy of this facility that the resident has the right to be free from any physical restraints. -Physical restraints defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -Procedures: 1. A physician's orders [REDACTED]. 3. Explain the potential negative outcomes of restraint use. Resident may also face a loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. 6. Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments and care plans. The Wander System Monitoring Program policy and procedure revised July 2018 was provided by the clinical resource (CR) on 6/30/2020 at 6:43 p.m. The policy read in pertinent part: -All residents identified to be at risk for wandering will have a wander-monitoring bracelet. -An initial wandering assessment will be completed on all new residents on admission. -One wander-monitoring bracelet will be placed on either the resident's wrist or approved alternate location, i.e. ankle or nonmetal back of resident's wheelchair. II.Resident #9 A.Resident status Resident #9, [AGE] years old, admitted to the facility on [DATE]. According to the resident's face sheet [DIAGNOSES REDACTED]. According to the 4/11/2020 MDS assessment the resident was cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. The resident did not have wandering behaviors. She required supervision for most activities of daily living (ADL) except bathing, dressing and personal hygiene where she required assistance of one person. The resident was ambulatory with supervision and used a walker. The MDS did not document that the resident had any type of wander/elopement alarm. B.Record review The elopement/wanderer risk care plan revised on 3/16/2020 documented the resident was at risk for wandering related to dementia. The goal was to maintain safety for the resident. Interventions included document wandering behavior and attempted diversional interventions, identify pattern of wandering and monitor wanderguard placement. A review of the June 2020 physician's orders [REDACTED]. The 6/29/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The Wanderguard consent form documented the resident's daughter provided consent for the wanderguard on 6/30/2020 (during the survey). A review of the residents progress notes from 3/1/2020 until 6/30/2020 documented the resident made three attempts to exit seek; twice on

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F 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) 6/29/2020 and once on 5/31/2020. The June 2020 treatment administration record (TAR) documented to check for function of wanderguard every Sunday with a start date of 3/13/2020, discontinued 6/30/2020 and check wanderguard placement on right ankle every shift with a start date of 6/30/2020. -There was no documentation indicating the resident was being monitored for wandering attempts which could indicate the necessity for using the wanderguard. III.Resident #11 A.Resident status Resident #11, [AGE] years old, admitted to the facility on [DATE]. According to the resident's computerized physician's orders [REDACTED]. According to the 6/10/2020 MDS assessment the resident was cognitively impaired with a BIMS score of six out of 15. The resident did not have wandering behaviors. She required assistance of one person with ADLS and was independent with eating. The resident ambulated throughout the facility in a wheelchair and required supervision only. The MDS did not document that the resident had any type of wander/elopement alarm. B. Record review The elopement/wanderer risk care plan revised on 5/20/2020 documented the resident was at risk for wandering related to dementia. The goal was to maintain safety for the resident. Interventions included assess for fall risk, check placement and function of wanderguard, document wandering behavior and attempted diversional interventions, and identify pattern of wandering. A review of the June 2020 CPO revealed there was no order for the resident to have a wanderguard or to monitor wandering behaviors only an order to check the placement and function of the wanderguard. The 6/5/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The most recent wanderguard consent form documented verbal consent was given on 1/1/19. A review of the residents progress notes from 3/1/2020 until 6/30/2020 documented the resident made no attempts to exit the facility. IV. Resident #12 A.Resident status Resident #12, [AGE] years old, admitted to the facility on [DATE]. According to the resident's CPO [DIAGNOSES REDACTED]. According to the 6/25/2020 MDS assessment the resident was mildly cognitively impaired with a BIMS score of nine out of 15. The resident did not have wandering behaviors. He required assistance with ADLS and was independent with eating. The resident required a walker for ambulation and supervision. The MDS did not document that the resident had any type of wander/elopement alarm. B.Record review The elopement/wanderer risk care plan revised on 6/22/2020 documented the resident was at risk for wandering related to a history of attempts to leave the facility unattended. The goal was to maintain safety for the resident. Interventions included assess for fall risk, distract resident from wandering by offering pleasant diversions, structured activities and check wanderguard placement. A review of the June 2020 CPO revealed there was no order for the resident to have a wanderguard or to monitor wandering behaviors only an order to check the placement and function of the wanderguard. The 6/19/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The most recent wanderguard consent was signed on 6/30/2020, during the survey. A review of the residents progress notes from 6/18/2020 until 6/30/2020 documented the resident attempted to exit seek once on 6/19/2020. V.Resident #10 A.Resident status Resident #10, [AGE] years old, admitted to the facility on [DATE]. According to the resident's CPO [DIAGNOSES REDACTED]. According to the 6/25/2020 MDS assessment the resident was mildly cognitively impaired with a BIMS score of nine out of 15. The resident did not have wandering behaviors. She required supervision with ADLs except bathing where she was totally dependent. The resident was ambulatory and required only