STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065235	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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)
E 0007 **Level of harm -** Actual harm **Residents Affected -** Few	**Address patient/client population and determine types of services needed.** Based on record review and staff interviews, the facility failed to develop and maintain an emergency preparedness plan (EPP) which addressed the following criteria in the event of an emergency. Specifically, the facility failed to identify potential at-risk residents. This failure to identify potential at-risk residents created the likelihood of immediate and serious outcomes for any at-risk residents. Findings include: A. Emergency preparedness interview The nursing home administrator (NHA), interim director of nursing (IDON), and the regional maintenance supervisor (RMS) were interviewed on 8/5/2020 at approximately 3:00 p.m. They said the facility had just hired a new maintenance supervisor, so the NHA and RMS were the staff who currently had the most information about the emergency preparedness binders. They said they were unsure if their EPP included information on what to do if a resident was unable or unwilling to evacuate the facility. They said on the South building they had two secure units, one specifically geared toward dementia, and the other had residents with more behaviors. The RMS said he was unable to locate any special provisions in the EPP which addressed their resident population specifically, and the potential for them to be resistant to evacuating. Cross-reference F689 for accident hazards for failure to evacuate Resident #1, when the decision was made to evacuate the South building. B. Record review 1. The Introduction to the Emergency Management Plan, dated 2009, provided by the NHA on 5/4/2020 at approximately 5:00 p.m., read in pertinent part: The purpose of this plan is to provide an all-hazards approach to guide (name of facility) in the event of an emergency, a crisis, or a disaster scenario that would affect the safety and well-being of our residents and employees as well as community members stricken by the situation. As an Emergency Management Plan, the specific procedures detailed for various emergencies should be utilized. The desired outcome is to protect and preserve the residents, employees and facility from such emergencies. 2. The document titled Emergency Response: Emergency Procedure- Fire was provided by the NHA on 5/4/2020 at approximately 5:00p.m., read in pertinent part: The following procedure is utilized in the event of an actual fire, smoke conditions, or smell of smoke in the facility. -Staff begins evacuation according to the size of the fire and the amount of smoke production. The Incident Commander gives guidance on evacuation type. See evacuation below: Phase I: Evacuate the rooms on either side and directly across from the room that is on fire. Move residents to an area away from the fire. This type of evacuation is used during the initial stages of a small fire. Additionally, rooms directly below or above the room of fire origin may be considered for evacuation, especially if fire sprinkler discharge has occurred. Phase II: Evacuate all residents from the smoke compartment where the fire has occurred to the opposite smoke compartment (through the smoke doors). This type of evacuation is used when moderate smoke conditions are present or the welfare of the residents is in jeopardy based on the situation. Additionally, wings or hallways directly below or above the room of fire origin may be considered for evacuation, especially if fire sprinkler discharge has occurred. Phase III. Fire Department Ordered Evacuation. Evacuate all residents from the building by whatever means possible. This type of evacuation is only used during a major fire or severe smoke conditions are present or the welfare of the residents is in jeopardy based on the situation. Additionally, wings or hallways directly below or above the room of fire origin may be considered for evacuation, especially if the fire sprinkler discharge has occurred. The order of evacuation is: Ambulatory residents Residents with assistive devices Residents in wheelchairs Bedridden residents There were no supporting policies, procedures, other guidance documents provided which addressed at-risk residents or residents who refused to evacuate the facility. C. Staff interviews The NHA and the corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. They said that piece (evacuation of all residents including residents that may be difficult to evacuate) was missed as part of the EPP. They said they were in the process of reviewing and updating their EPP to ensure they have everything covered.
E 0009 **Level of harm -** Actual harm **Residents Affected -** Few	**Include a process for Emergency Preparedness collaboration.** Based on record review and interviews, the facility failed to have a process for collaborating with local, tribal, regional, State or Federal emergency preparedness officials. Specifically, the facility failed to participate in collaborative and cooperative community planning efforts to maintain an integrated response during a disaster or emergency. Cross-reference F689 for accident hazards for failure to evacuate Resident #1, when the decision was made to evacuate the South building. Findings include: A. Record review 1. The Introduction to the Emergency Management Plan, dated 2009, provided by the NHA on 5/4/2020 at approximately 5:00 p.m., read in pertinent part: The Emergency Management Plan has been distributed to individual administrative personnel and departments within the facility and corporation (if applicable) as well as other relevant organizations, including but not limited to local emergency responders and municipal, township, county and state agencies. B Interviews The local fire chief was interviewed on 8/6/2020 at 10:30 a.m. He said there had been a lack of communication between the fire department and the facility for a couple of years now. He said in the past the facility had communicated with the fire department about access to codes for the secure doors for the South building, but currently the fire department did not have any of the access codes for the building. The NHA and the corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. They said they were in the process of reaching out to the local fire department as well as the police department to attempt to work together in emergency situations. The NHA said prior to 8/2/2020 the facility had no contact with the fire department regarding the facilities emergency preparation plan.
E 0037 **Level of harm -** Actual harm **Residents Affected -** Few	**Establish staff and initial training requirements.** Based on interviews and record review, the facility failed to have a completed emergency preparedness training program. Specifically, the facility failed to provide sufficient emergency preparedness training and testing to the staff members after the facility had a fire with an unsuccessful evacuation of all of the residents. This failure to provide sufficient training and testing to all staff created the likelihood of immediate and serious outcomes for all of the residents residing in the facility. Cross-reference F689 for accident hazards for failure to evacuate Resident #1, when the decision was made to evacuate the South building. Findings include: I. Facility emergency preparedness plan The emergency preparedness planning and resource manual was reviewed with the nursing home administrator (NHA) and regional maintenance supervisor on 8/5/2020 at approximately 1:00 p.m. They said they were currently doing fire drills on paper, and were not actually conducting fire drills due to the Federal Waiver 1135, which allowed nursing facilities to conduct fire drills by talking with staff about the facilities fire training program. II. Record review Copies of all staff training with attendance rosters, provided by the NHA on8/6/2020 at 11:36 a.m., revealed all the staff had been trained on the the following: Staff training: -Residents who can ambulate would be directed by staff to a designated safety assembly area as identified on (the) evacuation plan for a head count after all residents are rescued/evacuated. -Bedbound/bariatric residents who can tolerate transfers by wheelchair would be evacuated by staff using appropriate wheelchair (regular or bariatric) to the designated safety area for a head count. -Bedbound residents who cannot tolerate a wheelchair would be placed on a mattress by staff and transported out of their location to the designated safety area for a head count. Post

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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E 0037 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) evacuation measures: -Evacuation signs that are kept on fire doors would be placed on all resident exterior door handle that has the resident evacuated to indicate that the resident is out of the room. III. Observation Mock fire drill on 8/6/2020 at 11:14 a.m. on Pioneer Hall (secure unit in the South building) The dietary manager (DM) was on Pioneer Hall and was told by the Life Safety Inspector (LSI) #1 there was a fire in a resident room, and to do what you would do in a real fire, act like this is a real fire. -At 11:16 a.m., the DM removed Resident #10 from his room (where the mock fire was located). The DM left the door to the room open, not containing the fire in the resident room. -At 11:18 a.m., The DM was unable to get his key card to open the secure unit door, an unidentified CNA assisted the DM in opening the door, the DM did not tell the CNA there was a fire on the unit. -At 11:19 a.m., The DM walked the resident down the South Hallway to evacuate the resident to the South Patio. During the drill, the DM never called out there was a fire, told any other staff members working the hallway there was a fire, or pulled the fire alarm. III. Staff interview The DM was interviewed on 8/6/2020 at 11:23 a.m. He said he had fire training last night (8/5/2020), and he was also responsible for providing the training to all of the dietary staff. He said during the training he learned about evacuating the residents and placing a tag on the resident's door after the room had been evacuated. The NHA was interviewed on 8/6/2020 at 11:26 a.m. She said the drill was not good. She said the DM never told any other staff there was a fire, the fire alarm was never pulled to notify the fire department of a fire, and the resident should have been evacuated past the smoke doors, not off of the Pioneer Unit on the South Hallway. The NHA said she would begin immediately re-training all of the staff to ensure they knew the proper procedure during a fire.
E 0039 **Level of harm** - Actual harm **Residents Affected** - Few	**Conduct testing and exercise requirements.** Based on interviews and record review, the facility failed to conduct exercises to test the emergency preparedness plan at least annually. Specifically, the facility failed to complete a thorough analysis of the facility's response to their tabletop exercise and revise the emergency plan as needed. This failure to complete a thorough analysis of the tabletop exercise created the likelihood of immediate and serious outcomes for all of the residents residing in the facility. Findings include: I. Facility emergency preparedness plan The Emergency Preparedness Management Plan (EPMP) was reviewed with the nursing home administrator (NHA) and corporate regional consultant (CRC) on 8/17/2020 at approximately 10:00 a.m. They said they had currently hired a new maintenance supervisor, and the old maintenance supervisor had done the tabletop exercise, so they would need to review their EPMP binders to attempt to locate the tabletop exercise. II. Record review Copies of all participation in emergency preparedness exercises were provided by the NHA on 8/17/2020 at 1:30 p.m. The documentation revealed the facility did a tabletop exercise using a tornado as the emergency. III. Staff interview The NHA and the corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The NHA said she recalled the tornado tabletop exercise and they had evacuated the building during the tabletop, but during the tabletop exercise they had faciled to complete a thorough analysis, which would have identified any residents who might be difficult to evacuate for whatever reason. Cross-reference F689 for accident hazards for failure to evacuate Resident #1, when the decision was made to evacuate the South building. The CRC said the facility would begin the process of reviewing their EPMP to ensure they were addressing all of the identified concerns.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to maintain a sanitary, orderly, and comfortable environment for Resident #1 and Resident #7, and in the basement of the South building. Specifically, the facility failed to: - Ensure walls and floors and widows were free from food and drink debris, spit and other bodily fluids in Resident #1's room, and the resident's outside window well was free from food containers, plastic cups, and rotting food debris. This, coupled with Resident #1's unaddressed behaviors (cross-reference F742), contributed to Resident #1 residing in a room with unacceptable living conditions - walls covered in splatted debris, pests (cross-reference F925) and strong odors. - Ensure the sump pump was working in the basement of the South building was working to prevent standing water. The failed sump pump resulted in standing water in the basement, which contributed to growth of mold from the stagnant water. Findings include: Facility policy The facility's Quality of Life- Homelike Environment policy and procedure, revised May 2017, was provided by the NHA on 5/10/2020 at approximately 4:00 p.m. It read in pertinent part: Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: clean, sanitary and orderly environment. A. Failure to ensure walls and floors and widows were free from food and drink debris, spit and other bodily fluids in Resident #1's room, and the resident's outside window well was free from food containers, plastic cups, and rotting food debris. Failure to ensure Resident #7's blinds worked. 1. Resident #1 a. Resident #1's room observations and staff interviews 8/5/2020 at 12:20 p.m. The resident's room was a single occupancy room. The entire window and the middle two-thirds of the walls in the room were covered with splatters in various shades of black, brown, pink and opaque material. 8/6/2020 at 10:00 a.m. The resident's room had not been cleaned; it remained in the same condition as observed on 8/5/2020. Certified nurse aide (CNA) #4 was interviewed on 8/5/2020 at 12:28 p.m. She said Resident #1 would frequently throw anything at the staff and at the walls in his room. She said he also frequently spit at the staff and on the floor and his walls. She said staff would attempt to redirect him when he was throwing and spitting, but nothing really works, he'll just keep spitting and throwing things. The CNA said staff tried to clean his room when he would leave his room, but that did not happen very often, so staff would quickly try to clean until he became angry and began spitting and throwing things. A housekeeper (HK) was interviewed on 8/6/2020 at 9:59 a.m. She said she tried to clean Resident #1 room everyday but she was frequently unable to clean it because he would spit at her and yell at her to get out. The HK said the walls, window and floor were covered in spit and everything Resident #1 threw at the wall, including food, drinks, and feces. The housekeeping supervisor (HKS) and the HK were observed attempting to clean Resident #1's room on 8/6/2020 at 10:45 a.m. Both staff members were using metal scrappers in an attempt to remove debris from the floor and the walls. Most of the debris was not removed easily; it appeared to have been on the walls and floor for some time. At 10:49 a.m., the resident became upset with the housekeeping staff and began spitting on the floor and wall. At 10:50 a.m., the HKS asked the resident if he wanted the housekeeping staff to leave his room. The resident continued to spit on the floor and wall, and began throwing cookies on the floor. At 10:52 a.m., the housekeeping staff left the resident's room. They were unable to remove most of the debris off the floor, walls or windows. b. Window and window well outside Resident #1's room. On 8/5/2020 at 4:35 p.m., Resident #1 was lying in bed in his room. Multiple flies were observed in the resident room, coming through the resident's open window which did not have a screen. On 8/6/2020 at 10:20 a.m., Resident #1 sat in his room on the bed eating a cookie. Multiple flies were in the resident's room, landing on the cookie the resident was eating. The window well was observed on 8/6/2020 at 12:15 p.m., The window well had approximately eight Styrofoam take-out food containers as well as numerous clean and Styrofoam cups, and a dozen Styrofoam ice cream containers. The food containers still contained food in various stages of rotting. There was a strong odor from the food debris and flies flying all over the food. The resident's window was open to his room as there was no screen in place to prevent the flies from entering the resident's room. The regional maintenance supervisor (RMS), social service director (SSD), and interim director of nursing (IDON) observed the window well outside Resident #1 room on 8/6/2020 at 12:21 p.m. The IDON said Resident #1's behavior was care planned; however, the SSD said it did not matter if the behavior had been care planned, staff still needed to be monitoring outside the window to ensure trash was not accumulating. The SSD said the resident had a history of [REDACTED]. The RMS said he would get a screen placed on Resident #1s window and ensure maintenance and/or the housekeep department monitored outside the resident's window to ensure food debris were not accumulating. 2. Resident #7 a. Resident #7 was interviewed on 8/6/2020 at 9:35 a.m. He said the blinds in his room were currently not working properly, and he wanted them open so he could read in his room. Observations revealed there were two separate vertical window blinds in Resident #7 room. The first set of blinds was unable to twist open or be pushed open, leaving the blinds covering the window and not allowing any natural light into the room. The second set of blinds was able to slightly twisted open, but were not able to be pushed open. b. The nursing home administrator (NHA) and the maintenance assistant (MA) were interviewed on 8/6/2020 at 10:41 a.m. The MA said several of the blinds in resident rooms on the South unit were no longer working, and he was in the process of replacing them. The MA