supervision. The MDS did not document that the resident had any type of wander/elopement alarm. B.Record review The elopement/wanderer risk care plan revised on 6/5/2020 documented the resident was at risk for wandering related to disoriented to place. The goal was for the resident to not leave the facility unattended. To maintain safety for the resident. Interventions included document wandering behavior, monitor for fatigue and weight loss, provide structured activities and check wanderguard placement. A review of the June 2020 CPO revealed there was no order for the resident to have a wanderguard or to monitor wandering behaviors only an order to check the placement and function of the wanderguard. The 6/12/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The most recent wanderguard consent was signed on 1/14/2020. A review of the resident's progress notes from 3/2/2020 until 6/30/2020 documented the resident made no attempts to exit seek. VI.Resident #8 A.Resident status Resident #8, [AGE] years old, admitted to the facility on [DATE]. According to the resident's CPO [DIAGNOSES REDACTED]. According to the 4/28/2020 MDS assessment the resident was not cognitively impaired with a BIMS score of 15 out of 15. The resident did not have wandering behaviors. She required supervision with ADLS. The resident used a walker and wheelchair for ambulation. The MDS did not document that the resident had any type of wander/elopement alarm. B.Record review The elopement/wanderer risk care plan revised on 3/17/2020 documented the resident was at risk for wandering related to history of attempts to leave the facility. The goal was for the resident to maintain safety. Interventions included document wandering behavior and check wanderguard placement and function. A review of the June 2020 CPO revealed there was no order for the resident to have a wanderguard or to monitor wandering behaviors only an order to check the placement. The 6/3/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The most recent wanderguard consent was signed on 1/20/2020. A review of the resident's progress notes from 3/2/2020 until 6/29/2020 documented the resident made no attempts to exit seek. VII. Resident #7 A. Resident status Resident #7, under the age of 60, admitted to the facility on [DATE]. According to the resident's face sheet the resident's [DIAGNOSES REDACTED]. According to the 4/28/2020 MDS assessment the resident was not cognitively impaired with a BIMS score of 15 out of 15. The resident did not have wandering behaviors. He required supervision with ADLS. The resident used a wheelchair for ambulation and required supervision. The MDS did not document that the resident had any type of wander/elopement alarm. B.Record review he elopement/wanderer risk care plan revised on 5/29/2020 documented the resident was at risk for wandering related to wandering aimlessly. The goal was for the resident to maintain safety. Interventions included apply wanderguard for safety and elopement risk, distract resident, document wandering behavior, check wanderguard placement and function and provide structured activities. A review of the June 2020 physician's orders [REDACTED]. The summary also documented to monitor for placement. There was no documentation to monitor wandering behaviors. The 6/3/2020 elopement/wandering evaluation documented the resident was a high risk for wandering. The most recent wanderguard consent was signed on 6/30/2020 during the survey. A review of the resident's progress notes from 3/2/2020 until 6/29/2020 documented the resident made no attempts to exit seek. VIII. Staff interviews The social services director (SSD) and the social work consultant (SWC) were interviewed on 6/30/2020 at 4:50 p.m. Both the SSD and the SWC did not consider a wanderguard a restraint. The SSD and the SWC were interviewed again at 5:42 p.m. The SSD said only three of the six residents in the facility had consents for their wanderguard but they would work on getting the rest. The SSD said they would assess the need for the wanderguard quarterly, during the resident's care conference and complete an elopement assessment quarterly. Both the SSD and the SWC said that moving forward they would review and update the policy to reflect that wanderguards are restraints, they would make sure they were reviewing the necessity of the wanderguard during the care conference, determine if they could use something else for the resident instead of the wanderguard and ensure they had an order and consent for every resident that had a wanderguard.
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 timely and thoroughly investigate an allegation of abuse, neglect or mistreatment and injuries of unknown origin for one (#2) of three residents reviewed out of three sample residents. Specifically, the facility failed to ensure, provide, and maintain evidence the allegation of neglect for Resident #2 was investigated thoroughly. Cross reference F600: Failure to prevent abuse and neglect Findings include: I. Facility policy and procedure The Incident accident Reporting policy and procedure provided by the director of nursing (DON) on 6/30/2020 at 8:45 p.m., revised May 2020, documented in pertinent part: -An Incident/Accident Report will be completed for incidents or accidents involving residents. -The administrator will coordinate an investigation of the event as needed. This investigation would be separate from the Incident/Accident Report Investigation. II. Resident status Resident #2, under the age of [AGE] years old, was admitted to the facility on [DATE] and discharged on [DATE]. According to the June 2020 computerized physician's orders [REDACTED]. The resident did not have a [DIAGNOSES REDACTED]. The resident required assistance with activities of daily living (ADL) but was independent with eating and ambulation. The MDS coded the resident as receiving both an antipsychotic and antidepressant medication. The resident was 73 tall and weighed 174 pounds. III. Incident background A. Change of condition 6/12/2020 The medical record was reviewed and revealed the resident experienced a change of condition on 6/12/2020 resulting in unresponsiveness. The 6/12/2020 Event/Change of Condition note documented: Possible [MEDICAL CONDITION] activity, 1625 (4:25 p.m.) resident was non-responsive, shaking, vital signs: 107/75, 98.0, p(ulse)111, r(espiratory) 21, Oxygen at 2 liters (72%). Physician and family notified. Resident sent to hospital. B. Paramedic interview On 6/26/2020 at 1:17 p.m. the paramedic who had been dispatched to the facility and picked up Resident #2 was interviewed. She said that when she arrived at the facility none of the staff at the front door were aware of why she was there. After she informed them that she had been dispatched about a resident on the secure unit, they escorted her back to the secure unit. She said she, with her coworkers, entered the secure unit and then were sent to the

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) shower room. In the shower room she observed the resident sitting in a wheelchair, in his clothes, receiving a shower. She said the resident was red in appearance, felt hot to the touch and was unresponsive. She said his heart rate was 182 beats per minute. She said facility staff who were in the shower room were unable to say exactly how long the resident had been outside. She said one nurse said five hours and another employee said thirty minutes. She said the resident was transported to the hospital. She said when they got to the hospital the emergency room physician said that the resident had suffered hyperthermia and heat stroke. C. Hospital history and physical The hospital history and physical form, dated 6/12/2020 at 5:25 p.m., documented the resident's chief complaints was hyperthermia (abnormally high body temperature)/altered mental status. The document further read: This patient comes to the emergency department via EMS (emergency medical service). Resident is a [AGE] year old male with a PMHx (past medical history) of hypothermia, AMS (altered mental status), subarachnoid hemorrhage, aneurysm, anxiety, and recent pneumonia [DIAGNOSES REDACTED]. Per EMS, patient was outside in the sun between 2-5 hours, as nursing staff did not check on for several hours. Today is a very hot day. Temperatures are nearly 100 degrees F. Patient was found unconscious by nursing staff at his nursing home with no change after putting he patient in cold shower. Patient remained unconscious upon EMS arrival, with them noting some tonic or [MEDICAL CONDITION] activity in route to the ED (emergency department). EMS then administered 0.5 mg IV (intravenous) [MEDICATION NAME] and patient subsequently became more alert and responsive, with tremors ceasing. EMS then administered an additional 2 mg Versed. Upon arrival to the ED, patient is easily aroused to voice .He states he remembers being outside, and when I asked him if nursing staff forgot about him, he laughed. On physical examination the patient appeared in moderate to severe acute cardiorespiratory distress and was alert and answering questions appropriately. Initial vital signs are interpreted as febrile (having or showing symptoms of a fever), [MEDICAL CONDITION](rapid heartbeat), tachypnea (rapid breathing) and [MEDICAL CONDITION] (oxygen deprivation). Mucous membranes of the mouth are dry. Sunburn to bilateral thighs. Medical decision making and course in the ED with interpretation/review of diagnostic studies: After considering the history, physical exam, signs and presenting symptoms I believe that this patient has symptoms of hyperthermia. Differential [DIAGNOSES REDACTED]. Laboratory results interpreted: Renal function was found to be acute [MEDICAL CONDITION] with BUN (blood urea nitrogen) and Creatinine of 18 and 1.61 respectively. Final impressions/Diagnoses: [REDACTED]. Suspected [DIAGNOSES REDACTED], 3. Heat exposure, 4. Hyperthermia . IV. Facility investigation The facility investigation was provided by the nursing home administrator (NHA) on 6/26/2020. The investigation was started on 6/23/2020 (11 days after the resident went to the hospital and four days after the survey start date). The investigation was completed on 6/23/2020. The investigation showed LPN #1 and a CNA were interviewed. However, the report only indicated the LPN #1 and CNA were interviewed although the activity director had also observed the resident sitting outdoors on 6/12/2020. The interviews were delayed and completed on 6/26/2020 which was 14 days after the incident. The investigation included a summary of the video surveillance from the 6/12/2020 incident. The investigation failed to show that the facility could not substantiate neglect. The DON provided information that the staff were educated on 6/19/2020 how hot weather affected senior citizens with Alzheimer ' s dementia. The education included, to place residents on 15 minute checks. However, the investigation failed to show the resident was placed on 15 minute checks. There was no further information. Sign in sheets were provided and documented the 6/21/2020 sign in sheet documented 15 CNAs and one nurse were educated. The 6/22/2020 sign in sheet documented seven CNAs were educated and the 6/23/2020 sign in sheet documented six CNAs and one nurse were educated. The conclusion of the facility was that the resident did not suffer neglect but did go to the hospital as a result of possible [MEDICAL CONDITION] activity. V. Interviews The NHA and DON were interviewed on 6/19/20 at 3:20 p.m. The DON and the NHA both confirmed the resident was found outside unresponsive and sent to the hospital emergently. The DON said an investigation was not completed. The DON said there was no reason to complete any type of investigation, residents go to the hospital all of the time. The NHA, DON, ADON, director of clinical services (DCS) and clinical resource (CR) were interviewed on 6/26/20 at 5:12 p.m. The NHA said their investigation related to Resident #2 was completed on 6/23/2020. He said he had talked to the CNA who was working on the secure unit at the time and LPN #1. He said the surveillance at this time video had been reviewed and it was clear the resident had never been left outside alone. The NHA was interviewed on 6/30/2020 at 6:03 p.m. He confirmed he did not know anything about the situation with Resident #2 until the first day of the survey, which was the day the investigation was initiated.