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) confirmed Resident #7's blinds were not functioning, and stated he would add them to the list of blinds needing to be replaced. The NHA said they were in the process of remodeling the South unit and the blinds in the common areas were also getting replaced as they also were not functioning. B. Failure to ensure the sump pump in the basement of the South building basement was working to prevent standing water. 1. Observations On 8/6/2020 at 3:21 p.m., the basement in the South building was observed to have three to five inches of standing water. The basement included a boiler room and an electrical room, which the facility also used for storage. Sheets of drywall were stored on a piece of plywood. The plywood was under water and black in color. Half of the drywall sheets had a large ring of black colored mold. The sheets were wet to the touch and fell apart when they moved. Also observed in standing water: window screens in various sizes, several cardboard boxes, various marketing items, such as outside banners, and wood boards of various sizes. 2. Staff interviews The RMS was interviewed on 8/6/2020 at 3:25 p.m. He said he was unaware of the standing water in the basement and was unsure what the cause was. He said the sump pump, which assists in removing standing water, was not working properly. He said he was not sure if the sump pump was broken or if it was not working. He said electricians were in the building replacing lighting fixtures and had the electricity turned off to the sump pump. The NHA and RMS were interviewed on 8/6/2020 at 4:42 p.m. The NHA said it had been a very rainy season and she thought that was where the water had come from in the basement. The RMS said he was unable to determine why the sump pump was not working, and said a plumper had been called today to assess the source of the water and determine if the sump pump was functional. The RMS was interviewed again on 8/10/2020 5:23 p.m. He said they had removed all of the water damaged items and thrown them away. He said the plumber had determined the sump pump was broken and it was replaced. He said the facility had purchased a back-up sump pump in the event of the new sump pump no longer working. The RMS said the facility maintenance director would be monitoring the basement daily to ensure it was not flooding with water.
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 record review and interviews, the facility failed to protect two of two residents reviewed out of nine total sample Residents (#3 and #4) from physical abuse by Resident #2. Record review and interview revealed on [DATE], Resident #3, who was severely cognitively impaired and known to take food and drinks from others, picked up Resident #2's juice and started drinking it. Resident #2 became upset and pushed Resident #3 several times in the face. One to one monitoring of Resident #2 was in place after the incident until [DATE], when the facility initiated 15-minute monitoring checks. On [DATE], while on 15-minute checks, Resident #2 hit Resident #4 when Resident #4, who was known to go into other residents' rooms and rummage through their things, entered Resident #2's room. Staff found Resident #4 on the floor in Resident #2's room and Resident #2 told the first staff at the scene, I beat the s*** out him because he was in my room. Hospital records revealed Resident #4 sustained bilateral subdural hematomas, four right-side rib fractures, four left side rib fractures, a L1 compression fracture, a nasal bone fracture and bilateral zygomatic arch (cheek bones) fractures. The facility failed to take steps to protect Resident #3 and Resident #4, both at risk for abuse due to their known behaviors, from physical abuse. Resident #4 sustained significant injuries. Findings include: I. Facility policy and procedure The nursing home administrator (NHA) on [DATE] at 3:30 p.m. provided the facility Abuse Prevention Program policy, revised [DATE], for review. It read in pertinent part, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. As part of the resident abuse prevention, the administration will: -protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual; -develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of [REDACTED]. II. Resident-to-resident physical abuse [DATE] involving Residents #2 and #3 A. Residents #2 and #3 1. Resident #2, age 63, admitted to the facility on [DATE], and readmitted on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident was moderately cognitively impaired with a BIMS of ten out of 15. The resident required one-person limited assistance with dressing, toileting, and personal hygiene. He required supervision for bed mobility, transfers, and eating. The resident's care plan dated [DATE] with a revision date of [DATE] identified the resident as having extreme mood changes, manic episodes, and depressive episodes. Pertinent interventions included redirect with music when manic or experiencing increased agitation, counseling as tolerated, validate feelings and encourage him to talk about his feelings, encourage resident to sit and listen to music. 2. Resident #3, age 59, admitted to the facility on [DATE], readmitted on [DATE], and passed away on [DATE]. According to the April computerized physician orders [REDACTED]. The resident's minimum data set (MDS) assessment revealed that the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of 5 out of 15. The resident required two-person extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and supervision with set up help for eating. The resident's care plan dated [DATE] identified the resident as having behaviors that disrupt the rights of others and the behaviors place him in danger. The care plan read the resident exhibited verbal aggression towards staff and others with no known triggers, took food and drink from others, he will take fluids (water, pop, coffee) from anyone and from anywhere he sees it. Pertinent inventions included ensuring that the resident was offered drinks outside of mealtimes and to offer finger foods. B. Resident-to-resident abuse [DATE] and facility response 1. Incident Resident #3's record revealed a nurse progress note written cord on [DATE] at 8:35 a.m. read: This nurse heard Resident #2 swiftly propelling himself in his wheelchair (w/c) back to the nurses station (NS). This nurse was at the medication cart in the NS and I turned around immediately. Resident #2 verbalized to Resident #3, Don't drink my juice! Don't drink my juice! Before I could reach area Resident #2 used his open hand several times to push on Resident #3's left cheek. Residents were separated immediately. Residents environment changed. As this nurse was propelling Resident #3 in the w/c he had no signs or symptoms of pain/discomfort or fear noted or reported. Skin assessed once back to room, remains intact, and no new skin concerns at this time . Police department called. 2. Facility response Resident #2's record revealed the interdisciplinary team (IDT) met [DATE] and Resident #2 was placed on one-to-one, a decision was made to have the psychiatrist review Resident #2's medications, and Resident #2 was educated on the importance of keeping his hands to himself. The resident agreed, he wouldn't hurt anyone. Further record review revealed the IDT met again on [DATE] and a decision was made to do 15-minute checks x 72 hours. It also read social services was pursuing counseling. The admissions coordinator (AC), who was acting as the interim social services director during the month of [DATE], was interviewed on [DATE] at 3:00 p.m. The social services director (SSD) and the interim director of nursing (IDON) were also present for the interview. The AC said that Resident #3 had picked up Resident #2's juice and started drinking it. She said that Resident #2 had become upset and pushed Resident #3 in the face. The AC confirmed Resident #2 was put on 1:1 monitoring after the incident. The SSD said that Resident #2 was taken off the 1:1 on [DATE] and placed on 15 minute checks. The NHA and the clinical regional consultant (CRC) were interviewed on [DATE] at 9:05 a.m. The NHA said that Resident #3 was known for wandering and he had a history of [REDACTED]. He should always have a drink with him. She said she was not sure if Resident #3 had just had a drink or not before he took Resident #2's juice. Resident #2 was placed on a 1:1 and when he did not have any additional behaviors, the decision was made to remove the 1:1. She said that abuse was substantiated. 3. Failures in facility response Review of Resident #2's care plan revealed no reference to the [DATE] incident, including what triggered it (perceived loss of juice) or to the need for and the plan to monitor the resident, first with a one to one sitter, and then for every 15 minutes checks around the clock. Further, review of Resident #3's record revealed that although the facility knew the resident had a behavior that placed him in danger (wandering and taking drinks), there was no monitoring plan for the resident and no update to his care plan after the incident to prevent further abuse. III. Resident-to-resident physical abuse [DATE] involving Residents #2 and #4 A. Resident #2 and #4 1. Resident #2 - see above 2. Resident #4 Resident #4, age 82, admitted to the facility on [DATE], readmitted on [DATE], and passed away on [DATE]. According to the [DATE] CPO, [DIAGNOSES REDACTED]. The [DATE] MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. The resident used a manual wheelchair and required extensive assistance of two for bed mobility and extensive assistance of one for transfers The resident's care plan dated [DATE] with a revision date of [DATE] identified the resident as having behavioral disturbances that seriously disrupt the rights of other residents and that he will go into

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) other residents' rooms and rummage through their things, taking items at times. Pertinent interventions included in-service staff to monitor the resident's movements and surroundings and redirect as necessary, staff will frequently check residents' location and redirect if needed to the dining room or activities room, or wherever the resident wishes other than (other) residents' rooms. B. Resident-to-resident abuse [DATE] with significant injuries and facility response 1. Facility investigation A nurse progress note written in Resident #2's medical record on [DATE] at 1:02 a.m. documented the following: At 6:20 p.m. (on [DATE]) a certified nurse aide (CNA) yelled from down the hall that she needed help and wanted the nurse. This nurse went down the hall and saw Resident #2 sitting in the hall just outside of his room looking into the room. Resident #2 stated, He was in my room. Resident #4 was laying on the floor on his left side next to the heater/air conditioner (AC) unit. The first CNA at the scene stated that Resident #2 told her, I beat the s*** (explicit language) out of him because he was in my room. Skin assessment was done on Resident #2 with no injuries, no elevations or marks noted on hands or elsewhere. Resident #2 was wearing rings on both hands. Resident #2 denied pain. He was immediately placed on 1:1 observation, he remained in his room with door closed after Resident #4 was taken out of room for further assessment and treatment . A nurse progress note written in Resident #4's medical record by the ADON on [DATE] at 9:11 p.m. read Resident #4 had multiple discolored areas to his face, ears and head. When asked what happened, the resident closed his hand and pointed to his head. The local police department and the on-call physician were notified; the physician gave a verbal order to send the resident to the hospital for further evaluation. A nurse progress note written in Resident #4's medical record on [DATE] at 10:43 p.m. by the nurse who responded to the CNA's call read, At 6:20 p.m. a CNA yelled from down the hall that she needed help and wanted the nurse. This nurse went to the room. Resident #4 was laying on the floor on his left side near the heater/AC unit. Resident was breathing with mild grunting sound, eyes open, a moderate amount of blood was on the floor around his head. Resident was demonstrating range of motion (ROM) in his lower extremities and did move his right arm on his own. Resident #4 was alert, but initially appeared cognitively slow to respond. He demonstrated movement of his head and appeared to have no significant cervical injury. Resident appeared to want to get up, assisted to his w/c. Neurological checks initiated. Initial Glasgow Coma Score at 10, quickly improving to 15 after 10 to 15 minutes. Blood was cleaned to reveal injuries: Right temple laceration 3 centimeters (cm) x 0.3 cm laceration with elevation. Right earlobe discoloration. Right cheek discoloration 2 cm x 3 cm. Left temple superficial abrasion 1 cm x 1 cm. Left temple discoloration with elevation 5 cm x 4 cm. Left cheek discoloration 3 cm x 4 cm. Right chest discolored area 2 cm x 1 cm. Cold packs were applied to sites of elevation. Resident denied pain, but Tylenol 650 mg was given. Vital signs: temperature 97.3, heart rate 73, respirations 24, blood pressure ,[DATE]. Oxygen saturation (SaO2) 88% on room air, going up to 93% on room air within 15 minutes . A nurse progress note written in Resident #4's medical record on [DATE] at 12:43 a.m. documented the hospital notified the facility Resident #4 had a brain bleed considered serious bodily injury and that they would be stabilizing him, then sending him to another hospital. 2. Hospital reports An emergency department report [DATE] at 2:35 a.m. documented, An [AGE] year-old male came into the ED via emergency medical service (EMS) as a transfer from another hospital for traumatic subdural hemorrhage. Per transfer paperwork, the patient lives in a nursing home in the dementia care unit where he was assaulted by another resident. Patient has a laceration on the right side of his forehead that was stapled at the outside facility. He also has significant bruising to the left and right sides of his face and his right ear is swollen and bruised. Patient is normally confused secondary to his history of dementia and is unable to answer any questions here at the ED but he does mumble. Patient also has a history [MEDICAL CONDITION] left sided deficits. Patient was found to have a 5mm right subdural hemorrhage on his Computerized tomography (CT) of the head and was transferred here for a higher level of care . He is a full code. As he is unable to actually articulate where he is hurt and they had only done a head and neck CT at the other facility. I did a full trauma workup. This revealed nasal fractures, again the subdural hemorrhage, multiple rib fractures on each side of his chest. No pneumothorax or hemothorax. No evidence of visceral injury to his pelvis. L1 compression fracture that I'm not sure is actually acute however I also don't have any previous comparisons. He does have an auricular hematoma over the right ear however I do not think that this requires drainage at this time. I then discussed the case with the trauma surgeon on-call who agreed for admission. Due to the presence of multiple injuries he did request to have him be monitored in the neuro trauma unit. The patient was hemodynamically stable at this time and currently does not need oxygen although this may change given his multiple rib fractures. The [DATE] at 11:32 a.m. discharge summary report read in part, that the resident demonstrated bilateral small acute subdural hematomas, acute intraparenchymal hemorrhagic contusion on the right temporal lobe, bilateral nasal bone fractures, bilateral zygomatic arch fractures, rib fractures of right ribs ,[DATE], rib fractures of left ribs ,[DATE], and L1 (lumbar) compression fracture. The patient was admitted to service in the neurotrauma intensive care unit for further evaluation and care . The patient was ready for discharge and discharged back to his nursing facility in stable condition. The resident expired at the facility on [DATE]. 3. Facility operations director's statement written on [DATE] On the morning of [DATE], while interviewing Resident #2 on a grievance complaint filed by him, Resident #2 made reference to hitting Resident #4. During my interview with Resident #2 I made a statement that he shouldn't be beating up other residents and his reply was that he didn t beat him up, he only hit him. I told him that's the same thing. He then demonstrated how he hit Resident #4 by forming a fist with his left hand and placing his knuckles on his left chin. I asked him if he hit him with his rings on and he said he always has his rings on. 4. Staff interviews The AC, during her interview on [DATE] at 3:00 p.m. (see above) said that she interviewed Resident #2 on [DATE]. She said that Resident #2 voiced to her that he thought that Resident #4 came into his room and was trying to get something out of his drawers. She said Resident #2 told her that Resident #4 had fallen to the floor out of his w/c. The AC said that Resident #4 had a history of [REDACTED]. She said that Resident #2 was on 15 minute checks at the time of the incident, and that he was placed on 1:1 monitoring following the incident. The SSD, during her interview with the AC and the interim DON on [DATE] at 3:00 p.m. said adult protective services (APS) had investigated and filed a case against Resident #2 because the altercation with Resident #4 was considered an incident against an at-risk adult. The SSD said that she identified after the second resident to resident altercation involving Resident #2 that juice and food appeared to be triggers for him. She said that when other residents wander into his space with the perceived threat that they are going to take the food or drink from him, he gets upset. The SSD said that she had care planned that for Resident #2. The interim DON said that Resident #2 would remain on one to one for as long as it was necessary and he realized that what he had been doing was wrong. The ADON, during her interview on [DATE] at 2:18 p.m. (see above) she said that she thought Resident #2 had been on a one to one (on [DATE]) because of a previous altercation with a resident. She said she believed he was now on one to one indefinitely because the facility could not afford to have him hurt anyone else. The NHA during the interview on [DATE] at 9:05 a.m. with the clinical regional consultant (CRC), said Resident #4 was known to always be looking for snacks. She was not sure if he had been headed out to smoke and then veered into Resident #2's room. She said they knew something happened in the room, but there were just no witnesses to confirm. She Resident #2 said that Resident #4 fell initially, then he stated that he beat the s**** (explicit language) out of him. She said the second incident occurred between the 15-minute checks. She said abuse was substantiated. C. Failures in facility response Although the resident's care plan was updated [DATE] to include one on one due to behaviors, contrary to the SSD statement above, there was no evidence Resident #2's triggers - food and juice being taken from him - were added to his care plan. Moreover, staff knew Resident #4 had behaviors that disrupted the rights of others, placing him at risk for resident to resident abuse. Staff also were directed in his care plan to monitor Resident #4's movements and surroundings and to frequently check his location. However, there was no evidence in facility's investigation (see above) the facility had attempted to determine when staff had last checked on Resident #4 to ensure his safety. Finally, interviews indicated staff had not been trained to ensure one to one monitoring of Resident #2 would be effective. -Activity assistant (AA) #1 was interviewed on [DATE] at 4:55 p.m. She said she was currently providing Resident #2 a one to one. She said the resident was on one to one because he had girls over and they would give him drugs. The AA said she would sit outside the resident's room and make sure that nobody was throwing drugs through the resident's window, as that had happened in the past. The AA said she was unsure the last time she had any behavior training, but if she had any, it would have been on the computer. -CNA #1 was interviewed on [DATE] at 2:03 p.m. She said this was the first time she was assigned to the one to one for Resident #2. She said she was not sure why she was doing the one to one, but was told she just needed to make sure the resident did not need anything. The CNA said she had not received any training specific to the one to one of Resident #2, nor had she received any behavior training from the facility in the month she had been working in the facility.
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.**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to report a [MEDICAL CONDITION] to state survey and certification agency for one (#4) of two residents reviewed for abuse out of 10 sample residents. Specifically, the facility failed to ensure that a [MEDICAL CONDITION], as a result of physical abuse to Resident #4 was reported timely. Findings include: I. Facility policy and procedure The Abuse Investigation and Reporting policy, revised July 2017, was provided by the nursing home administrator (NHA) on 8/10/2020 at 3:30 p.m. It read in pertinent part, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management. II. Altercation 4/16/2020 that resulted in Resident #4's [MEDICAL CONDITION] A. Resident status Resident #4, age 82, was admitted on [DATE], readmitted on [DATE] from the hospital, and passed away on 5/4/2020. According to the April 2020 computerized physician orders [REDACTED]. The 4/25/2020 minimum data set (MDS) assessment revealed the resident had cognitive impairments and had moderately impaired decision making skills based on the staff assessment for mental status. B. Record review A nurse progress note written in Resident #4 's medical record on 4/17/2020 at 12:43 a.m. documented the following: At 9:25 p.m. the hospital called and gave report on Resident #4. The registered nurse (RN) stated that Resident #4 had a ' brain bleed ' considered ' serious bodily injury ' and that they would be stabilizing him, then sending him to another hospital. RN stated that they would be calling the local police department and giving information to them. POA/Guardian was called at 9:33 p.m. and informed of Resident #4's condition and his imminent transfer to another hospital. Administrator and on-call nurse notified of the resident's condition and transfer.Cross reference F600 for failure to keep Resident #4 free from physical abuse from Resident #2. The 4/17/2020 at 2:35 a.m. Emergency Department (ED) report documented the following in pertinent part: An [AGE] year-old male came into the ED via emergency medical service (EMS) as a transfer from another hospital for traumatic subdural hemorrhage (bleeding on the brain). Per transfer paperwork, the patient lives in a nursing home in the dementia care unit where he was assaulted by another resident. Patient has a laceration on the right side of his forehead that was stapled at the outside facility. He also has significant bruising to the left and right sides of his face and his right ear is swollen and bruised. This revealed (via head and neck computerized tomography) nasal fractures, again the subdural hemorrhage, multiple rib fractures on each side of his chest. The patient was hemodynamically stable (blood was stable) at this time and currently does not need oxygen although this may change given his multiple rib fractures. The 4/19/2020 at 11:32 a.m. discharge summary report from the hospital documented the following in pertinent part: The patient was evaluated at an outside facility, but given findings related to closed head injury, the patient was transferred here for further evaluation and care. He had work up, which ultimately demonstrated bilateral small acute subdural hematomas, acute intraparenchymal hemorrhagic contusion on the right temporal lobe (head injury), bilateral nasal bone fractures, bilateral zygomatic arch fractures (facial bone fractures), rib fractures of right ribs 3-7, rib fractures of left ribs 4-7, and L1 (lumbar) compression fracture. The patient was ready for discharge and discharged back to his nursing facility in stable condition. C. Staff interview The nursing home administrator and the clinical regional consultant (CRC) were interviewed on 8/17/2020 at 9:05 a.m. The CRC said We were remiss in reporting the brain bleed. It was a failure on our part to report that correctly. The NHA and I discussed it on several occasions, had we reported it, it may have raised the seriousness of the incident. III. Facility follow-up Review of the information reported by the facility, conducted on 8/1/2020, revealed that the NHA reported the [MEDICAL CONDITION] incident on 8/17/2020 at 5:03 p.m. following the survey exit, which was not timely. The altercation that occurred between Resident #2 and Resident #4 was reported timely.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the comprehensive care plan for four (#1, #2, #5 and #6) of four out of nine sampled residents was reviewed and revised timely to include the instructions needed to provide effective and person-centered care for each resident. Specifically, the facility failed to: -Review and revise Resident #1's and #2's care plan when new behavior concerns were identified and update interventions and approaches when they were identified; and, -Review and revise Resident #5's and Resident #6's care plan when skin concerns were identified and update or include interventions to help prevent further skin breakdown. Findings include: I. Facility policy and procedure The Care Plan, Comprehensive Person-Centered policy, revised December 2016, was provided by the nursing home administrator (NHA) on 8/10/2020 at 3:30 p.m. It read in pertinent part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the residents physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The IDT must review and update the care plan: when there has been a significant change in condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly in conjunction with the required quarterly MDS (minimum data set) assessment. II. Failure to revise and update behavior interventions A. Resident #1 1. Resident status Resident #1, age 70, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 7/20/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with the brief interview for mental status (BIMS) not able to be completed with the resident. According to the staff assessment for mental status, the resident had modified independence making decisions regarding tasks of daily life. The resident displayed inattention and disorganized thinking. He displayed physical behavior symptoms directed towards others one to three days and verbal behavior symptoms directed towards others daily. Those behaviors put the resident at significant risk for physical illness and injury, significantly interfered with his care and significantly interfered with his participation in activities or social interactions. Those identified behaviors put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The resident rejected care on a daily basis. He required set-up assistance with bed mobility, transfers, walking, and locomotion, one person assistance with dressing, eating, and toileting, and two person extensive assistance with personal hygiene. 2. Record review The resident safety care plan, initiated on 8/5/2020 (during the time of the survey) had been updated and documented the following: The resident is at risk for severe bodily injury or death second to non compliance for evacuation during an emergent situation, non compliance with practical use of dishes or flatware and historical attempts to break windows. 8/5/2020- Resident #1 refused to leave his room during a fire despite prodding by staff and emergency personnel. The goal was for the resident not to sustain any severe injury from emergency evacuations or attempt to evacuate him from any harmful situation. Pertinent approaches included: during an evacuation explaining to the resident the need to leave the room, and if he refuses to have a staff member with a good relationship with him assist with the evacuation. Offering the resident his favorite snacks (cookies and ice cream) in an attempt to get him to evacuate. Calling the fire department or the police to assist with the evacuation. The behavior care plan, initiated on 3/13/2017 and revised on 8/7/2020 (during the time of the survey), revealed the resident could become explosive with verbal outbursts with no identifiable triggers as evidenced by throwing cups, spitting on the walls, windows, and floors and cursing at staff related to his [DIAGNOSES REDACTED]. The resident will frequently become agitated stating that a fat bastard who used to run the facility stole money from him, the resident is not currently taking any medications as he refuses. The goal was for the resident to cause no injuries to himself or other due to his behaviors, as well as to be redirected from behaviors before they increased and caused harm to himself or others. The pertinent approaches included, assessing for pain or discomfort as the reason for the increased behaviors. Caregivers provide the opportunity for positive interaction, attention by stopping and talking with the resident when they are passing by. Minimize potential behaviors by offering snacks such as ice cream and cookies, playing music and one-to-one socialization about his time driving a truck. 3. Staff interview The social service director (SSD) was interviewed on 8/6/2020 at 12:30 p.m. She said the safety care plan had been added to the residents care plan after he refused to evacuate during a fire in