F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**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 interview and record review the facility failed to ensure the resident received treatment and care in accordance with professional standards of practice for one (#1) of three residents reviewed for skin assessments, out of six sampled residents. Specifically, the facility failed to: -Develop and implement a consistent skin monitoring system to address various altered skin integrity issues. -Notify Resident #1's physician (PHYS) regarding the skin integrity changes. -Develop and implement a skin monitoring system designed to identify the potential for alterations in skin integrity due to daily administration of [MEDICATION NAME]; an antibiotic (Ab) medication pharmaceutically known to alter skin integrity. Resident #1's skin integrity had changes which involved bruising which changed to blisters, and bleeding. The facility failed to monitor Resident #1's skin prior to starting [MEDICATION NAME] and after starting failed to monitor the side effects to [MEDICATION NAME] and subsequently prevent: dispersion of bruising on her body, some bruising of which changed to blisters, and large amounts of bleeding she sustained from the injury to her skin integrity; the extent of which required her to be hospitalized , causing the resident to receive a blood transfusion and deemed a potential risk of elder abuse. Findings include: I. Facility policy According to the Policy/Procedure-Nursing Assessment: Skin Assessment, provided by the director of nursing (DON) on 6/26/2020, the care plan would be implemented. There was no documentation in this policy which identified the facility had a system to consistently monitor a resident's skin for medication side effects, such as with antibiotics. II. Professional reference According to the Mayo Clinic: [MEDICATION NAME], 2020, https://www.mayoclinic.org/drugs-supplements/[MEDICATION NAME]-oral-route/side-effects/drg- 229, (6/26/2020), [MEDICATION NAME] could cause side effects such as: red [MEDICAL CONDITION], redness or other discoloration of the skin, unusual bleeding or bruising, hives, welts; one was to check with a healthcare professional regarding these side effects. According to the RxList: [MEDICATION NAME] (Doryx), 2020, https://www.rxlist.com/doryx-side-effects-drug-center.htm, (6/26/2020), side effects included darkened skin color and one was to get emergency medical help if there were severe skin reactions which included skin pain, red or purple skin rash that spread, and caused blistering and peeling. According to the RxList: [MEDICATION NAME] (Doryx), 2020, https://www.rxlist.com/[MEDICATION NAME]-[MEDICATION NAME]-side-effects-drug-center.htm#overview, (6/26/2020), side effects involving the skin included: maculopapular and [DIAGNOSES REDACTED]tous rashes, toxic [MEDICATION NAME] necrolysis, and exfoliative [MEDICAL CONDITION], III. Resident #1 A. Resident status Resident #1, less than [AGE] years of age, was admitted on [DATE] and discharged on [DATE]. The June 2020 computerized physician orders (CPO) revealed [DIAGNOSES REDACTED]. According to the 5/12/2020 minimum data set (MDS) assessment she was unable to complete the brief interview for mental status (BIMS) and received a designation of 99. She had open non-pressure related [MEDICAL CONDITION] and required the application of nonsurgical dressings. On the 6/13/2020 MDS, it was an incomplete record, there was no documentation section which addressed the non-pressure related [MEDICAL CONDITION] present on her skin. The resident required extensive assistance with all activities of daily living.The resident had two falls without injury and other [MEDICAL CONDITION], rashes or cuts. The resident was receiving hospice services. B. Record review 1.Computerized physician's orders According to the June 2020 CPOs, Resident #1 was admitted under the care of the physician (PHYS) on 2/20/2020; the facility-identified, provider of contact, with respect to Resident #1's ongoing care needs, which included her skin integrity. 2.Care plans The care plan, initiated on 5/8/2020 and revised on 6/8/2020, identified she had an actual impairment to skin integrity due to decreased mobility. Interventions included to monitor the side effects of antibiotics, which could exacerbate skin injury, and report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc., to the PHYS. The care plan, initiated on 5/20/2020 and revised on 5/21/2020, identified she was administered [MEDICATION NAME] for [MEDICAL CONDITION] of the lower extremities. Interventions included to monitor and document side effects, and report any new or worsening symptoms to the PHYS. Staff were to monitor, document, and report to the PHYS: tender skin, reddened area that spread, red spots on reddened skin, and blisters that formed. C. Failure to continually monitor various skin integrity issues to resolution; before [MEDICATION NAME] was being administered. According to the 5/28/2020 Hospice Comprehensive Assessment and Plan of Care Update Report, she had a 5/20/2020 hospice physician

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	065283	A. BUILDING _____ B. WING _____	06/30/2020

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) order for [REDACTED].Record review A.Absence of daily skin monitoring documentation Record review of Resident #1's medical record revealed there was no daily monitoring of her skin for the side effects while she administered [MEDICATION NAME], nor monitoring of her skin after its administration. There was no documentation in the hospice notes to reflect bruising on Resident #1's body was monitored on a continual basis. There was no documentation that the interdisciplinary team (IDT) developed a plan to monitor the bruises on her skin until they resolved. B. Failure to perform skin assessment on shower day According to the 5/19/2020 progress notes, Resident #1 refused a shower; there was no documentation the facility assessed Resident #1's skin for altered skin integrity. C.Care plan The care plan, initiated on 2/27/2020. It identified she had a self-care performance deficit. Interventions included she required one to two staff for toileting, bed mobility, and transfers. The care plan, initiated on 5/2/2020 and revised on 5/4/2020, identified she had [MEDICAL CONDITION] to bilateral gluteal folds. Interventions included to monitor and document location and size of skin injury, report abnormalities, failure to heal, signs/symptoms of infection, maceration, etc., to the PHYS. D. Failure to provide physician order skin treatment According to the May and June 2020 treatment administration records (TARs) there was no documentation her altered skin integrity was monitored on a continual basis. According to June CPO's, Resident #1 had a 5/2/2020 order for the facility to: cleanse the [MEDICAL CONDITION] to Resident #1's right and left gluteal folds with wound cleanser, apply [MEDICATION NAME] and cover them with border foam dressing, twice a day, until healed. Review of the following skin evaluations and subsequent review of Resident #1's medical record (to include the May 2020 TAR) revealed there was no further documentation to reflect the altered skin integrities documented on the skin evaluations were monitored until they resolved: -On 5/14/2020 Resident #1 had scabs to her bilateral lower extremities and mild redness to her pannus area. There was no documentation to indicate the size and number of scabs she had and the measurement of the area of redness to her pannus area; actions which would be taken to indicate a monitoring system was in place. E. Failure to notify Resident #1's PHYS of changes to her skin integrity According to the 6/2/2020 skin evaluation, provided by the facility on 7/8/2020 at 4:27 p.m., after a fall she sustained bruising in her lower extremities which turned into blisters. There was no documentation to reflect Resident #1's PHYS was informed of the bruising which turned into blisters; there was no physician orders to indicate a need to treat blisters was communicated to the PHYS. According to the 6/4/2020 electronic MAR (eMAR) Resident #1 had extensive bruising to her legs. There was no further documentation in this eMAR note which identified the quantity, exact location, size, and color of all the bruises. There was no documentation Resident #1's PHYS was notified of all the bruises. According to the 6/6/2020 skin evaluation, the facility documented Resident #1 had old bruises on bilateral upper extremities. There was no further documentation in this progress note which identified the quantity, location, size, and color of all the bruises. Record review of her medical record revealed there was no prior documentation of bruising to her upper extremities from May 2020 to 6/6/2020 and no documentation to reflect Resident #1's PHYS was notified of all the bruises to her bilateral upper extremities. According to the progress notes: -On 6/5/2020 Resident #1 was found on the floor in a pool of blood, hospice was contacted. There was no documentation to reflect Resident #1's PHYS was informed of the bleeding. -On 6/8/2020 Resident #1 had bruises, blisters, and open areas to bilateral legs. There was no further documentation which identified the quantity, exact location, size, and color of all the bruises. There was no documentation to reflect Resident #1's PHYS was notified of all the bruises. -On 6/10/2020 a post-fall assessment revealed no acute injuries. There was no documentation which identified the facility performed a skin assessment and to monitor the quantity, exact location, size, and color of all the bruises Resident #1 had on her body at this time. There was no documentation to reflect Resident #1's PHYS was notified of all the bruises on Resident #1's body. -On 6/13/2020 at 4:00 a.m. she bled from a right, front leg hematoma and was sent to the emergency room (ER); and was admitted into the hospital. The facility notified hospice. There was no documentation to reflect Resident #1's PHYS was notified of the hematoma. Failure to monitor skin integrity due to side effects of [MEDICATION NAME] V. Resident #1 began receiving [MEDICATION NAME] According to the 5/28/2020 Hospice Comprehensive Assessment and Plan of Care Update Report, she had a 5/20/2020 hospice order for 100 mg of [MEDICATION NAME] twice a day through 5/30/2020. According to the May 2020 MAR indicated [REDACTED]. A. Failure to continually monitor various skin integrity issues to resolution; -On 5/21/2020 Resident #1 had excoriation on her abdominal fold. There was no documentation to indicate Resident #1's scabs to her bilateral lower extremities resolved; actions which would be taken to indicate a monitoring system was in place. -On 5/28/2020 there was no documentation to indicate Resident #1's scabs to her bilateral lower extremities or the excoriation on her abdominal fold resolved; actions which would be taken to indicate a monitoring system was in place. -On 5/30/2020 there was no documentation to indicate Resident #1's scabs to her bilateral lower extremities or the excoriation on her abdominal fold resolved; actions which would be taken to indicate a monitoring system was in place. The facility documented there were no 'new' skin issues. B. Failure to provide skin treatment According to the 5/25/2020 progress note an unidentified staff documented they were to cleanse the [MEDICAL CONDITION] to Resident #1's bilateral gluteal folds with wound cleanser, apply [MEDICATION NAME] and cover them with border foam dressing, but could not complete the treatment because they had to tend to another resident's urgent needs. There was no documentation the facility completed this treatment on this day. According to the May 2020 TAR, there was no documentation the facility provided the treatment order to cleanse the [MEDICAL CONDITION] to Resident #1's bilateral gluteal folds with wound cleanser, apply [MEDICATION NAME] and cover them with border foam dressing on 5/25/2020 and 5/28/2020. There was no documentation in the progress notes or Resident #1's medical record the facility provided the treatment on 5/28/2020. C. Altered skin integrity led to bleeding requiring hospitalization According to the 6/5/2020 hospice record Resident #1 was found on the floor in a pool of blood and the facility called 911. According to