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) the facility. She said the approaches on the behavior care plan had not been updated recently, and he frequently damaged or threw items like CD players, and he currently did not have a CD player in his room. The SSD said when she was working with the resident she had success with cookies and ice cream, but there behavior documentation was inconsistent for the resident, and there were never any interdisciplinary team (IDT) meetings so she was unsure how successful the interventions were for other staff members, or of they had any additional interventions that were successful. The NHA was interviewed on 8/17/2020 at 9:00 a.m. She said Resident #1 typically was more agreeable on Fridays, she thought due to it being associated with pay days. The NHA said the facility could use that time to possibly clean the resident's room, or attempt showers or skin checks. The NHA said that information was not in the resident's care plan, but should be. B. Resident #2 1. Resident status Resident #2, age 63, was admitted on [DATE] and readmitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/28/2020 MDS assessment revealed that the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) of ten out of 15. The MDS did not identify any behaviors that the resident displayed. The resident required one person limited assistance with dressing, toileting, and personal hygiene. He required supervision for bed mobility, transfers, and eating. 2. Record review The PASRR (preadmission screening and resident review) level II care plan, initiated on 4/12/2017 and revised on 4/17/2020, revealed that Resident #2 experienced extreme mood changes, manic episodes, and depressive episodes. He would become very possessive regarding his belongings and would become physically aggressive. The goal was for the resident to remain stable and have a reduction in behaviors and symptoms, and no [MEDICAL CONDITION], and medication compliance through the next review date. The pertinent interventions included placing the resident on a one-to-one staff supervision until effects of medication changes are known and then re-evaluate, encourage the resident to participate in activities of choice/interest, encourage the resident to verbalize his concerns before becoming physical, monitor the resident's mood and participation in care, redirect others away from the resident's belongings, redirect with music when manic or experiencing increased agitation, and reports any concerns of behaviors and symptoms to physician or psychiatrist. - Resident #2's care plan was not updated with his behaviors previous to 4/16/2020 that were known to the staff until after two incidents of physical abuse that occured on 4/16/2020 with another resident. 3. Staff interview The social services director (SSD), admissions coordinator (AC) and interim director of nursing (IDON) were interviewed on 8/10/2020 at 3:00 p.m The SSD said that there were some of Resident #2's triggers care planned but only after his second abuse altercation that occured on 4/16/2020. The SSD said when other residents wandered into his space, he perceived it as a threat that they were going to take the juice or food from him III. Failure to revise and update identified skin concerns and interventions A. Resident #5 1. Resident status Resident #5, age 82, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/12/2020 MDS assessment revealed that the resident was moderately cognitively impaired with a BIMS score of eight out of 15. The resident required two person extensive assistance for bed mobility, transfers, and dressing, extensive assistance of one person for toilet use and personal hygiene, and supervision of one person for eating. He was at risk for pressure ulcers, he had one or more unhealed stage one pressure ulcers that required a dressing with application of ointment or medication. 2. Record review The at risk for skin breakdown care plan, initiated on 5/13/2020, revealed that the resident was at risk for skin breakdown related to his history of falls, [MEDICAL CONDITION], right sided [MEDICATION NAME] wall contusion, and diarrhea. The goal was for the resident to remain free from skin breakdown through the next review period. The interventions included to assist the resident with peri-care and hygiene needs as needed and monitor skin for any signs of irritation related to incontinent episodes, assist with toileting throughout each shift and as needed, and complete a skin inspection weekly by a licensed nurse, observe for redness, open areas, scratches, cuts, bruises and document per facility protocol for skin concerns. The wound care consulting physician orders [REDACTED]. cleanse with wound wash 2. apply [MEDICATION NAME] to both heels 3. leave left heel open to air 4. cover right with dry dressing. The skin impairments/wounds, physician orders [REDACTED].#5's comprehensive care plan. 3. Staff interviews The staff development coordinator (SDC), who was also the infection control preventionist (ICP), was interviewed on 8/13/2020 at 12:20 p.m. She said she was in charge of the wound care since the director of nursing was no longer employed by the facility. She said that when wound rounds are done weekly on Tuesdays, the team included the physical therapist, herself and the wound care provider nurse practitioner (NP). She said the NP initiated orders and interventions for wound care and treatment. She said for Resident #5, he should have blue boots, his heels floated, and be repositioned every two hours. She said any wound treatment, orders or interventions were to be care planned but she was not responsible to update the care plan and just inputted the wound orders. -The interventions initiated by the NP (see above) were not updated on the resident's care plan. B. Resident #6 1. Resident status Resident #6, age 90, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 6/19/2020 MDS assessment revealed that the resident was cognitively intact with a BIMS of 14 out of 15. The resident required two-person extensive assistance with bed mobility and transfers. She required one-person extensive assistance for dressing, toilet use, and personal hygiene. She was totally dependent for bathing. She was frequently incontinent of urine and always incontinent of her bowel. The MDS revealed that the resident was at risk for developing pressure ulcers/injuries. She had an unstageable pressure ulcer due to coverage of the wound bed by slough (a mass of dead tissue separating from an ulcer) and/or eschar (dry, black, hard necrotic tissue), and four venous/arterial ulcers present. She had a pressure reducing device for her bed. She was receiving pressure ulcer/injury care. She did not have a turning/repositioning program. 2. Record review The at risk for skin breakdown care plan, initiated on 2/27/2020 and last updated on 8/5/2020 (during the survey), revealed that Resident #6 was at risk for skin breakdown related to cognition and limited mobility, and a history of skin breakdown. The care plan revealed that the resident had actual skin breakdown of a blood blister to her right calf, blisters to bilateral (both) heels and a wound to her right inner buttock. The goal was for the resident to not experience any new skin breakdown and if she did experience any new skin breakdown, staff was to act promptly. The pertinent interventions included to assist the resident with peri care and hygiene as needed, monitor skin for any signs of irritation related to incontinent episodes, utilization of an air mattress to prevent further skin breakdown, resident to be seen every week on wound rounds until all skin issues are resolved, float heels as needed to prevent further skin breakdown, encourage resident to periodically get out of her wheelchair as she prefers to sit in it throughout the day, keep skin clean and dry as the resident is incontinent of bowel and bladder, assist with toileting throughout each shift and as needed, monitor/document location, size and treatment of [REDACTED]. The wound care nurse practitioner consulting physician orders [REDACTED]. There were also orders for her wheelchair cushion to be evaluated, nutritional supplements, bilateral walking shoes/boots, and an air mattress. -The right lateral mid-foot wound, right distal, lateral fifth metatarsal wound, and right second toe wound were not updated on the care plan, nor was there an update for the walking boots or wheelchair cushion that were ordered by the nurse practitioner. The Weekly Pressure Ulcer Skin assessment dated [DATE] (four total assessments), identified that Resident #6 had wounds to her left medial heel, right fifth metatarsal (pinky toe), right heel, and back. -The pinky toe wound and the back wound were not updated on the resident's care plan. The August 2020 CPO revealed the resident had the following wound care orders: -Left medial heel - cleanse with wound wash, pat dry, and apply [MEDICATION NAME], one time a day for arterial wound; -Right lateral mid-foot and right lateral heel - cleanse with wound cleanser, pat dry, and apply [MEDICATION NAME], one time a day for arterial wounds; -Right fifth lateral metatarsal - cleanse with wound cleanser, pat dry, apply [MEDICATION NAME] and dry dressing, one time a day for arterial wound; -Left buttocks - cleanse and apply barrier cream (calcified tissue). Continue to monitor for changes, one time a day for wound care to left buttock; and, -Mid back - cleanse with wound cleanser, pat dry, apply [MEDICATION NAME] & cover with dry dressing, one time a day for pressure wound. The right lateral mid-foot wound and the left buttock wound were not updated on the resident's care plan IV. Staff interviews The minimum data set coordinator (MDSC), who was contracted and worked offsite, was interviewed on 8/12/2020 at 12:36 p.m. The MDSC said the facility staff were responsible for their care plans. She said she checked to see if the resident had a care plan for the care areas identified by an MDS assessment but she did not look in depth at the care plans created by the respective departments. She said if she noticed that something was missing from the comprehensive care plan she would notify the facility. The assistant director of nursing (ADON) was interviewed on 8/13/2020 at 2:18 p.m. She said the wound care NP made recommendations for new orders and interventions related to wound care. She said any wounds, recommendations for new orders and interventions should be care planned. She said she thought the SDC/ICP was responsible for adding the wound care orders and interventions to the care plan. The ADON said when the floor nurses received orders they should add the information to the care plan. She said that department staff do not necessarily review the resident's care plans in their care conference. She acknowledged that the resident care plans needed to be updated and accurate to provide individualized care. She said she thought that the MDSC updated the care plans as well. She said that she vaguely remembered the previous director of nursing (DON) mentioning that corporate wanted all

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) the care plans updated so they were more personalized. She said that the DON had mentioned that they were going to update at least five care plans a day, but there was no plan put into place to start that process. The NHA and corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The NHA said she had identified in October 2019 that the resident care plans were not updated and personalized as they needed to be. The NHA said the DON and the MDS coordinator were responsible for beefing up care plans, but they have gone through a couple of DONs since then and the MDS coordinator worked off-site and did not have daily interaction with the residents.
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide a meaningful program of activities for four (Resident #1, #2, #7 and #8) of five residents reviewed for activities of 10 sample residents. Specifically, the facility failed to: -Provide meaningful activities that met the interests for Resident #1, #2, #7 and #8; and -Review Resident #1, #2, #3, #4 and #5 quarterly/annual activity participation in a timely manner; -Provide updated activity calendars to the residents on the South unit; and, -Provide scheduled evening activities. Cross-reference F742 for treatment and services for behavioral health. The facility failed to accurately document behaviors on the South unit, to develop person centered approaches, and provided specialized training to staff. Findings include: I. Facility policy and procedures The activity programs policy and procedure, last revised June 2018, was provided by the nursing home administrator (NHA) on 8/10/2020 at approximately 12:00 p.m. The policy read in pertinent part: -The activity program is provided to support the well-being of residents and to encourage both independence and community interaction. -Activities offered are based on the comprehensive resident-centered assessment and the preferences of each resident. -Scheduled activities are posted in the resident bulletin board. Activity schedules are also provided individually to residents who cannot access the bulletin board. II. Resident #1 A. Resident #1 status Resident #1, age 70, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 7/20/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment with the brief interview for mental status (BIMS) not able to be completed with the resident. According to the staff assessment for mental status, the resident had modified independence making decisions regarding tasks of daily life. The resident displayed inattention and disorganized thinking. It was very important for the resident to listen to music, be around animals, and participate in his favorite activities, it was somewhat important for the resident to keep up with the news. B. Record review The activity care plan, last revised on 5/21/2020, documented the resident was resistant to attend any group activities, placing him at risk for psychosocial well-being issues. The resident preferred to stay in his room, and he did not like to be around any person and became verbally aggressive when talked to. The goal was for the resident to not spit on activity staff when they were providing a one-to-one activity program. The pertinent approaches included: -Allowing the resident to stand in the hallway activity area to listen to music; -Providing a CD (compact disk) player in his room and replacing it when the resident broke it; -Resident prefers to socialize with staff, he will very seldom carry conversations with other residents; and, -Resident preferred activities are: rummaging in his room, standing in the hallway by the other residents door listening to music, and standing in the common area talking to staff as they pass by. August 2020 activity participation records were requested for Resident #1, the facility provided a document titled: Additional Activity Charting d/t (due to) COVID-19 for the following dates on 8/5/2020, 8/6/2020, 8/7/2020, 8/8/2020, 8/9/2020 and 8/10/2020. Resident #1 was documented as receiving an in room one-to-onesocial on each of those dates. There was no additional activity participation documentation, including any independent activities the resident participated in. A review of the resident quarterly and annual activity assessment, for the past year, revealed the resident had been assessed on the following dates on12/4/19 and 8/12/2020(during the time of the survey). C. Observations On 8/4/2020 at 4:46 p.m. the resident was observed laying in his bed with his eyes open, there was no meaningful activity occurring, and the resident did not have a radio in his room. On 8/5/2020 at 12:16 p.m. the resident was observed walking in and out of his room to the nurses station, several staff members were observed passing the resident, none were observed stopping and attempting to engage the resident in conversation. On 8/5/2020 at 12:40 p.m. Resident #1 was observed in the hallway by the nurses station. The resident was attempting to engage licensed practical nurse (LPN) #1 in a conversation about old television shows. The LPN did not engage in conversation with the resident, and instead asked the resident if he wanted a cookie. The resident turned and left the nurses station and began cursing loudly. On 8/6/2020 at 9:48 a.m. The resident was observed walking in and out of his room, several staff members were observed walking past the resident, none attempted to engage the resident in conversation. There was no CD player or music playing in the residents room. III. Resident #2 A. Resident #2 status Resident #2, age 63, was admitted on [DATE]. According to the August 2020 CPOs, [DIAGNOSES REDACTED]. According to the 5/1/2020 MDS assessment, the resident had moderate cognitive impairment with a BIMS score of 10 of 15. It was very important for the resident to listen to music, keep up with the news, go outside, and participate in his favorite activities, it was somewhat important for the resident to have reading materials and participate in activities with other people. C. Record review The activity care plan, last revised 5/13/2020, documented the resident was very active in scheduled groups of choice, and was able to plan his own leisure activities. The goal was for the resident to maintain involvement in cognitive stimulation, social activities as desired, through the next review. The pertinent approaches included: -Assisting the resident with arranging community activities, and letting the resident know when shopping trips were taking place. -The resident's preferred activities are shopping and going out to lunch. -Provide an activities calendar, and notify when there are any changes to the activity calendar. August 2020 activity participation records were requested for Resident #2, the facility provided a document titled: Additional Activity Charting d/t (due to) COVID-19 for the following dates on 8/5/2020, 8/6/2020, 8/7/2020, 8/8/2020, 8/9/2020 and 8/10/2020. Resident #2 was documented as receiving an in room one-to-one social on each of those dates, except for 8/10/2020. He was also documented as participating in am morning walk outside on 8/5/2020, there was no additional activity participation documented for Resident #2. A review of the resident quarterly and annual activity assessment, for the past year, revealed the resident had been assessed on the following dates on 11/6/19 and 8/12/2020 (during the time of the survey). IV. Resident #7 A. Resident #7 status Resident #7, age 65, was admitted on [DATE]. According to the August 2020 CPOs, [DIAGNOSES REDACTED]. According to the 8/14/2020 MDS assessment, the resident was cognitively intact with a BIMS score of 14 of 15. It was very important for the resident to participate in his favorite activities, and somewhat important for him to have reading materials and to keep up with the news. B. Resident interview Resident #7 was interviewed on 8/6/2020 at 9:30 a.m. He said there was nothing that really ever happened in the facility. He said the staff would pass him a paper in the morning (Daily Chronicle), but that was about it. He said he liked to go out of the facility, but that was no longer happening. C. Record review The activity care plan, last revised 12/30/19, documented the resident had little to no group activity involvement related to the resident wishing not to participate. The goal was for the resident to express satisfaction with the type of activities and level of activity involvement including his leisure time activities when asked, through the review date. The pertinent approaches included: -Ensure the resident knows when shopping trips were scheduled as he looks forward to this and has a very specific list of items he likes to get. -Staff will attempt to provide one-to-one social visits as the resident will allow and do so outside of the residents room to respect his privacy and desire not to have people in his room. August 2020 activity participation records were requested for Resident #7, the facility provided a document titled: Additional Activity Charting d/t (due to) COVID-19 for the following dates on 8/5/2020, 8/6/2020, 8/7/2020, 8/8/2020, 8/9/2020 and 8/10/2020. Resident #7 was documented as receiving an in room one-to-one social on each of those dates, except for 8/10/2020. He was also documented as participating in daily chronicles on 8/6/2020, 8/8/2020 and 8/10/2020. A review of the resident quarterly and annual activity assessment, for the past year, revealed the resident had been assessed on the following dates on12/14/19 and 8/13/2020 (during the time of the survey). V. Resident #8 A. Resident #8 status Resident #8, age 80, was admitted on [DATE]. According to the August 2020 CPOs, [DIAGNOSES REDACTED]. It was very important for the resident to participate in reading, her favorite activities and religious programs. It was somewhat important for the resident to participate in music, news and group activities. B. Record review The activity care plan, last revised 5/13/2020, documented the resident was active in scheduled groups of choice throughout the day. The goal was for the resident to maintain involvement in cognitive stimulation and social activities as desired through the review date. Pertinent approaches included: -The resident's preferred activities are