the 6/5/2020 skin evaluation Resident #1fell at 4:00 a.m. and later bled from her lower extremities and was sent to the hospital. V. Follow up A. Hospital documentation of altered skin integrity and concerns of harm According to the the 6/13/2020 emergency medical system (EMS) report Resident #1 had a right lower leg hematoma which burst, due to a fall, which resulted in the exposure of bone and tendon. There was large amounts of blood on the floor, the right lower leg was drenched in blood, there was 750ml of blood on the floor, a significant portion of flesh was missing from the right lower leg, and the bleeding was not controlled. According to the 6/13/2020 hospital documents Resident #1 had acute blood loss [MEDICAL CONDITION], required a blood transfusion, had bruising all over her body in various stages of healing, her platelets were 6 on arrival, she could be spontaneously bleeding from this, and there were concerns of elder abuse. The discharge summary revealed she had diffuse ecchymoses (bruising) on all extremities. The impression was acute blood loss with bruising; a forensic nurse examiner was contacted to investigate Resident #1's bruising. Resident #1's representative requested hospital admission due to facility concerns of Resident #1's bruising. Resident #1 did not return to the facility. B. Police report of altered skin integrity and concerns of harm According to the undated police report, Case #13CN 716, Resident #1 fell and was found with large amounts of blood on the floor, approximately 750ml of blood, the bleeding was not controlled at this time, and she was transported to the hospital from the facility. VI. Facility interviews A.Staff interviews The DON, assistant director of nursing (ADON) and the nursing home administrator (NHA) were interviewed on 6/19/2020 at 3:20 p.m. The DON said the follow-up for all skin issues should be consistent and there were skin issues identified on one skin assessment for Resident #1 (she did not identify which one) which the facility should have continued to monitor until the skin issue was resolved. The nurse management team had done some education with nurses about monitoring and tracking wounds and skin issues but the facility had not started a performance improvement plan (PIP). The licensed practical nurse (LPN) # 4 and registered nurse (RN) #3 were interviewed on 6/26/2020 at 7:13 p.m. They said nurses were to monitor for all changes in a resident's skin, to include medication side effects. Nurses were to document if there were changes in residents' skin, like bruising or bleeding. and notify the physician if there were side effects to medications that affected a resident's skin. Nurses were to monitor resident's skin changes, such as bruising or bleeding, until they resolved. The DON was interviewed a second time on 6/26/2020 6:50 p.m. She said she knew antibiotics could thin the blood and cause bruising. The facility did not monitor for side effects [MEDICATION NAME] on Resident #1's skin and should have. The facility did not discuss the concerns of her skin (bleeding, bruising, blisters, or need for labs) with the hospice doctor nor her PHYS, and should have. In the future, the facility would ill monitor residents' skin when on [MEDICATION NAME] and other antibiotics. B. Physician interview The PHYS was interviewed on 7/12/2020 at 7:12 p.m. She said she was Resident #1's primary care physician. She said [MEDICATION NAME] was an antibiotic which could cause unusual bruising and altered skin issues, to include bleeding. Staff should monitor residents' skin who were administered [MEDICATION NAME], daily, with each administration and thereafter because effects to skin could occur even after residents no longer received the medication. Staff should look for ecchymotic (bruise-like) areas on their skin and check for bleeding. She would have written an order for [REDACTED]. The facility did not inform her that Resident #1 was administered [MEDICATION NAME]; nor that she had bleeding, blistering, and bruising issues of her skin. She wanted to know about

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F 0684 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 5) Resident #1's condition while she was administered [MEDICATION NAME]; although she was on hospice, she was Resident #1's PHYS. It was also important for her to have been notified because [MEDICATION NAME] could interact with her other medications, Resident #1 could have experienced an allergic skin reaction to it (which would be different than the side effects of bruising), and her platelets could have been altered which could have increased her risk for bleeding. When a resident has any skin change while on [MEDICATION NAME], the standard of practice would be to notify her the PHYS, notify the family, immediately stop administering the [MEDICATION NAME], and send the resident to the hospital for evaluation. No other antibiotic would be administered until they were worked-up at the hospital. Moving forward, she wanted the next nurse who took an order for [REDACTED]. The facility should monitor all bruising (bruise-like skin changes) from when it occurs and until it is resolved; if not resolved it should be reviewed in case there is a bleeding problem. C. Non-facility pharmacist interview The a non-facility pharmacist (NFPHAR) was interviewed on 6/28/2020 at 8:30 a.m. She said [MEDICATION NAME] can cause hypersensitive skin reactions, changes in skin, which can appear discolored or like bruises. If there were skin reactions while on it, [MEDICATION NAME] should be discontinued and skin treatments should be implemented. VII. Facility follow-up A.Skin assessments 1.Performance improvement plan (PIP) related to skin assessment The DON provided an undated performance improvement plan (PIP) which documented the following, in pertinent part: -Issue: Incomplete skin assessment/documentation and follow-up; -Identification of others: The facility has determined that all residents have the potential to be affected. -Actions taken/systems put into place to reduce the risk of future occurrence include: 1. In-service education program addressing skin assessment guidelines, documentation and follow-up, 2. Audit completed on 6/30/2020 included review of recent skin assessment findings, current treatment orders, and confirming skin assessment schedule. -Ongoing monitoring to ensure the practice will not recur: 1. Five skin assessments x weekly x twelve weeks. 2. The PIP will be monitored at the monthly quality Assurance meeting until compliance has been met. B.Monitoring antibiotic use 2. Performance improvement plan (PIP) The in-service training report was provided by the DON which documented on 6/30/2020 eight nurses received the education. The DON provided an undated PIP which documented the following, in pertinent part: -The facility identified it did not monitor the side effects of an antibiotic according to its care plan. -On 6/30/2020 the DON trained the nursing staff to monitor for the side effects of medications due to all residents had the potential to be affected by medication side effects; particularly antibiotics (Abs). -The current census was to be reviewed to identify residents who received Ab treatments. Have the physician initiate an order for [REDACTED]. An admission template would be utilized. -The order listing reporting would be reviewed within 48 hours and initiation of side effect monitoring on Ab classification was ensured. A daily clinical review template would be utilized. -The infection surveillance log would be reviewed for observed side effects (if any documented) during the monthly Quality Assurance meeting; until compliance was met. A surveillance log template would be utilized.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on record review and interview, the facility failed to conduct yearly certified nurse aide (CNA) performance reviews and provide training based on the annual reviews for four (CNA #1, CNA #2, CNA #3, and CNA #4) out of five facility CNAs reviewed for annual reviews and training. Specifically, the facility failed to provide performance evaluation reviews annually and provide regular in-service education on the outcome of these reviews to include 12 hours of continuing education to CNA staff. Findings include: I. Facility policy and procedure The Competency policy, undated, was provided by the director of nursing (DON) on 6/30/2020 at 4:30 p.m. It documented in pertinent part: Policy Explanation and Compliance Guidelines: -Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or performance evaluations. II. Record review The facility was unable to provide annual performance evaluations annual reviews for CNA #1, CNA #2, CNA #3, CNA #4. A review of CNA transcripts for in-service trainings on 6/20/2020 at 3:00 p.m., revealed the last documented training was over a year ago for the following four CNAs: CNA #1, with a hire date of 5/1/09, the last documented training was 5/23/19. CNA #2, with a hire date of 7/27/18, last documented training was 5/23/19. CNA #3, with a hire date of 1/15/03, last documented training was 5/23/19. CNA #4, with a hire date of 2/25/19, last documented training was 5/23/19. III. Interviews The DON and staff development coordinator (SDC) were interviewed on 6/30/2020 at 3:35 p.m. The SDC said there was no one in charge of tracking the CNA training to ensure they were being completed annually, and that was why the training fell through the cracks. The DON said the facility was in the process of organizing a skills fair to ensure all of the staff were current on their required training. IV. Follow up The facility provided additional information on 7/2/2020 via email which indicated CNAs received training on infection control, COVID-19, personal protective equipment (PPE) and staff morale from 4/6/2020 to June 2020. Although, the training occurred frequently, the training was not based on the individual annual performance evaluations.
F 0908 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Keep all essential equipment working safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interview the facility failed to ensure emergency respiratory equipment was available in four of four crash carts throughout the facility. Specifically the facility failed to ensure: -The crash cart on the Sterling Unit (secure unit) was inspected daily during the night shift and contained all essential items; - The crash cart on the Durango Unit was being monitored daily during the night shift and was stocked with all items; - The crash cart on the Montrose unit was stocked with all essential items, was being monitored daily during the night shift and the licensed practical nurse (LPN) who was working on the hall knew where to find the crash cart and it was readily available; - The crash cart on the Golden unit was stocked with all essential items and was being monitored daily during the night shift. Findings include: A. Facility policy and procedure The crash cart policy and procedure, provided by the director of nursing (DON) and revised May, 2019 documented in pertinent part: -The modified crash cart will routinely be stored at each nurse's (sic) station. -The central supply designee will check the modified crash cart every a.m. and restock as necessary. -The director of nursing (DON) or assistant director of nursing (ADON) will monitor to assure all equipment is in working order every a.m. -Equipment to be included on the modified crash art at all times: oxygen tank, oxygen mask and nasal canula, oxygen tubing, stethoscope, Ambu bag, oral airway, gloves, and dressings. B. Record review According to the facility census and condition there were 19 residents in the facility that required respiratory treatment and 18 residents who required mechanically altered diets including pureed and all chopped food (indicating potential swallowing difficulties). The [DIAGNOSES REDACTED]. The crash cart contents form, documented that the form should be completed nightly by the night (7:00 p.m. - 7:00 a.m. shift) and should be placed in the DON's box. It had a line for every day of the month for the staff who reviewed to indicate the contents had been checked and were on the crash cart. The equipment which was verified to be on the cart included: Ambu bag with mask, clipboard with pen (monitoring sheet), 1 flashlight with batteries, 