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F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) country rides, out to lunch and reading her bible. -Invite the resident to scheduled activities. -Provide with an activities calendar. August 2020 activity participation records were requested for Resident #7, the facility provided a document titled: Additional Activity Charting d/t (due to) COVID-19 for the following dates on 8/5/2020, 8/6/2020, 8/7/2020, 8/8/2020, 8/9/2020 and 8/10/2020. Resident #8 was documented as receiving an in room one-to-one social on each of those dates. The resident was not documented as participating in any additional activities. A review of the resident quarterly and annual activity assessment, for the past year, revealed the resident had been assessed on the following dates on 8/12/2020 (during the time of the survey). C. Observations On 8/4/2020 at 4:20 p.m. the resident was observed standing in the hallway, not participating in any meaningful activities. Several staff were observed walking past the resident. None of the staff offered the resident independent leisure activities. No activities were scheduled on the calendar. On 8/5/2020 from 1:50 p.m. to 2:15 p.m the resident was observed standing in the hallway, there was a bingo game taking place in the activity room. Several staff were observed walking past the resident. None of the staff invited or encouraged the resident to participate in the bingo game. VI. Staff interviews Activity assistant (AA) #2 was interviewed on 8/6/2020 at 9:37 a.m. She said the facility was no longer doing lunch or shopping outings due to COVID-19. She said those activities had not been replaced on the calendar and she was unsure what the activity department was doing for residents who preferred activity was outings. The AA said she had taken Resident #2 on a walk outside, but that was the only outing he had been on in a few months. The AA said several of the residents like the outings, but they were currently not providing them. The AA said there were approximately four activities each day for the South unit, but only two to three of the activities were led by the activity staff. The AA said for example the Daily Chronicle listed every weekday morning was just a piece of paper she would hand out to the residents and it was not an activity they did as a group. The AA said the in room one-to-one social visits were basically saying hi to the resident in their room. The AA said there currently was not a calendar completed for August 2020, so she was using the July 2020 calendar. She said she was not sure if she was going by the day of the week or the date. She said it would be very confusing for the residents and she was unsure how they knew the daily activities that were occurring. The activity director (AD) was interviewed on 8/10/2020 at 4:14 p.m. She said she currently had four staff members, including herself who provided the activities to the residents. She said AA #2 did the activity programming on the South unit on Monday through Friday, and one activity staff member worked the weekend and covered all of the activities for both buildings for approximately 80 residents. The AD said the facility had not been providing evening activities since March 2020 and currently the latest activity offered on the South unit was at 4:00 p.m. The AD said she had fallen behind in her documentation and it was at least six months behind because she had been so busy trying to adapt the activity programming to COVID-19 guidelines. The AD said the residents should be provided a calendar in their room and a calendar should be posted in the common area. The AD said the calendar had been provided to the residents and posted in the common area after she was notified. The NHA and corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The NHA said they were in the process of trying to improve the activity department but when COVID-19 started in March 2020, the facility had been unable to get vendors to come in. The NHA said the AD should follow the MDS schedule and should be completing assessment when they are due quarterly. VII. Facility follow-up On 8/10/2020 at approximately 5:00 p.m. AA#2 was observed passing out August 2020 calendars to the residents and hanging the calendar in the common areas.
F 0684 **Level of harm** - Minimal harm or potential for 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 observations, record review and staff interviews, the facility failed to ensure three (#1, #5 and #6) of four out of 10 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to: -Complete accurate and thorough skin assessments for Resident #5 and #6 to reflect the resident's current skin conditions; and, -Complete timely skin assessments for Resident #1 and #6. Findings include: I. Facility policy and procedure The Pressure Ulcers/Skin Breakdown -Clinical Protocol policy, last revised April 2018, was provided by the nursing home administrator (NHA) on 8/10/2020 at approximately 3:30 p.m. The NHA said the facility only had the one skin policy and it did not clearly differentiate between pressure ulcers, non pressure ulcers, or other skin concerns. The NHA said skin checks needed to be completed weekly for all of the residents, and she was not sure if the policy clearly stated that. Review of the policy identified that it did not clearly differentiate between types of skin issues, nor did it state that skin checks were to be completed weekly. II. Resident #6 A. Resident status Resident #6, age 90, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 6/19/2020 MDS assessment revealed that the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. The resident required two-person extensive assistance with bed mobility and transfers. She required one-person extensive assistance for dressing, toilet use, and personal hygiene. She was totally dependent for bathing. She was frequently incontinent of urine and always incontinent of her bowel. The MDS revealed that the resident was at risk for developing pressure ulcers/injuries. She had an unstageable pressure ulcer due to coverage of the wound bed by slough (a mass of dead tissue separating from an ulcer) and/or eschar (dry, black, hard necrotic tissue), and four venous/arterial ulcers present. She had a pressure reducing device for her bed. She was receiving pressure ulcer/injury care. She did not have a turning/repositioning program. B. Failure to complete accurate and thorough skin assessments for residents to reflect the residents current skin condition 1. Observations Resident #6 was observed on 8/6/2020 at 1:15 p.m. lying in her bed as LPN #2 performed a skin assessment on the resident and changed her wound dressings. Resident #6 was observed to have the following skin issues two scabs and two bruises on her right knee and lower leg; a small bruise to her left leg below the knee; her left second toe had blanchable redness but no open areas on the toe; an open wound to the right foot on the lateral side of the ankle; healing scabs on top of the third and fourth toes of her right foot; and her left forearm had scattered healing bruising with one long bruise near her left elbow. 2. Record review Review of the non-pressure skin assessment completed by LPN #2 on 8/6/2020 documented the resident had right knee scabs, a skin issue on her right shin (did not document if it was a bruise, scab, or open area), a skin issue on her left shin (did not document if it was a bruise, scab, or open area), and a skin issue on her left knee (did not document if it was a bruise, scab, or open area). The skin assessment did not document anything regarding the redness to her left second toe, the open wound to the right foot, the scabs on the toes on her right foot, or the bruises on her left forearm. Review of the wound care provider consultant notes dated 4/14/2020 through 7/21/2020 documented the wounds to the resident's right lateral metatarsal, right heel, left heel, and right lateral foot were all arterial wounds, not pressure wounds. Review of the pressure skin assessments revealed that the arterial wounds were documented by facility staff as stage II pressure wounds on the following dates: -Right lateral metatarsal wound was documented as a pressure wound on 5/19/2020, 6/2/2020, 6/16/2020, 6/23/2020, and 7/2/2020; -Right heel wound was documented as a pressure wound on 5/19/2020, 6/23/2020, 7/2/2020, and 8/5/2020; -Left heel wound was documented as a pressure wound on 6/2/2020, 6/16/2020, 6/23/2020, and 8/5/2020; -Right lateral foot wound was documented as a pressure wound on 6/2/2020, 6/16/2020, 6/23/2020, and 7/2/2020. 3. Staff interview The staff development coordinator/infection control preventionist (SDC/ICP) was interviewed on 8/13/2020 at 12:21p.m.She said she was responsible for wound tracking. She said she was unsure of why she was tracking the wounds on the resident's feet as pressure ulcers and the wound care nurse practitioner tracked them as arterial. The wound care consultant nurse practitioner (NP) was interviewed on 8/13/2020 at 1:30 p.m. She said Resident #6 had arterial wounds on her feet and an unstageable pressure wound on her left buttocks. She said she was not aware that the SDC/ICP was confused about the wounds on her feet not being pressure ulcers. She said she provided the information and education during each visit. C. Failure to complete timely skin assessments 1. Record review Review of the electronic medical record revealed that Resident #6 did not have a skin assessment documented on the following dates: -No skin assessments were documented between 3/16/2020 and 4/13/2020; -No skin assessments were documented between 4/13/2020 and 5/4/2020; During the time that the skin assessments were not documented, Resident #6 had a pressure ulcer to her left buttock and arterial wounds to both of her feet. 2. Staff interview The assistant director of nursing (ADON) was interviewed on 8/13/2020 at 2:18 p.m. She said when a floor nurse discovered a skin issue, they should perform a skin assessment, call the doctor, notify her and the SDC/ICP (who is the wound care nurse), and make a progress note. She said skin assessments should be done weekly on every resident. III. Resident #1 A. Resident status Resident #1, age 70, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 7/20/2020 minimum data set (MDS) assessment, the resident had severe

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) cognitive impairment with the brief interview for mental status (BIMS) not able to be completed with the resident. According to the staff assessment for mental status, the resident had modified independence making decisions regarding tasks of daily life. The resident displayed inattention and disorganized thinking. He displayed physical behavior symptoms directed towards others one to three days and verbal behavior symptoms directed towards others daily. Those behaviors put the resident at significant risk for physical illness and injury, significantly interfered with his care and significantly interfered with his participation in activities or social interactions. Those identified behaviors put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The resident rejected care on a daily basis. He required set-up assistance with bed mobility, transfers, walking, and locomotion, one person assistance with dressing, eating, and toileting, and two person extensive assistance with personal hygiene. B. Record review The residents skin care plan, last revised on 4/3/2020, revealed the resident was at risk for skin breakdown related to incontinence, refusal of baths, history of [MEDICAL CONDITION] and a [DIAGNOSES REDACTED].The goal was for the resident to remain free of skin breakdown through the rest of the review. The pertinent approaches included: Skin inspection: The resident requires skin inspection weekly by licensed nurse. Observe for redness, open areas, scratches, cuts, bruises and document per facility protocol for skin concerns, initiated on 11/27/2019. On 8/4/2020 a review of Resident #1 Skin assessments revealed the following skin assessment had been documented: -3/29/2020: Skin assessment- non-pressure ulcer was completed -4/10/2020: Skin assessment- non-pressure ulcer was completed No other skin assessments were documented in Resident #1 medical record. A review of Resident #1 CPO revealed the following order: -Weekly skin assessment along with weekly summary, every day shift every Friday, document with the following key: D- dry, I- intact, NI- not intact, N- new, O- old. A review of Resident #1 Medication Administration Record [REDACTED]. -April 2020 MAR indicated [REDACTED]. -May 2020 MAR indicated [REDACTED]. -June 2020 MAR indicated [REDACTED]. -July 2020 MAR indicated [REDACTED]. -August 2020 MAR indicated [REDACTED]. C. Staff interviews The nursing home administrator (NHA) was interviewed on 8/10/2020 at approximately 12:30 p.m. She said Resident #1 frequently refused skin checks, and she assumed staff was still attempting to complete a skin assessment, but because it was Resident #1 norm to refuse the staff assistance and they had just become accustomed to the refusal, and had not documented the refusal. The assistant director of nursing (ADON) was interviewed on 8/13/2020 at 2:19 p.m. She said she was the staff member who had entered the order for weekly skin assessment for Resident #1 into the computerized MAR. She said she was unsure why staff was not documented, but they should be using the key and documenting in the MAR for Resident #1. IV. Resident #5 A. Observation Resident #5 was observed on 8/6/2020 at 12:03 p.m. lying in his bed. He had a small scab less than one centimeter (cm) in diameter on his left upper shoulder, a right elbow hematoma (blood or bruising under the skin) that was large and covered his entire elbow, purple to red in color, estimated to be five to six cm in diameter, scattered bruising around his right lower arm, his right hand first digit had a round one cm bruise, slightly above where the wrist bends he had a bruise about one cm long, his right scapula (shoulder) had a two cm skin tear. His left and right heel had pressure ulcers with scabs on them. B. Record review The non-pressure skin assessment dated [DATE] documented in the cleft of the right thumb, measures 1 cm x 1 cm circular in shape, anterior section of the right wrist at the distal region 1 cm x 1cm and 2 cm x 1 cm region above the lateral radial notch descending downward to the medial anterior lateral aspect of the wrist. C. Staff interview The assistant director of nursing (ADON) was interviewed on 8/13/2020 at 2:18 p.m. She said she was aware of the bruises noted during the observed skin assessment for Resident #5 and they should have been documented.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident observation, record review and interviews, the facility failed to ensure two (#5 and #6) of three residents reviewed for pressure ulcers out of 10 total sample residents, received the treatment and services to prevent pressure ulcer development. Specifically, the facility failed to: -Prevent residents (#5 and #6) who admitted to the facility without a pressure ulcer from developing a pressure ulcer; and, -Ensure that interventions were in place and care planned to prevent further skin breakdown or pressure ulcer development (#5 and #6). Cross-reference F657 for care plan timing and revision. The facility failed to identify and implement new problems and concerns for Residents #5 and #6 regarding their skin concerns and interventions. Findings include: I. Facility policy and procedure The Pressure Ulcers/Skin Breakdown-Clinical Protocol policy, last revised April 2018, was provided by the nursing home administrator (NHA) on 8/10/2020 at approximately 3:30 p.m. The NHA said the facility only had the one skin policy and it did not clearly differentiate between pressure ulcers, non-pressure ulcers or other skin concerns. II. Professional reference According to the National Pressure Injury Advisory Panel (NPIAP) Prevention and treatment of [REDACTED].cvph.org/data/files/NPIAP% 9.pdf (third edition published 2019, retrieved on 8/4/2020), it read in part, Excess moisture on the skin surface (e.g. due to increased perspiration or incontinence) also increases skin vulnerability to damage related to skin maceration, pressure, and shear forces. Maintaining skin integrity is essential in the prevention of pressure injuries. Implement a skin care regimen that includes keeping the skin clean and appropriately hydrated, and cleansing the skin promptly after episodes of incontinence. Repositioning and mobilizing individuals is an important component in the prevention of pressure injuries. Extended periods of lying or sitting on a particular part of the body and failure to redistribute the pressure on the body surface can result in sustained deformation of soft tissues, and ultimately, in tissue damage. Repositioning involves a change in position of the lying or seated individual at regular intervals, with the purpose of relieving or redistributing pressure and enhancing comfort. Mobilization involves assisting or encouraging a person to move or shift into a new position. Individuals who cannot reposition themselves will require assistance in this activity. No support surface provides complete pressure relief. Pressure is always applied to some area of the skin. Turning and repositioning for pressure redistribution must therefore occur regularly. Pressure and shear forces are important considerations in the development of pressure injuries in seated individuals. Limit time spent sitting out of bed for individuals at high risk of pressure injuries. III. Resident #6 A. Resident status Resident #6, age 90, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 6/19/2020 MDS assessment revealed that the resident was cognitively intact with a brief interview for mental status (BIMS) of 14 out of 15. The resident required two-person extensive assistance with bed mobility and transfers. She required one-person extensive assistance for dressing, toilet use, and personal hygiene. She was totally dependent for bathing. She was frequently incontinent of urine and always incontinent of her bowel. The MDS revealed that the resident was at risk for developing pressure ulcers/injuries. She had an unstageable pressure ulcer due to coverage of the wound bed by slough (a mass of dead tissue separating from an ulcer) and/or eschar (dry, black, hard necrotic tissue), and four venous/arterial ulcers present. She had a pressure reducing device for her bed. She was receiving pressure ulcer/injury care. She did not have a turning/repositioning program. B. Observation Resident #6 was observed on 8/6/2020 at 1:15 p.m. lying in her bed as licensed practical nurse (LPN) #2 performed a skin assessment on the resident and changed her wound dressings. The resident had an air mattress on her bed and a wedge pillow was present in the bed. The resident was observed to have severe kyphosis (an excessive outward curve of the spine resulting in an abnormal rounding of the upper back). Her upper mid back was observed to have a two to three centimeter (cm) pressure wound present. There was a dressing on the wound that LPN #2 removed, cleansed the wound, applied ointment, and redressed the wound. Resident #6 was observed to have a scabbed area to her left buttock approximately one cm in diameter. There was no dressing noted on the wound and it was left open to air after the nurse cleansed the wound and applied a barrier cream. C. Record review 1. Left buttock stage 2 pressure ulcer The nursing admission assessment dated [DATE] revealed the resident admitted to the facility with scattered bruises to both arms, a scab to the top of her left hand near the pinky finger, a scab to her left wrist, scattered bruises to both, redness/abrasion to mid-spine, and dry flaky skin. -There were no skin concerns noted on the buttocks at the time of admission. The pressure ulcer skin assessment dated [DATE] documented the resident had a stage 2 pressure ulcer to her left inner buttock with an onset date of 3/10/2020. The wound measurements were documented as 1 cm in length by 0.4 cm in width with a depth of 0.5 cm. -There were no interventions documented in the assessment. There were no pressure skin assessments documented from 3/9/2020 through 5/19/2020. The pressure ulcer skin assessment dated [DATE] documented the resident had a stage 2 pressure ulcer to her left buttock with an onset date of March 2020. The wound measurements were documented as 1 cm in length by 0.5 cm in width with a depth of 0.8 cm. The wound had tunneling (a channel extending from a wound into and through subcutaneous tissue or muscle) of 0.8 cm. -There were no interventions documented in the assessment. There was no pressure skin assessment completed for the left buttock wound on 6/2/2020. The pressure ulcer skin assessment 6/16/2020: documented the resident had

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 9) a stage 4 pressure ulcer to her left buttock with an onset date of ongoing. The wound measurements were documented as 1 cm in length by 0.4 cm in width with a depth of 0.7 cm. The wound had tunneling of 0.7 cm. -There were no interventions documented in the assessment. There were no further pressure skin assessments completed for the left buttock wound after 6/16/2020. The non-pressure skin assessment dated : -3/11/2020: documented the resident had a tunneling wound to her left buttock with an onset date of unknown. The wound measurements were documented as 1 cm in length by 0.4 cm in width with a depth of 0.5 cm. The wound had tunneling of 1 cm. Interventions included repositioning her every two hours and as needed, and to encourage her to lay down during the day to offload her bottom. The repositioning intervention was not updated on the care plan. There were non-pressure skin assessments documented from 3/11/2020 through 5/26/2020. -5/26/2020: documented the resident had a tunneling wound to her left buttock with an onset date of March 2020. The wound measurements were documented as 1 cm in length by 0.4 cm in width with a depth of 0.8 cm. The wound had tunneling of 0.8 cm. -There were no interventions documented in the assessment. -6/2/2020: documented the resident had a stage 2 pressure sore to her left buttock with an onset date of ongoing. The wound measurements were documented as 1.3 cm in length by 0.8 cm in width with a depth of 0.3 cm. The wound had no tunneling . -The interventions documented in the assessment were for new dressing orders. There were no further none pressure skin assessments completed for the left buttock pressure ulcer. The weekly summary dated: -3/9/2020: documented a pressure injury to the left buttock -3/16/2020: documented a pressure injury to the right buttock instead of the left buttock. There were no weekly summaries completed between 3/16/2020 and 4/13/2020. -4/13/2020: documented that the resident had current pressure injuries with an opened area that tunneled on her left buttock. There were no weekly summaries completed between 4/13/2020 and 5/4/2020. -5/4/2020: documented the resident had current pressure injuries with a wound to the left buttock. -5/11/2020: documented the resident had current pressure injuries with an opened area on the left buttock with tunneling. -5/18/2020: documented the resident had current pressure injuries with a wound to the left buttock with treatment in place. -5/25/2020: documented the resident had current pressure injuries with a wound to the left buttock with treatment in place. -6/1/2020: documented the resident had current pressure injuries but did not document the left buttock wound. -6/8/2020: documented the resident had current pressure injuries but did not document the left buttock wound -6/15/2020: documented the resident did not have current pressure injuries but did document that she had a left buttock skin issue that was being treated. -6/22/2020: documented the resident had current pressure injuries and the left buttock area was healing. -6/29/2020: documented the resident had current pressure injuries and an area to the left buttock that was being treated. -7/2/2020: documented the resident did not have current pressure injuries, but had an area to the left buttock that was being treated and was calcified. -7/6/2020: documented the resident had current pressure injuries and an area to the left buttock that was healing. -7/15/2020: documented the resident had current pressure injuries and a calcified area to the left buttock that was being treated. There was no further mention of the left buttock pressure injury on the weekly summaries following 7/15/2020. The wound care provider consultant notes dated 4/14/2020 through 6/23/2020 documented the wound to the resident's left buttock as a pressure ulcer. The wound care nurse practitioner documented on 6/23/2020 that the wound had received an outcome of resolved. The notes documented the wound was not changing and the area was now considered calcified tissues. -The recommendations were for staff to continue to monitor the wound and apply barrier cream. 2. Mid-spine stage 2 pressure ulcer The nursing admission assessment dated [DATE] revealed the resident admitted to the facility with scattered bruises to both arms, a scab to the top of her left hand near the pinky finger, a scab to her left wrist, scattered bruises to both, redness/abrasion to mid-spine, and dry flaky skin. A non-pressure skin assessment completed on 2/25/2020 documented the resident had redness to the curvature of her spine. A weekly summary, that includes assessment of the skin, dated 3/2/2020 did not reveal any redness to the resident's spine. Further review of the non-pressure skin assessments, pressure skin assessments, and weekly summaries documented in the electronic medical record revealed that there was no further documentation of redness to the resident's spine until 7/8/2020. The non-pressure skin assessment dated [DATE] revealed the resident had a superficial abrasion to the bony prominence (area of bone close to the skin's surface) of her upper mid-vertebrae. The surrounding skin was documented as pink/red and blanchable (superficial reddening of the skin that turns white when pressed on, and becomes red again when no longer being pressed). The weekly summary dated 7/8/2020 documented the resident had an abrasion to her mid upper back, but that she did not have any current pressure injuries. The weekly summary dated 7/15/2020 documented the resident had an area to her mid back that was being treated and was covered with a dressing. There were no pressure or non-pressure skin assessments completed for 7/15/2020. On 7/21/2020, a pressure skin assessment was completed that documented the resident had a stage 2 pressure ulcer to her mid-back with an onset date of July. There were no measurements documented in the assessment. The weekly summary dated 7/22/2020 documented the resident had a pressure injury and breakdown to her spine. The weekly summary dated 7/27/2020 documented the resident had a pressure injury to her mid back. The pressure skin assessment for 7/29/2020 had no documentation entered into it and was never completed. The weekly summary dated 8/3/2020 documented the resident had a current pressure injury and an open area to her back. The pressure skin assessment dated [DATE] documented the resident had a stage 2 pressure ulcer to her back with an onset date of ongoing. The wound measurements were documented as being 5 cm long by 1.5 cm wide with a depth of 0.1 cm. The periwound (tissue surrounding the wound) was red with moderate drainage. -The assessment documented that repositioning was being used as an intervention to improve wound integrity. There were no further pressure skin assessments documented after 8/5/2020. The weekly summary dated 8/10/2020 documented the resident did not have any current pressure injuries or any skin issues. The weekly summary dated 8/17/2020 documented the resident had a current pressure injury to her mid back. Review of the wound care provider consultant notes dated 7/21/2020 revealed no documentation regarding the resident's mid back pressure wound. Review of the care plan revealed that the pressure ulcer to the resident's mid back was not updated on the care plan. The repositioning intervention documented in the 8/5/2020 pressure skin assessment was not updated on the care plan, nor were any other interventions added to prevent further worsening of the pressure ulcer. The care plan did not indicate that the resident was on a turning and repositioning program. Review of the Braden scale for predicting pressure sore risk assessment completed on 2/25/2020 revealed the resident was at moderate risk for developing a pressure ulcer. Review of the progress notes revealed the following documentation regarding the mid-back wound: -7/8/2020: Nurse was notified by certified nurse aide (CNA) that patient had a skin tear to mid upper back. No assessment, small abrasion was observed with the very top layer of skin missing, Area was bright red 1x0.5 cm and surrounding skin pink/red and blanchable. No pain reported. Area was cleaned, skin prep applied, and [MEDICATION NAME] put on. Doctor notified and supervisor. WCTM (will continue to monitor). -7/14/2020: At start of shift patient's wound dressings were changed. On changing dressing to back, it was observed that the wound has increased in size and slough is now visible to wound bed. Surrounding skin continues to be pink but blanchable. Toes to the right foot also have small dark spots. Patient observed to continue to have poor appetite and fluid intake and requires queuing and Encouragement to eat. Patient weighed and current weight is 85lbs. Supervisor notified of the patient's change of condition. Patient has gotten out of bed this shift and complained with off loading back as tolerated. WCTM. -8/3/2020: Continue to take ABO (antibiotics) for wound infection (to foot). No signs or symptoms of adverse reaction/complications at this time. Wound to mid upper back continues to have slough with small-moderate drainage. Wound to the right fifth metatarsal has some purulent drainage during dressing change. wounds were cleaned and treatment orders followed. Will continue to monitor patient. -8/13/2020: Called registered nurse (RN) from hospice. Discussed need for cushion to back secondary to wound to back is deteriorating secondary to pressure on back from non-padded wheelchair. We decided that hospice will purchase/rent a reclining wheelchair and we would roll up an egg crate mattress or equivalent and place a gel cushion by where the kyphosis is. All will be delivered today. -The interventions mentioned in the above progress note were not updated on the resident's care plan. Review of the resident's physician order [REDACTED]. -Order dated 7/22/2020: cleanse with wound cleanser, pat dry, apply [MEDICATION NAME] and cover with dry dressing one time a day. -Order dated 8/15/2020: cleanse wound, pat dry, apply santyl to wound bed, cover with dry dressing every day shift. 3. Additional documentation The 2/25/2020 Braden Scale Assessment revealed Resident #6 had a score of 14, indicating that she was at moderate risk for the development of pressure ulcers. The at risk for skin breakdown care plan, initiated on 2/27/2020 and last updated on 8/5/2020 (during the survey), revealed that Resident #6 was at risk for skin breakdown related to cognition and limited mobility, and a history of skin breakdown. The care plan revealed that the resident had actual skin breakdown of a blood blister to her right calf, blisters to bilateral (both) heels and a wound to her right inner buttock. The goal was for the resident to not experience any new skin breakdown and if she did experience any new skin breakdown, staff was to act promptly. The pertinent interventions included to assist the resident with peri care and hygiene as needed, monitor skin for any signs of irritation related to incontinent episodes, utilization of an air mattress to prevent further skin breakdown, resident to be seen every week on wound rounds until all skin issues are