1 extension cord, non rebreather, oxygen face mask, goggles, gloves, sterile 4x4s, non-sterile 4x4s, oxygen tank and gauge, pulse oximeter, backboard, suction machine, suction canisters, nasal cannula, humidifier, blood pressure cuff and stethoscope. C. Observations and staff interviews The locked shower room on the Sterling Unit was entered with licensed practical nurse (LPN) #2 on 6/26/2020 at approximately 3:00 p.m. The covered crash cart was observed up against the wall. In front of the crash cart, preventing access to the crash cart, was two empty biohazard bins with red bags inside with the lids open and two over bed tables. LPN #2 said I'm embarrassed to see this; it's awful. She agreed the crash cart was difficult to access if needed especially in an emergency. She retrieved the crash cart from the back wall and removed the cover. She reported the suction [MEDICATION NAME], and Ambu bag were not on the machine and the oxygen canister was empty. The registered nurse (RN) #1 was interviewed on 6/26/2020 at approximately 3:20 p.m. She removed the cover of the crash cart and the clipboard with the daily check. The document indicated that the cart had not been checked the night before on 6/25/2020. RN #1 said the crash cart should be audited every night to ensure it was stocked. LPN #3 was interviewed on 6/26/20 at approximately 3:45 p.m. She said she did not know where the crash cart was for the Montrose Unit and found a certified nurse aid who pointed to the supply closet with the coded door. LPN #3 initially said she could not remember the code but eventually did. She said this was her first day on the floor by herself. Upon entry to the supply closet, the cart was observed sitting in front of the cabinets. There were no supplies observed on the cart. The LPN said it would have been impossible to use because there was nothing on the cart. At 3:50 p.m. the director of nursing walked into the supply closet and confirmed there was nothing on the cart therefore would not be an usable if required. The crash cart located at the Golden Unit nurse ' s station was observed with the ADON on 6/26/2020 at approximately 3:20 p.m. After she viewed the crash cart item list, she confirmed it was missing an ambu bag with mask, an O2 tank key (used to confirm O2 supply that was in the tank and provide access to O2 usage), a pulse oximeter, a backboard, and a humidifier. The ADON was interviewed on 6/26/2020 at approximately 3:25 p.m. She said based upon items missing from the crash cart and review of previous,

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RIDGEVIEW POST ACUTE	5230 E 66TH WY COMMERCE CITY, CO 80022

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 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 6) incomplete, crash cart item lists, the crash cart had not been checked for a long period of time as it should have been by the night nurses. The DON was interviewed on 6/26/20 at approximately 4:13 p.m. She said crash carts should be stocked with the items listed on the content sheets and ready for use with residents in times of emergencies. D. Additional staff interviews The DON and director of clinical services (DCS) was interviewed on 6/30/2020 at 3:31 p.m. She said currently there were nurses on each unit that had not been educated but will continue to get all staff educated. She said since she started working at the facility she has never looked at the crash carts but now she will start going through them everyday. The DCS said until the new company purchased the facility (3/1/2020) the building did not have crash carts. E. Facility follow-up 1. Revised policy and procedure The crash cart policy and procedure, provided by the director of nursing (DON) and revised May 2019 (this was the updated policy from above, however the date was not changed) documented in pertinent part: -It is the policy of this facility that a modified crash cart will routinely be stored at the designated area. -The director of nursing (DON) and/or designee will check the modified crash cart everyday restock as necessary maintained at each nurses' station for use during emergency situation. -The DON and/or designee will monitor to assure all equipment is in working order. -Equipment to be included on the modified crash art at all times: oxygen tank, oxygen mask, oxygen tubing, oxygen wrench, Ambu bag, flashlight, suction machine, suction catheter, suction [MEDICATION NAME], extension cord, gloves, and gauze. 2. Performance Improvement Plan (PIP) The DON provided an undated PIP on 6/26/2020. The form documented, in pertinent part: -Issue: Missing supplies and inconsistent signatures on crash cart logs. -Identification of others: The facility has determined all residents with a full code directive have the potential to be affected. -Actions taken/systems put into place to reduce the risk of future occurrence include: (Crash cart policy and checklist/log attached); 1. Inventory for the four crash carts have been replenished and updated with current inventory checklist and log; 2. In-service provided to all nursing staff on crash cart inventory, reporting/replacing items used to DON and/or designee; 3. In-service RN staff crash cart log durites and replacement of missing inventory. -Ongoing monitoring to ensure the practice will not recure (sic); 1. DON and/or designee will conduct daily checks for all crash carts for a period of twelve weeks. 2. PIP will be monitoring (sic) at the monthly QA (quality assurance) meeting until compliance has been met. 3. Updated Crash Cart Checklist The Emergency Crash Cart Checklist, which was a spreadsheet where the staff responsible for auditing should indicated by date the following: Ambu bag, O2 (oxygen) tank, O2 wrench, O2 tubing, O2 mask, suction machine, suction catheter, suction [MEDICATION NAME], extension cord, flashlight, gauze, box of gloves and nurse initial. The spread sheet had a line for every day of the month. 4. Staff In-service Sign In The Staff In-service Sign In dated 6/26/2020, subject Crash Cart, revealed six nurses had received training. The Staff In-service Sign In dated 6/30/2020, subject Crash Cart, revealed six nurses had received training.