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	065235	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 10) resolved, float heels as needed to prevent further skin breakdown, encourage resident to periodically get out of her wheelchair as she prefers to sit in it throughout the day, keep skin clean and dry as the resident is incontinent of bowel and bladder, assist with toileting throughout each shift and as needed, monitor/document location, size and treatment of [REDACTED]. The wound care nurse practitioner consulting physician orders [REDACTED]. There were also orders for her wheelchair cushion to be evaluated, nutritional supplements, bilateral walking shoes/boots, and an air mattress. -The right lateral mid-foot, right distal, lateral fifth metatarsal wound, and right second toe wound were not updated on the care plan, nor was there an update for the walking boots or wheelchair cushion that were ordered by the nurse practitioner. The Weekly Pressure Ulcer Skin assessment dated [DATE] (four total assessments), identified that Resident #6 had wounds to her left medial heel, right fifth metatarsal (pinky toe), right heel, and back. -The back wound was not updated on the resident's care plan. The August 2020 CPO revealed the resident had the following wound care orders: -Left medial heel - cleanse with wound wash, pat dry, and apply [MEDICATION NAME], one time a day for arterial wound; -Right lateral mid-foot and right lateral heel - cleanse with wound cleanser, pat dry, and apply [MEDICATION NAME], one time a day for arterial wounds; -Right fifth lateral metatarsal - cleanse with wound cleanser, pat dry, apply [MEDICATION NAME] and dry dressing, one time a day for arterial wound; -Left buttocks - cleanse and apply barrier cream (calcified tissue). Continue to monitor for changes, one time a day for wound care to left buttock and, -Mid back - cleanse with wound cleanser, pat dry, apply [MEDICATION NAME] & cover with dry dressing, one time a day for pressure wound. The right lateral mid-foot wound and the left buttock wound were not updated on the resident's care plan. D. Staff interviews LPN #2 was interviewed on 8/6/2020 at 1:15 p.m. LPN #2 said the Resident #6's pressure wound on her back started as a small open area in July 2020. She said the resident was then diagnosed with [REDACTED]. LPN #2 said they did not have any special preventive measures for the back wound and the resident's wheelchair did not have any adjustments for her protruding spine. She said that the buttock pressure ulcer was calcified and no more treatments besides barrier cream were needed per the wound care provider. LPN #2 said the resident was on a turning and repositioning schedule every two hours, she had a wedge cushion to elevate her heels, and an air mattress for overall skin protection. -Review of the medical record revealed the resident did not have a turning and repositioning intervention updated on her care plan. The staff development coordinator/infection control preventionist (SDC/ICP) was interviewed on 8/13/2020 at 12:21p.m. She said most of Resident #6's wounds were on her feet and they had been tracking the resident's wounds since she took over as the wound care nurse around the end of May or beginning of June 2020. She said the resident's right midfoot and left medial heel had been resolved during wound rounds this past Tuesday (8/4/2020). She said the wounds on the resident's feet were arterial, and the wound on her back was a pressure ulcer. She said maybe the wound care nurse practitioner initially got it backwards and charted the resident's feet wounds as pressure or maybe she herself misunderstood what the wound care nurse practitioner said. She said she did not read the wound care provider's notes. She said she did not have access to the site where the notes can be downloaded from, and she is not given a copy of them when they are downloaded. She said the previous director of nursing (DON) used to get the notes. She said she was unsure of who received the notes currently. She said the resident sits up in her wheelchair quite a bit. She said she had talked to the hospice nurse about providing a wedge to see if we could alleviate pressure on the back of the chair or maybe a blanket could be placed there. She said hospice was going to look into that, to see if they might be able to provide something to help. She said she had talked to them on 8/4/2020 but she was unsure if they had provided anything. She said she had worked the night shift on Tuesday 8/11/2020, and was not in on Wednesday 8/12/2020, so she had not followed up yet. The wound care consultant nurse practitioner (NP) was interviewed on 8/13/2020 at 1:30 p.m. She said Resident #6 had arterial wounds on her feet and an unstageable pressure wound on her left buttocks. She said she provided the information and education during each visit. She said her company provided wound care education if the facility requested it. She said there had not been a request for education from the facility. She said she participated in wound rounds at the facility every Tuesday via telehealth on a cellular phone or a laptop. She indicated that in July 2020 she had missed the 14 days that the team was quarantined. She said she was unsure if anyone had looked at wounds during that time but she hoped someone had. She said she gave recommendations to the facility about interventions, but she cannot write orders in the facility. She said the facility needed to ask the primary physician. She said she had seen some of her recommendations followed, but she was unable to see if all of the recommended interventions were in place because the visits were conducted via telehealth. She said she received verbal confirmation from the staff that the interventions were in place. She said that if the resident or the primary physician refused the recommended interventions she would expect to be notified. She said she always covered the location of the wound and the etiology with the SDC/ICP. She said she tried to provide as much education as possible during the visit. IV. Resident #5 A. Resident status Resident #5, age 82, was admitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 8/12/2020 MDS assessment revealed that the resident was moderately cognitively impaired with a BIMS score of eight out of 15. The resident required two person extensive assistance for bed mobility, transfers, and dressing, extensive assistance of one person for toilet use and personal hygiene, and supervision of one person for eating. He was at risk for pressure ulcers, he had one or more unhealed stage 1 pressure ulcers that required a dressing with application of ointment or medication. B. Observation and interview Resident #5 was observed on 8/6/2020 at 12:03 p.m. lying in his bed. He had a small scab less than one centimeter (cm) in diameter on his left upper shoulder, a right elbow hematoma (blood or bruising under the skin) that was large and covered his entire elbow, purple to red in color, estimated to be five to six cm in diameter, scattered bruising around his right lower arm, his right hand first digit had a round one cm bruise, slightly above where the wrist bends he had a bruise about one cm long, his right scapula (shoulder) had a two cm skin tear. His left and right heel had pressure ulcers with scabs on them. The resident did not have on he padded boots, his heels were resting on a folded blue blanket and there was not an air mattress on his bed. Licensed practical nurse (LPN) #3) said he did not recall if the resident had the elbow bruise last week. He said the resident should have preventive measures in place to help prevent skin breakdown. He said that the resident should be wearing boots (they were not on the resident during assessment) and his heels should be floating (heels were rested on a folded blue blanket). C. Record review 1. Left heel The pressure ulcer skin assessment dated ; - 5/26/2020 documented the resident had a 1.7 centimeter (CM) x 1.5 cm suspected deep tissue injury (SDTI)) on his left heel.The interventions were to float resident's heel (have them off the bed) and to reposition (help the resident make changes in positioning) The onset date was unknown. -6/2/2020 documented the resident had a 3.3 cm x 4 cm stage 2 left heel blister. The interventions were to float the resident's heels and repositioning. The onset date was upon admission. Review of the electronic medical record (EMR) revealed no further monitoring of the pressure ulcer on the pressure ulcer skin assessments The non-pressure skin assessment dated ; - 6/9/2020 documented the resident had a 4 cm x 4 cm DTI (deep tissue injury) on his left heel. The onset date was upon admission - 6/16/2020 documented the resident had a 3.5 cm with a depth of 4 cm DTI on his left heel. The intervention was for the resident to lie down in bed to decrease swelling. The onset date was upon admission. -6/23/2020 documented the resident had a 2.5 cm with a depth of 3.6 cm DTI on his left heel. The onset date was ongoing. -7/2/2020 documented the resident had a 3 cm x 3 cm DTI on his left heel. The onset was ongoing. -7/21 documented the resident had a 3 cm x 1cm DTI on his left heel The intervention was to float his heels. -7/25/2020 documented both of the resident's heels had slight eschar (dead tissue that falls off from healthy skin) 3 to 4 inches x 1 inch. The intervention included to float heels while in bed and padded cushion boots when sitting. The onset date was unknown. -8/5/2020 documented the resident has a 0.4 cm x 0.5 cm DTI on his left heel. The intervention was to float his heels and use the boots. The weekly summary dated; -7/11/2020 documented the resident had a healing blister to both heels. -7/18/2020 documented that both heel wounds had slight eschar and were heeling without signs and symptoms of infection. -8/1/2020 documented the resident's left heel pressure site was healing well. The intervention was to reposition the resident every two hours. 2. Right heel The pressure ulcer skin assessment dated ; - 5/26/2020 documented the resident had a 4 cm x 3.5 cm suspected deep tissue injury (SDTI) on his right heel.The interventions were to float the resident's heel (have them off the bed) and to reposition (help the resident make changes in positioning) The onset date was unknown. -6/2/2020 documented the resident had a 3.8 cm x 5.5 cm stage 2 right heel blister. The onset date was upon admission. Review of the EMR revealed no further monitoring of the pressure ulcers on the pressure ulcer skin assessments The non-pressure skin assessment dated ; - 6/9/2020 documented the resident had a 5 cm x 4 cm DTI on his right heel. The onset date was upon admission - 6/16/2020 documented the resident had a 1.5 cm with a depth of 3.6 cm DTI on his right heel. The onset date was :upon admission. -6/23/2020 documented the resident had a 5 cm with a 3.5 cm depth DTI on his right heel. The onset date was ongoing. 7/2/2020 documented the resident had a 3.5 cm x 3 cm DTI on his right heel. The onset date was ongoing.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 11) -7/21/2020 documented the resident had a 1.4 cm x 1.5 cm DTI on his right heel. The onset date was ongoing. -7/25/2020 documented both of the resident's heels had slight eschar (dead tissue that falls off from healthy skin) 3 to 4 inches x 1 inch. The intervention included to float heels while in bed and padded cushion boots when sitting. The onset date was unknown. -8/5/2020 documented the resident has a 1 cm x 1 cm DTI on his left heel. The intervention was to float his heels and use the boots. The onset date was upon admission. The weekly summary dated; -7/11/2020 documented the resident had a healing blister to both heels. -7/18/2020 documented that both heel wounds had slight eschar and were heeling without signs and symptoms of infection. -8/1/2020 documented the resident's right heel pressure site was healing well. The intervention was to reposition the resident every two hours. The wound care provider consultant notes dated 6/9/2020 through 7/21/2020 documented the wounds to the resident's heels were pressure ulcers. The recommendations included floating heels, boots to both heels (dated 6/9/2020) and an air mattress (dated 7/2/2020). 3. Left buttock The non-pressure skin assessment dated [DATE] documented the resident had an open shearing spot to his left buttock. The onset date was 7/24/2020. The weekly summary dated 8/4/2020 documented the resident had a small resolving open area to his left buttocks. Review of the EMR revealed no further monitoring of the open shearing area to the resident's left buttock. The wound care provider consultant notes dated 6/9/2020 through 7/21/2020 revealed no monitoring of a left buttock wound. 4. Coccyx The weekly summary documented 8/1/2020 documented that the resident had an open shearing area to his coccyx and it was healing well. The intervention was to reposition the resident every two hours. The non-pressure skin assessment dated [DATE] documented the resident had a 3 cm stage 1 decub (pressure ulcer) rectangular open area to his coccyx that was blanchable with light pressure. -The interventions included turning and repositioning the resident and encouraging increase in protein intake. The wound care provider consultant notes dated 6/9/2020 through 7/21/2020 revealed no monitoring of the coccyx wound. 5. Additional documentation The nursing admission assessment dated [DATE] documented that the resident had slight bruising to his right rib area. There were no other skin concerns noted. The at risk for skin breakdown care plan, initiated on 5/13/2020, revealed that the resident was at risk for skin breakdown related to his history of falls, [MEDICAL CONDITION], right sided [MEDICATION NAME] wall contu
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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. This affected residents residing on two South building secure units, including Resident #1, all of whom were at risk for harm due to dementia and/or behavioral disturbances that placed their safety in danger. Record and video review and interviews revealed the facility experienced a fire in the dining room on 8/2/2020 and staff decided to evacuate the building. Resident #1, severely cognitively impaired with behavioral disturbances that placed him at risk for harm, including daily resistance to cares (cross-reference F742), refused to evacuate the building. Staff left Resident #1 in his room behind a closed door after evacuating all the other residents from the building. The facility failed to identify and address Resident #1's daily resistance to cares and failed to anticipate and plan for the difficulty in evacuating residents, including Resident #1, whose dementia and/or behaviors placed them at risk in an emergent situation such as fire. (Cross-reference EP 0007). The facility further failed to provide sufficient emergency preparedness training and testing of staff after the 8/2/2020 fire and the unsuccessful evacuation of Resident #1 on the South secure unit. (Cross-reference EP 0009, EP 0037 and EP 0039). These failures created the likelihood of serious adverse outcome for Resident #1 who staff were unable to evacuate in an emergent situation, as well as other residents potentially resistive to staff requests and/or staff assistance to evacuate. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy Resident #1, with short-term and long-term memory loss, and modified independence making decisions regarding tasks of daily life, admitted to the facility on [DATE]. The facility had a fire on 8/2/2020 at approximately 8:15 a.m. on the South secure unit where Resident #1 and other residents with mental illness and behaviors resided. Interviews with facility staff and video review revealed the facility decided to evacuate the South unit. Staff, unable to get Resident #1 to evacuate the facility, shut his door and left him in his room without staff supervision. On 8/4/2020, the facility confirmed there had been a fire in the South unit and staff were unable to evacuate Resident #1. At the time, the facility had no plan in place on how to evacuate Resident #1 or any other resident who refused to evacuate. Certified nurse aide (CNA) #5, who attempted to evacuate Resident #1 on 8/2/2020, was unable to recall any fire training as of 8/2/2020, and observations of two mock fire drills revealed staff unprepared to respond properly to an emergent fire situation. On 8/4/2020 at 6:32 p.m., the nursing home administrator (NHA) and the interim director of nursing (IDON) were informed the facility failures above created the likelihood for serious harm for Resident #1 and other at risk residents on the secure units if the failures were not corrected immediately. B. Facility plan to remove immediate jeopardy On 8/5/2020 at 6:15 p.m., the facility submitted a plan to abate the immediate jeopardy. The abatement plan read: All residents will be assessed by 8/7/2020 by the SSD (social services director) or designee to determine their level of awareness with fire safety drills and evacuation compliance. In the event specific interventions are determined to be needed by the SSD or designee such will be care planned by 8/10/2020 and staff will be educated on the interventions. Evacuation plan of all residents would be added to the emergency preparedness binder and the facility assessment binder on 8/5/2020 as indicated below: -In an emergency, all residents would be evacuated to an assigned safety location in the various locations of each unit. The alarm is not allowed to be shut off by anyone except the local fire department who has jurisdiction over the situation. -Prior to the arrival of the Fire department, it is required by facility staff to safely evacuate all residents to safety. -Residents are to be monitored and continuously reassured to calm down during these stressful times. -All residents must be evacuated to safety zone by any means possible. Residents Who Refuse to Evacuate -During an emergent situation you might encounter residents that refuse to evacuate. In this situation you will attempt every measure possible as identified in their individual care plan. Primary Goal -The Primary goal in an emergency is to rescue all residents from a life threating (sic) event. Staff education All staff would be educated on how to properly evacuate all residents to safety by 8/6/2020: -Residents who can ambulate would be directed by staff to a designated safety assembly area as identified on (the) evacuation plan for a head count after all residents are rescued/evacuated. -Bedbound/bariatric residents who can tolerate transfers by wheelchair would be evacuated by staff using appropriate wheelchair (regular or bariatric) to the designated safety area for a head count. -Bedbound residents who cannot tolerate wheelchair would be placed on a mattress by staff and transported out of their location to the designated safety area for a head count. Post evacuation measures -Evacuation signs that are kept on fire doors would be placed on all resident exterior door handle that has the resident evacuated to indicate that the resident is out of the room. -This education would be done prior to the shift start of staff by the DON, ADON, SDC or department heads completed by 8/6/2020. - Plan will be taken to AD HOC QAPI by 8/11/2020. Once 1135 waiver put in place by the President after of the declaration of a national emergency is lifted, facility staff will be trained through the following by Maintenance Director: -Thru In-service -Fire Drills -Relias (computerized training) -Return demonstration -Mock evacuation exercises -Actual evacuation exercise C. Removal of immediate jeopardy On 8/5/2020 at 6:15 p.m., the NHA and the IDON were notified the immediate jeopardy was abated, based on the abatement plan above. However, deficient practice remained at an E level, a pattern with the potential for more than minimal harm. II. Facility policy The NHA provided the facility's Emergency Response and Emergency Procedure: Fire on 8/4/2020 at 5:00 p.m. It read in pertinent part: The following procedure is utilized in the event of an actual fire, smoke conditions, or smell of smoke in the facility. -Staff begins evacuation according to the size of the fire and the amount of smoke production. The Incident Commander gives guidance on evacuation type . Phase I: Evacuate the rooms on either side and directly across from the room that is on fire. Move residents to an area away from the fire. This type of evacuation is used during the initial stages of a small fire. Additionally, rooms directly below or above the room of fire origin may be considered for evacuation, especially if fire sprinkler discharge has occurred. Phase II: Evacuate all residents from the smoke compartment where the fire has occurred to the opposite smoke compartment (through the smoke doors). This type of evacuation is used when moderate smoke conditions are present or the welfare of the residents is in jeopardy based on the situation. Additionally, wings or hallways directly below or above the room of fire origin may be considered for evacuation, especially if fire sprinkler discharge has occurred. Phase III. Fire Department Ordered Evacuation. Evacuate all residents from the building by whatever means possible. This type of evacuation is only used during a major fire or severe smoke conditions are present or the welfare of the residents is in jeopardy based on the situation. Additionally,

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) wings or hallways directly below or above the room of fire origin may be considered for evacuation, especially if the fire sprinkler discharge has occurred. The order of evacuation is: -Ambulatory residents -Residents with assistive devices -Residents in wheelchairs -Bedridden residents III. Facility fire 8/2/2020 and facility response A. Video and timeline documented the fire and Resident #1's failure to evacuate According to recorded video provided by the facility and a written timeline provided by the IDON, there was an electrical fire on 8/2/2020 in the South building where residents resided on Pioneer secure hall and the South secure unit. The timeline revealed: -8:15 a.m. Fire starts in the dining room on South unit in an overhead fluorescent lighting fixture. -8:16 a.m. South unit residents began evacuating the dining room and moving behind smoke doors on South unit. -8:18 a.m. Unidentified staff member extinguished the fire, and staff began evacuating South unit residents to the South patio due to large amounts of smoke. -8:22 a.m. Staff members continue to check the resident rooms on the South unit, staff observed placing pillows on the outside of the evacuated resident rooms. -8:27 a.m. Residents on Pioneer unit begin to evacuate. -8:28 a.m. The fire department arrives and fire fighters escorted into the facility by one of the maintenance assistants. -8:49 a.m. According to written timeline provided by IDON, South smoke doors opened by fire fighters (attempt to re-direct Resident (#1) out of the room (refuses) smoke is now free from building. -8:49:17 a.m. According to the video recording provided by the assistant director of nursing (ADON), Resident (#1's) room door remained closed. At no time are any staff or firefighters noted opening and/or entering the resident room. Throughout the video recording, no staff members entered Resident #1's room. The door remained closed during the video recording provided by the Assistant DON. B. Interviews revealed Resident #1 refused to evacuate and remained in his room without staff supervision, contrary to Resident #1's safety as well as facility policy. 1. In an interview on 8/5/2020 at 12:40 p.m., CNA #5 said she was working the day of the fire on the South unit. She said there were approximately four residents in the dining room, and they had just finished their breakfast when the nurse started yelling fire. The CNA said she saw the light fixture in the dining room was on fire, so they removed the residents from the dining room and closed the door to the dining room. The CNA said staff working began moving all of the residents to the other side of the smoke doors, beyond the nurses ' station on the South unit. The CNA said a nurse made the decision to evacuate the South unit and Pioneer hallway in the South building, so all of the staff began evacuating the residents on the South unit to the South patio. The CNA said she came back into the building to continue to assist with evacuating, and she attempted to get Resident #1 (who resided on the South unit) to evacuate, but his reply was F*** (expletive) you, turn that s*** (expletive) off. The CNA said she told the nurse she was unable to evacuate Resident #1, so the nurse and the CNA made the decision to shut his door and place a pillow in front of the door. The CNA said she was unsure why she placed a pillow in front of the resident's door, and thought she should have placed a trashcan in front of the door. 2. In an interview on 8/6/2020 at 10:30 a.m., the local fire chief said there had been a lack of communication between the fire department and the facility for a couple of years. He said that in the past, the facility had communicated with the fire department about the access to codes for the secure doors on the South building, but currently the fire department did not have any of the access codes for the building. The fire chief said communication was important since both of the units in the South building were secure neighborhoods. The fire chief said his team was not aware of Resident #1's refusal to evacuate the building on 8/2/2020 during the fire. The fire chief said if the facility made the determination to evacuate any area of its campus (North or South building), they would be responsible for completing the evacuation. The fire chief said the fire department would assist with evacuation as needed, but the facility would need to complete the initial evacuation, as they were expected to be able to evacuate all of the residents safely. IV. Facility failures A. Failure to identify and address Resident #1's daily resistance to cares and failure to anticipate and plan for the difficultly in evacuating residents, including Resident #1, whose behaviors placed them at risk in an emergent situation such as fire. 1. Resident #1 Resident #1, age 70, admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 7/20/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment; the resident could not complete the mental status exam. According to the staff assessment for mental status, the resident had modified independence making decisions regarding tasks of daily life. -The resident displayed inattention and disorganized thinking. He displayed physical behavior symptoms directed toward others one to three days and verbal behavior symptoms directed towards others daily. These behaviors put the resident at significant risk for physical illness and injury, significantly interfered with his care and significantly interfered with his participation in activities or social interactions. These identified behaviors put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The resident rejected care on a daily basis. -The resident required set-up assistance with bed mobility, transfers, walking, and locomotion, one-person assistance with dressing, eating, and toileting, and two=person extensive assistance with personal hygiene. 2. Record review A review of Resident #1's medical record on 8/4/2020 at 5:00 p.m. revealed there was no documentation in the resident's progress notes regarding the fire on 8/2/2020, or the resident's refusal to evacuate during the fire. A review of Resident #1's care plan prior to 8/4/2020 and facility notice of immediate jeopardy, revealed no care plan for the resident's rejection to cares or his refusal to evacuate the facility during an emergency, or any interventions to respond and facilitate his evacuation if the resident refused. On 8/5/2020 at 6:15 p.m. after notification of immediate jeopardy, the facility updated Resident #1's care plan to read: The resident is at risk for severe bodily injury or death second to noncompliance for evacuation during an emergent situation, noncompliance with practical use of dishes or flatware and historical attempts to break windows. 8/5/2020-Resident #1 refused to leave his room during a fire despite prodding by staff and emergency personnel. -The goal was for the resident not to sustain any severe injury from emergency evacuations or attempt to evacuate him from any harmful situation. -Pertinent approaches included: during an evacuation explaining to the resident the need to leave the room, and if he refuses to have a staff member with a good relationship with him assist with the evacuation. Offering the resident his favorite snacks (cookies and ice cream) in an attempt to get him to evacuate. Calling the fire department or the police to assist with the evacuation. 3. Other residents at risk (cross-reference EP 0007) According to 4/28/2020 facility assessment, the facility resident profile included the following diseases/conditions, physical and cognitive disabilities: Psychiatric/Mood disorders including, [MEDICAL CONDITION], impaired cognition, [MEDICAL CONDITION], post-traumatic stress disorder, anxiety disorder and behaviors that need interventions. Services and care the facility offers based on resident's need included: hospice, bariatric care, palliative care and respite care. In an interview on 8/5/2020 at approximately 3:00 p.m., the NHA, interim director of nursing (IDON), and the regional maintenance supervisor (RMS) said they were unsure if their emergency preparedness plan (EPP) included information on what to do if a resident was unable or unwilling to evacuate the facility. They said the South building had two secure units, one specifically geared toward dementia, and the other for residents with more behaviors. The RMS said he was unable to locate any special provisions in the EPP that addressed residents with dementia and behaviors specifically, and the potential for them to be resistant to evacuating. Review of the Emergency Response: Emergency Procedure - Fire policy (see above) revealed no supporting policies, procedures, other guidance documents provided which addressed at risk residents or residents who refused to evacuate the facility. In an interview on 8/17/2020 at 9:00 a.m., the NHA and the corporate regional consultant (CRC) said the piece (evacuation of all residents including residents that may be difficult to evacuate) was missed as part of the EPP. B. Facility failure to provide sufficient emergency preparedness training and testing of staff after the 8/2/2020 fire and the unsuccessful evacuation of residents in the secure units. 1. On 8/6/2020 at 11:36 a.m., the NHA provided the following training, which she said all staff had completed: Staff education -Residents who can ambulate would be directed by staff to a designated safety assembly area as identified on (the) evacuation plan for a head count after all residents are rescued/evacuated. -Bedbound/bariatric residents who can tolerate transfers by wheelchair would be evacuated by staff using appropriate wheelchair (regular or bariatric) to the designated safety area for a head count. -Bedbound residents who cannot tolerate wheelchair would be placed on a mattress by staff and transported out of their location to the designated safety area for a head count. Post evacuation measures -Evacuation signs that are kept on fire doors would be placed on all resident exterior door handle that has the resident evacuated to indicate that the resident is out of the room. -This education would be done prior to the shift start of staff by the DON, ADON, SDC or department heads completed by 8/6/2020. -Plan will be taken to AD HOC QAPI by 8/11/2020. The NHA provided the signatures of all the staff in the building, showing they had completed the training. CNA #5, interviewed on 8/5/2020 at 12:40 p.m. said she had fire education on the morning of 8/5/2020, after the facility was notified of the immediate jeopardy, but was unable to recall any fire training prior to that. The CNA said during the 8/5/2020 training she was instructed to stay with any resident that was unwilling to evacuate the building. 2. Mock drill on Pioneer hall on 8/6/2020 (secure unit in the South building) - and staff's failure to properly respond. Observations: -At 11:14 a.m., the dietary manager (DM) was on Pioneer hall. Life

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	065235	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) Safety Inspector (LSI) #1 told the DM there was a fire in a resident room, and to do what you would do in a real fire, act like this is a real fire. -At 11:16 a.m., the DM removed Resident #10 from his room (where the mock fire was located). The DM left the door to the room open, not containing the fire in the resident room. -At 11:18 a.m., the DM was unable to get his key card to open the secure unit door. An unidentified CNA assisted the DM in opening the door. The DM did not tell the CNA there was a fire on the unit. -At 11:19 a.m., the DM walked the resident down the South unit to evacuate the resident to the South Patio. It took staff 16 minutes to evacuate the residents on the Pioneer hall. During the drill, the DM never called out there was a fire, told any other staff members working the hallway there was a fire, or pulled the fire alarm. Interview The DM was interviewed on 8/6/2020 at 11:23 a.m. He said he had fire training last night and said he was responsible for providing the training to all of the dietary staff. He said during the training, he learned about evacuating the residents and placing a tag on the resident's door after the room had been evacuated. The NHA was interviewed on 8/6/2020 at 11:26 a.m. She said the drill was not good. She said the DM never told any other staff there was a fire, the fire alarm was never pulled to notify the fire department of a fire, and the resident should have been evacuated past the smoke doors, not off the Pioneer Hall onto the South unit. The NHA said she would begin immediately re-training all of the staff to ensure they knew the proper procedure during a fire. 3. Mock drill on South unit on 8/6/2020 (secure unit in the South building)-and staff's failure to properly respond. Residents on the South unit were evacuated in six minutes. However, according to LSI #2, during the second mock fire drill, the facility kept the smoke barrier doors open when they were evacuating residents, which could lead to an increase in smoke, and requiring the facility to have to evacuate to the next smoke compartment. The staff also failed to pull the actual fire alarm, which would have notified the fire department, and staff failed to call the fire department to notify them of the fire, as a back-up. The result was the fire department was not made aware of the fire in the building. The NHA, IDON and the RMS were interviewed on 8/6/2020 at approximately 2:40 p.m. They stated there were still some concerns that needed to be addressed during drills (not pulling the alarm or notifying the fire department), as well as some things to work out on the best way to evacuate the residents in addition to getting them back into the facility after they had been given the all clear to re-enter the building. The NHA and the CRC were interviewed on 8/17/2020 at 9:00 a.m. They said as part of the immediate jeopardy process, they would be thoroughly looking into the emergency preparedness plan, and ensure it included all things like how to evacuate resistant residents. The CRC said the facility had begun the process of reaching out to the local fire department so they could have a collaborative approach to emergencies in the facility. (Cross-reference EP 0009, EP 0037 and EP0039 for failures in the facility's EPP and EPP training)
F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide appropriate treatment and services to five (#1, #2, #3, #4 and #9) of six out of nine total sample residents residing on the secured behavioral unit (South unit), all of whom displayed or were diagnosed with [REDACTED]. Specifically: Record review and interviews revealed the facility failed to accurately document and monitor resident behaviors on the South unit; failed to have an interdisciplinary team (IDT) that evaluated and discussed each resident on the South unit; and failed to develop a person-centered approach to each resident. Further, interviews revealed the facility failed to provide ongoing and specialized training to the staff members working on the South unit. These failures contributed to the facility's inability to effectively care plan and manage Resident #1's resistive behavior, and evacuate the resident during a fire in the dining room in the South unit (cross-reference F689 and F657). The facility failures also contributed to an inability to ensure residents were protected from Resident #2's rapid mood changes and Residents #3 and #4 were protected from unsafe behaviors that placed them in danger (cross-reference F600) and an inability of Residents #1, #2, #3, #4, and #9 to attain and maintain their highest practicable level of physical, mental and psychosocial well-being (cross-reference F585 and F679). Findings include: I. Failure to accurately document and monitor resident behaviors on the South unit (secure mental health unit), in order to identify changes in mental status, behavior and cognition; adjust interventions; and effectively manage unsafe behaviors. A. The facility Behavior, [MEDICAL CONDITION], Restraint, and Elopement Management policy and procedure, last revised April 2015, provided by the nursing home administrator (NHA) on 8/10/2020 at approximately 3:30 p.m., read, in pertinent part: Assessment: The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior and cognition, including: Onset, duration, intensity and frequency of behavioral symptoms; any precipitating or relevant factors or environmental triggers; and appearance and alertness of the resident related to observations. Monitoring: If the resident is being treated for [REDACTED]. Interventions will be adjusted based on the impact of behavior and other symptoms, including adverse consequences related to treatment. B. The facility's procedure for assessing and monitoring resident behaviors 1. Review of Resident #1, #2, #3, #4, and #9's records revealed handwritten and electronic behavior monitoring, some months both forms were completed and some months only one of these forms was completed. The manner of documentation was not consistent for all five residents (see below). 2. Interviews with the social services director (SSD) on 8/6/2020 at 12:30 p.m., the interim director of nursing (IDON) and SSD on 8/10/2020 at 3:05 p.m., the social services consultant (SSC) on 8/12/2020 at 1:44 p.m., and the corporate regional consultant (CRC) and NHA on 8/17/2020 at 9:00 a.m. revealed inconsistent expectations and understanding of behavior monitoring in the facility. The SSD reported nursing staff should be documenting all of a resident's behaviors on the electronic or handwritten behavior monitoring sheets. The IDON reported the facility charted behaviors by exception, therefore, documenting only when the resident exhibited a behavior. The SSC reported charting by exception should only be done when the facility had established a set of behaviors for the resident. She said the facility did not use baseline charting. The NHA reported that, ideally, behavior charting should be in the handwritten behavior monitoring and in nursing progress notes. The NHA agreed the facility did not use baseline charting. C. Residents #1, #2, #3, #4, and #9 Inconsistencies reported by staff (see above) were reflected in the residents ' behavior monitoring, and contributed to: staff's inability to manage Resident #1's resistive behavior, and evacuate the resident during a fire in the dining room in the South unit; staff's inability to protect Residents #3 and #4 from unsafe behaviors that placed them in danger; and the inability of Resident #1, #2, #3, #4, and #9 to attain and maintain their highest practicable level of physical, mental and psychosocial well-being. RESIDENT #1 1. Resident status Resident #1, age 70, admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. According to the 7/20/2020 minimum data set (MDS) assessment, the resident had severe cognitive impairment; staff were unable to complete a brief interview for mental status (BIMS) with the resident. According to the staff assessment for mental status, the resident had modified independence making decisions regarding tasks of daily life. The resident displayed inattention and disorganized thinking. He displayed physical behavior symptoms directed towards others one to three days, and verbal behavior symptoms directed towards others daily. These behaviors put the resident at significant risk for physical illness and injury, significantly interfered with his care and significantly interfered with his participation in activities or social interactions. These identified behaviors also put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The resident rejected care on a daily basis. The resident required set-up assistance with bed mobility, transfers, walking, and locomotion, one-person assistance with dressing, eating, and toileting, and two-person extensive assistance with personal hygiene. 2. Record review The secure unit care plan, initiated on 10/27/2018 and revised on 8/7/2020 during survey (8/4 - 8/17/2020), revealed the resident was on the secure unit for his safety/structure. The resident was a serious danger to himself or others due to his behaviors. The goal was for the resident to have his needs anticipated and met by the staff. The pertinent interventions included allowing the resident to leave the secure unit when he requested, and evaluating the appropriateness of the secure unit placement every quarter and as needed. The agitation care plan, initiated on 11/1/2018 and revised on 8/7/2020 during the survey, revealed the resident frequently became agitated about leaving the facility. He would state that he wished to return home, and he had a history of [REDACTED]. The goal was for the resident to cause no injury to himself or others due to his behaviors. The pertinent approaches included caregivers providing opportunity for positive interaction and attention, providing cookies to the resident, and providing music to calm/soothe the resident. The behavior care plan, initiated on 3/13/2017 and revised on

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 14) 8/7/2020 during the survey, revealed the resident could become explosive with verbal outbursts with no identifiable triggers as evidenced by throwing cups, spitting on the walls, windows, and floors and cursing at staff related to his [DIAGNOSES REDACTED]. The resident frequently became agitated stating that a fat bastard who used to run the facility stole money from him, the resident is not currently taking any medications as he refuses. The goal was for the resident to cause no injuries to himself or other due to his behaviors, as well as to be redirected from behaviors before they increased and caused harm to himself or others. The pertinent approaches included, assessing for pain or discomfort as the reason for the increased behaviors. Caregivers provide the opportunity for positive interaction, attention by stopping and talking with the resident when they are passing by. Monitor behavior episodes and attempt to determine the underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential cause. A 6/10/2020 pre-admission screening and resident review or PASRR Level II Mental Health Review (a third-party assessment and care planning process to support nursing home residents with mental illness or developmental/intellectual disabilities) indicated the facility was providing the following specialized services for the resident: (Name of resident) has a behavior plan to decrease negative behaviors to keep himself and others safe. Staff should continue to support the behavior plan to encourage positive interactions and support (name of resident) with feeling safe and getting his needs met. 3. Behavior monitoring for Resident #1 - Conflicting and inconsistent documentation June 2020: A review of the June 2020 handwritten Behavior Monitoring documented the resident was monitored for: -Spitting at staff every shift (two shifts per day) for [MEDICAL CONDITION]. Staff documented spitting behavior as occurring 17 out of 60 shifts. -Verbally explosive with no identifiable triggers every shift (two shifts per day) for [MEDICAL CONDITION]. Staff documented verbally explosive behavior as occurring 28 out of 60 shifts. On both of the June handwritten behavior tracking sheets, staff were to document the number of times the behavior occurred on the shift. On several of the shifts, the staff documented C, which was not listed on the key to the Behavior Monitoring document. A review of the June 2020 electronic Behavior Monitoring documented staff monitored the resident for the same two behaviors, but listed separated monitoring for verbally explosive behavior for [MEDICAL CONDITION] and for [MEDICAL CONDITION]. In all, the frequency of the behaviors was documented as much less. -Spitting at staff every shift (two shifts per day) for [MEDICAL CONDITION] was documented as occurring two out of 60 shifts to document the behavior. -Verbally explosive with no identifiable triggers for [MEDICAL CONDITION] was documented as occurring three out of 60 shifts to document the behavior. -Verbally explosive behavior with no identifiable triggers every shift for [MEDICAL CONDITION] and use of [MEDICATION NAME], was documented as occurring one out of 60 shifts to document the behavior. July 2020: A review of the July 2020 handwritten Behavior Monitoring was not possible. The monitoring was not in resident's medical record and not provided by the facility when requested. A review of the July 2020 electronic Behavior Monitoring documented the resident was being monitored for: -Spitting at staff every shift (two shifts per day) for [MEDICAL CONDITION]. Staff documented spitting behavior as occurring 22 out of 62 shifts. -Verbally explosive with no identifiable triggers every shift for [MEDICAL CONDITION] and use of [MEDICATION NAME]. Staff documented this behavior as occurring 30 out of 62 shifts. August 2020: A review of the August 2020 handwritten Behavior Monitoring was not possible. The monitoring was not available in the resident's medical record and not provided by the facility when requested. A review of the August 2020 electronic Behavior Monitoring documented the resident was being monitored for: -Physical aggression including throwing objects every shift (two shifts per day) [MEDICATION NAME]/personality change due to TBI. (Added to the behavior monitoring on 8/12/2020, during the survey.) Staff documented physical aggression as occurring two out of 12 shifts. -Spitting at staff every shift (two shifts per day). (Added to the behavior monitoring on 8/12/2020, during the survey.) Staff documented spitting behavior as occurring one out of 12 shifts to document the behavior. -Spitting at staff every shift (two shifts per day) for [MEDICAL CONDITION]. (Discontinued from the behavior monitoring on 8/12/2020, during the survey.) Staff documented spitting behavior as occurring 10 out of 23 shifts. -Verbally explosive with no identifiable triggers every shift for [MEDICAL CONDITION] and use of [MEDICATION NAME]. Staff documented this behavior as occurring 18 out of 34 shifts. 4. Outcome Record review and interview revealed the facility had a fire on 8/2/2020 at approximately 8:15 a.m. Interviews with facility staff and video reviews revealed the facility decided to evacuate the South Unit where Resident #1 resided. Although assessed to resist care daily, staff was unable to get Resident #1 to evacuate the facility during the fire. Staff shut his door and left him in his room without staff supervision. Review of behavior monitoring (see above) revealed staff had not identified Resident #1 resistance to cares as a behavior to monitor and, likewise, had not developed effective interventions to address it, placing Resident #1 in immediate jeopardy. (Cross-reference F689) RESIDENT #2 1. Resident status Resident #2, age 63, was admitted on [DATE], and readmitted on [DATE]. According to the August 2020 CPO, [DIAGNOSES REDACTED]. The 7/28/2020 MDS assessment revealed that the resident was moderately cognitively impaired with a BIMS of ten out of 15. The MDS did not identify any behaviors that the resident displayed. The resident required one-person limited assistance with dressing, toileting, and personal hygiene. He required supervision for bed mobility, transfers, and eating. 2. Record review The long term care/secure unit placement care plan, initiated on 2/20/2017 and revised on 3/24/2020, revealed the resident was on the secure unit due to his behavior placing him in danger. The goal was for the resident to have his needs anticipated and met by the staff. The pertinent interventions included secure unit placement to be evaluated every 30 days, quarterly and as needed and to participate in activities of choice. The PASRR LEVEL II care plan, initiated on 4/12/2017 and revised on 4/17/2020, revealed the resident experienced extreme mood changes, manic episodes, and depressive episodes. He becomes very possessive regarding his belongings and will become physically aggressive. The goal was for the resident to remain stable and have a reduction in behaviors and symptoms, and no [MEDICAL CONDITION], and medication compliance through the next review date. The pertinent interventions included, placing the resident on a one to one until effects of medication changes are known and then reevaluate, encourage the resident to participate in activities of choice/interest, encourage the resident to verbalize his concerns before becoming physical, monitor the resident's mood and participation in care, redirect others away from the resident's belongings, redirect with music when manic or experiencing increased agitation, and report any concerns of behaviors and symptoms to physician or psychiatrist. The resident's anxiety care plan, initiated on 3/8/2017, and revised 8/21/2018, revealed the resident experienced extreme restlessness and verbalized inability to slow down thoughts and rest. The goal was for the resident to have decreased anxiety over the next review period as evidenced by statement of decreased anxiety, no increase in behaviors, ability to participate in activities of choice and ability to participate in his own care. The pertinent interventions included redirect the resident as able, away from stressful or chaotic situations to decrease risk of anxiety, staff will encourage/assist resident to participate in diversional activities to decrease anxiety, and staff will monitor for and report to nurse any noted triggers/precipitating factors/situations that increase resident's anxiety. 3. Behavior monitoring for Resident #2 - Conflicting and inconsistent documentation June 2020: A review of the June 2020 handwritten Behavior Monitoring documented the resident was being monitored for: -Mania to include rapid speech, restlessness or irritability, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. Staff [MEDICAL CONDITION] times out of 60 shifts. -Episodes of rapid change in mood every shift for [MEDICAL CONDITION]/[MEDICATION NAME] use. Staff documented episodes of rapid speech behavior zero out of 60 shifts. A review of the June 2020 electronic Behavior Monitoring documented that the resident was being monitored for the same two behaviors and documented the same frequency as above; however, there were 55 shifts where there was no documentation completed for either behavior. July 2020 A review of the July 2020 handwritten Behavior Monitoring documented the resident was being monitored for: -Mania to include rapid speech, restlessness or irritability, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. Staff documented this behavior two out of 60 shifts. There were no interventions or outcomes documented. There were 12 shifts where there was no documentation completed. -Rapid change in mood every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. Staff documented this behavior four shifts out of 60 shifts. There were 13 shifts where there was no documentation completed. A review of the July 2020 electronic Behavior Monitoring documented the resident was being monitored for the same two behaviors; however,[MEDICAL CONDITION] documented one out of 60 shifts, which are not the same shifts documented on the handwritten Behavior Monitoring sheets and there were 5 shifts where there was no documentation completed. Rapid change in mood behavior was documented one out of 60 shifts, which was not the same shift documented on the handwritten Behavior Monitoring sheets, and there were 5 shifts where there was no documentation completed. August 2020: A review of the August 2020 handwritten Behavior Monitoring was not available in the resident's medical record and not provided by the facility when requested. A review of the August 2020 electronic Behavior Monitoring documented the resident was being monitored for: -Mania to include rapid speech, restlessness or irritability, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. [MEDICAL CONDITION] was documented three out of 33 shifts. There were four shifts where there was no documentation completed. 4. Outcome Record

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F 0742 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 15) review and interview revealed on 4/5/2020, Resident #2 became upset and pushed Resident #3 several times in the face. Then, on 4/16/2020, Resident #2 hit Resident #4 when Resident #4 entered Resident #2's room. Staff found Resident #4 on the floor in Resident #2's room and Resident #2 told the first staff at the scene, I beat the s*** out him because he was in my room. Hospital records revealed Resident #4 sustained bilateral subdural hematomas, four right-side rib fractures, four left side rib fractures, a L1 compression fracture, a nasal bone fracture and bilateral zygomatic arch (cheek bones) fractures. (Cross-reference F600) Behavior monitoring revealed that despite the incidents in April 2020, Resident #2'[MEDICAL CONDITION] rapid mood changes were not accurately or consistently monitored to prevent future physical abuse, to adjust interventions, and effectively manage unsafe behaviors. RESIDENT #3 1. Resident status Resident #3, age 59, admitted to the facility on [DATE], readmitted on [DATE], and passed away on 4/25/2020. According to the April CPO, [DIAGNOSES REDACTED]. The MDS assessment dated [DATE] revealed that the resident was severely cognitively impaired with a BIMS score of 5 out of 15. He displayed physical and verbal behavior symptoms directed towards others four to six days a week. Those behaviors put the resident at significant risk for physical illness and injury and significantly interfered with his care. Those identified behaviors put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment. The resident required two-person extensive assistance with bed mobility, transfers, dressing, toileting, and personal hygiene and supervision with set up help for eating. 2. Record review The secure unit care plan, initiated on 2/27/2020, revealed that the resident was moved to the secure unit on 11/19/18 after returning to the facility following an inpatient hospitalization at a behavioral health facility. The resident had behaviors that disrupted the rights of others. The behaviors placed him in danger and less restrictive alternatives had been unsuccessful. The goal was for the resident to have his needs anticipated and met by staff. Pertinent interventions included for the resident to be reviewed quarterly by the psychiatrist, and referrals as needed for mental health support. The PASRR Level II care plan initiated on 2/27/2020 and revised on 4/27/2020 after the resident passed away revealed the resident exhibited verbal aggression towards staff and others with no known triggers. He would make verbal threats, have a defensive stance, and exhibit rapid speech. The resident would take food and drink from others, and he would take fluids (water, pop, coffee) from anyone and from anywhere he saw it. The goal was for the resident to remain stable with reduction in behaviors and symptoms. Pertinent interventions included: to encourage the resident to verbalize his feelings and validate his feelings; to encourage/allow the resident to verbalize his concerns; to engage him in friendly conversation and redirection as tolerated; to ensure the resident was offered drinks outside of meal times; to redirect the resident as able when he had behaviors that may cause injury to himself; and to refill the resident's cup/glass when it was noted to be empty when in dining room for meals to decrease the risk of him taking/grabbing drinks from others. The anxiety care plan, initiated on 2/27/2020, revealed that the resident had episodes of anxiety as evidenced by rapid speech, repeating himself, shaking, and asking repetitive questions. The resident had a behavior of spitting on the walls of the unit. The goal was for the resident's acute episodes of anxiety to be relieved within ten minutes of staff intervention. Pertinent interventions included altering the resident's environment during an episode of anxiety by taking him on a walk, taking him to an activity or to another area, and reassuring the resident that his needs would be met. The sexually inappropriate behaviors care plan, initiated on 2/27/2020, revealed the resident would expose himself to urinate in inappropriate places and touch himself while out of his room. The goal was for the resident to refrain from exposing himself and/or touching himself while out of his room. Pertinent interventions included to ask/assist the resident to return to his room to do such acts in the privacy of his room, utilizing a two hour toileting schedule to assist the resident with exposing himself and urinating, redirecting the resident to engage in an activity or snack, and reminding the resident that such behavior is inappropriate and politely ask him to pull his pants up. A 1/17/2020 PASRR Level II Mental Health Review indicated the facility was providing the following specialized services for the resident: Staff at the nursing facility will provide an on-going evaluation of (name of resident) mood and psychiatric stability. Medication management is imperative. Close supervision of psychiatric symptoms will be reported to the primary care provider (PCP)/psychiatrist for further review and evaluation. Staff will need to monitor for any signs that he may be having an increase in his psychiatric symptoms as he does have a history of negative behaviors when not taking medications as prescribed. 3. Behavior monitoring for Resident #3 - Conflicting and inconsistent documentation February 2020: A record review revealed no handwritten Behavior Monitoring for February 2020. Per the assistant DON, the facility did not implement the handwritten Behavior Monitoring until March 2020. A review of the February 2020 electronic Behavior Monitoring documented that the resident was being monitored for: -Verbal aggression, throwing objects, every shift (two shifts a day) related to [MEDICAL CONDITION]. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Aggressively pacing with clenched fists every shift (two shifts a day) related to [MEDICAL CONDITION]. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Liquid seeking, resident will take liquids directly from others hands, every shift (two shifts a day) related to [MEDICAL CONDITION]. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Sexual inappropriateness: exposing self, urinating in inappropriate places, every shift (two shifts a day) related to unspecified mood affective disorder. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Confrontational, argumentative, demanding or threatening, every shift (two shifts a day) related to unspecified mood affective disorder. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Physical aggression towards staff and/or others, every shift (two shifts a day) for frontal temporal dementia/[MEDICATION NAME] use. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Physical aggression towards staff or others, every shift (two shifts a day) for [MEDICAL CONDITION]/iloperidone use. The order was entered on 2/27/2020 on the second shift. The physical aggression behavior was documented as occurring two shifts out of fives shifts. There were two shifts where no documentation was completed. -Uncontrollable laughing, pacing, causing irritability with inability to rest/calm, every shift (two shifts a day) for mixed [MEDICAL CONDITION]/[MEDICATION NAME] use. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. -Urinating in inappropriate places, being hyper sexual and unable to redirect, every shift (two shifts a day) for mixed [MEDICAL CONDITION] disorder/[MEDICATION NAME] use. The order was discontinued on 2/24/2020 when the resident went out to the hospital, and was not reinstated upon his return. There were 47 opportunities for documentation of behaviors. There was no documentation completed for any of the 47 opportunities. March 2020: A review of the March 2020 handwritten Behavior Monitoring documented the resident was being monitored for: -Extreme agitation, threatening behaviors, unable to be redirected, every shift (two shifts a day) for agitation/[MEDICATION NAME] use. The extreme agitation, threatening behaviors were documented as occurring 26 shifts out of 62 shifts. There were two shifts documented that no behaviors occurred. On several of the shifts, the staff documented C, which was not listed on the key to the Behavior Monitoring document. There were 34 shifts where no documentation was completed. -Physical aggression towards staff or others, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. The physical aggression behavior was documented as occurring 20 shifts out of 62 shifts. There were eight shifts documented that no behaviors occurred. On several of the shifts, the staff documented C, which was not listed on the key to the Behavior Monitoring document. There were 34 shifts where no documentation was completed. -Responding to internal stimuli (uncontrollable laughter, speaking to self), every shift (two days a shift) for paranoid [MEDICAL CONDITION]/[MEDICATION NAME] use. The responding to internal stimuli behavior was documented as occurring 13 shifts out of 62 shifts. There were ten shifts documented that no behaviors occurred. On several of the shifts, the staff documented C, which was not listed on the key to the Behavior Monitoring document. There were 34 shifts where no documentation was completed. A review of the March 2020 electronic Behavior Monitoring documented that the resident was being monitored for: -Extreme agitation, threatening behaviors unable to be redirected, every shift (two shifts a day)for agitation/[MEDICATION NAME] use. Contrary to the handwritten Behavior

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	065235	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PIONEER HEALTH CARE CENTER	900 S 12TH ST ROCKY FORD, CO 81067

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 0742 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 16) Monitoring documentation above, extreme agitation, threatening behavior was documented as occurring one shift out of 62 shifts. There were three shifts documented that no behaviors occurred. There were 58 shifts where documentation was not completed. -Physical aggression towards staff or others, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. Contrary to the handwritten Behavior Monitoring documentation above, physical aggression behavior related to [MEDICATION NAME] use was documented as occurring one shift out of 62 shifts. There were two shifts documented that no behaviors occurred. There were 59 shifts where documentation was not completed. -Physical aggression towards staff or others, every shift (two shifts a day) for [MEDICAL CONDITION]/[MEDICATION NAME] use. The physical aggression behavior related to [MEDICATION NAME] use was documented as occurring one shift out of 62 shifts. There were six shifts documented that no behaviors occurred. There were 55 shifts where documentation was not completed. -Physical aggression towards staff and/or others, every shift (two shifts a day) for agitation/[MEDICATION NAME] use. The physical aggression behavior related to [MEDICATION NAME] use was documented as occurring zero shifts out of 62 shifts. There were five shifts documented that no behaviors occurred. There were 57 shifts where documentation was not completed. -Physical aggression towards staff or others, every shift (two shifts a day) for [MEDICAL CONDITION] /iloperidone use. The physical aggression behavior related to iloperidone use was documented as occurring four shifts out of 62 shifts. There were two shifts documented that no behaviors occurred. There were 56 shifts where documentation was not completed. -Responding to internal stimuli (uncontrollable laughter, speaking to self), every shift (two days a shift) for paranoid [MEDICAL CONDITION]/[MEDICATION NAME] use. Contrary to the handwritten Behavior Monitoring documentation above, responding to internal stimuli behavior was documented as occurring three shifts out of 62 shifts. There were seven shifts documented that no behaviors occurred. There were 52 shifts where documentation was not completed. -Verbal aggression with inability to be redirected. (ie. yelling, cursing, demanding towards staff and/or other residents), every shift (two times a day) for paranoid [MEDICAL CONDITION]/[MEDICATION NAME] use. The verbal aggression behavior was documented as occurring zero shifts out of 62 shifts. There were six shifts documented that no behaviors occurred. There were 56 shifts where documentation was not completed. April 2020: A review of the April 2020 handwritten Behavior Monitoring documented the resident was being monitored for: -Extreme agitation, threatening behaviors, unable to be redirected, every shift (two shifts a day) f
F 0835 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility failed to provide sufficient leadership to address and/or avoid significant concerns. Findings include: I. Resident rights Cross-reference F585 for a homelike environment. The facility failed to create a homelike environment for Resident #1 and #7. II. Freedom from abuse, neglect and exploitation Cross-reference F600 for freedom from abuse. The facility failed to keep residents safe from resident to resident abuse. Cross-reference F609 for reporting of allegations of abuse. The facility failed to report an [MEDICAL CONDITION] that occurred as a result of a resident to resident altercation. III. Comprehensive resident centered care plans Cross-reference F657 for care plan timing and revision. The facility failed to identify and implement new problems and concerns for Residents #1 and #2 regarding their behaviors and Residents #5 and #6 regarding their skin concerns. IV. Quality of life Cross-reference F679 for activity programming to meet the interest and needs of each resident. The facility failed to provide structured and meaningful activities to Resident #1, #2, #7 and #8; in addition all residents who resided on the South unit. V. Quality of care Cross-reference F684 for quality of care. The facility failed to complete skin assessments in a timely manner. Cross-reference F686 for pressure ulcer care. The facility failed to provide treatment and services to prevent and heal pressure ulcers. Cross-reference F689 for accident hazards. The facility failed to have a plan to evacuate Resident #1, when the facility evacuated during a fire. VI. Behavioral health services Cross-reference F742 for behavioral health. The facility failed to accurately document behaviors on the South unit, to develop person centered approaches, and provided specialized training to staff. VII. Quality assurance and performance improvement (QAPI) Cross-reference F865 for the QAPI program and the facility putting forth a good faith attemp to address concerns. The failicy failed to identify and concerns related to behavior health, skin concerns, accident hazards and homelike environment concerns. VIII. Administration Cross-reference F837 for governing body. The facility failed to have an effective governing body that provided oversight to the facility. IX. Physical environment Cross-reference F914 for full visual privacy. The facility failed to ensure Resident #1 had full visual privacy. Cross-reference F925 for effective pest control program. The facility failed to ensure they had an effective pest program to control the flies in the facility. X. Leadership interviews The nursing home administrator (NHA) and corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The NHA said the facility had seen a lot of staff turn over and recently had several directors of nursing (DON), and each DON had their own day to day operations. The CRC said they were in the process of hiring a new DON, and when that person was hired they would insure that DON would follow the policies and procedures of the company. The NHA and CRC said they would begin educating all of the staff, including management, to ensure that all of the staff are on the same page. The NHA said that COVID-19 had really caused problems in the facility and that has caused everything else in the building to struggle, but that the areas identified management would be working on.
F 0837 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the governing body failed to implement policies regarding the management and operations of the facility. Specifically, the facility failed to ensure the governing body was providing oversight to the facility to ensure the facility was in compliance with state and federal regulations. Findings include: I. Facility policy The Administrative Management (Governing Board) policy and procedure, last revised (October 2017), provided by the nursing home administrator (NHA) on 8/10/2020 at 5:00 p.m., read in pertinent part: The governing body shall be responsible for the management and operation of the facility. The governing board is responsible for, but is not limited to: -Oversight of facility care and services and in accordance with professional standards of practice and principles; -Establishment and ongoing review of all administrative programs governing facility management and operations including: corporate compliance program, emergency preparedness and response program, quality assurance and performance improvement program; and staff orientation, training and development programs. II. Resident rights Cross-reference F585 for a homelike environment. The facility failed to create a homelike environment for Resident #1 and #7. III. Freedom from abuse, neglect and exploitation Cross-reference F600 for freedom from abuse. The facility failed to keep residents safe from resident to resident abuse. Cross-reference F609 for reporting of allegations of abuse. The facility failed to report an [MEDICAL CONDITION] that occurred as a result of a resident to resident altercation. IV. Comprehensive resident centered care plans Cross-reference F657 for care plan timing and revision. The facility failed to identify and implement new problems and concerns for Residents #1 and #2 regarding their behaviors and Residents #5 and #6 regarding their skin concerns. V. Quality of life Cross-reference F679 for activity programming to meet the interest and needs of each resident. The facility failed to provide structured and meaningful activities to Resident #1, #2, #7 and #8; in addition to all residents who resided on the South unit. VI. Quality of care Cross-reference F684 for quality of care. The facility failed to complete skin assessments in a timely manner. Cross-reference F686 for pressure ulcer care. The facility failed to provide treatment and services to prevent and heal pressure ulcers. Cross-reference F689 for accident hazards. The facility failed to have a plan to evacuate Resident #1, when the facility evacuated during a fire. VII. Behavioral health services Cross-reference F742 for behavioral health. The facility failed to accurately document behaviors on the South unit, to develop person centered approaches, and provided specialized training to staff. VIII. Quality assurance and performance improvement (QAPI) Cross-reference F865 for the QAPI program and the facility putting forth a good faith attempt to address concerns. The failicy failed to identify and concerns related to behavior health, skin concerns, accident hazards and homelike environment concerns. IX.

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F 0837 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 17) Administration Cross-reference F895 for administration. The facility failed to have an effective administration that provided oversight to the facility. X. Physical environment Cross-reference F914 for full visual privacy. The facility failed to ensure Resident #1 had full visual privacy. Cross-reference F925 for effective pest control program. The facility failed to ensure they had an effective pest program to control the flies in the facility. XI. Leadership interviews The NHA and corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The CRC stated that she will be adjusting her current role in the facility to ensure the facility was able to get back on track. The CRC said she would begin inserting herself more in a clinical role to assist with the nursing concerns that had been identified. She said she and the other corporate consultants would be providing more oversight to the facility, and stated they would assist in getting all of the management on the same page, so all of the staff in the building could have clear expectations.
F 0865 **Level of harm -** Actual harm **Residents Affected -** Few	**Have a plan that describes the process for conducting QAPI and QAA activities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to develop, implement, monitor and reevaluate its quality assurance performance improvement (QAPI) program to ensure the unique care and services the facility provided were maintained at acceptable levels of performance and continuously improved. Specifically, the facility's QAPI program failed to systematically self-identify, investigate, analyze and correct problems relating to quality of care, quality of life and resident safety. This failure contributed to serious adverse outcomes and the likelihood of further serious adverse outcome. Cross-reference F600, F742, and F689K Findings include: I. Facility policy The QAPI Committee policy and procedure, undated, was provided by the interim director of nursing (IDON) on 8/6/2020 at approximately 9:00 a.m., and read in pertinent part: Goals of the committee: the primary goal of the QAPI committee (is) to: -Establish and maintain and oversee facility systems and process to support the delivery of quality of care and services; -Promote the consistent use of facility systems and process during provision of care and services; -Help identify actual and potential negative outcomes relative to resident care and resolve them appropriately; -Support the use of root causes to help identify where patterns of negative outcomes point to underlying systemic problems; -Help departments, consultants, and ancillary services implement systems to correct potential and actual issues in quality of care; -Coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and -Coordinate and facilitate communication regarding the delivery of quality resident care within and among departments and services, and between facility staff, resident, and family members. II. The complaint survey (8/4 to 8/17/2020) revealed multiple areas in which the facility failed to deliver care and services to its complex and unique resident population at an acceptable level of performance. According to 4/28/2020 facility assessment, the facility's resident profile included the following diseases/conditions, physical and cognitive disabilities: psychiatric/mood disorders including, [MEDICAL CONDITION], impaired cognition, [MEDICAL CONDITION], post-traumatic stress disorder, anxiety disorder and behaviors that need interventions. The services and care the facility offered based on resident need included hospice, bariatric care, palliative care and respite care. The complaint survey findings revealed deficiencies in the facility's level of performance in protecting residents ' rights, in ensuring residents ' safety, in delivering quality resident care and in promoting residents ' quality of life that were neither new nor uncommon. However, there was no evidence the findings had triggered a QAPI plan with corrective actions prior to survey. (Cross-reference F835 and F837). Specifically: A. Cross-reference F600 and F609 - failure to protect residents from abuse and to report abuse. F600 cited at a G level, actual harm and F609 cited at D level, potential for more than minimal harm. Survey findings revealed Resident #2 physically abused two cognitively impaired residents (#3 and #4) with known behaviors that disrupted the rights of others and placed them in danger. One incident occurred 4/5/2020 and another 4/16/2020. The 4/16/2020 incident resulted in Resident #4 sustaining bilateral subdural hematomas, four right-side rib fractures, four left side rib fractures, a L1 compression fracture, a nasal bone fracture and bilateral cheek bone fractures. Resident #4's [MEDICAL CONDITION] was not reported to the state. B. Cross-reference F742 and F657 for failure to provide appropriate treatment and services to five residents (#1, #2, #3, #4 and #9) residing on the secured behavioral unit (South unit), all of whom displayed or were diagnosed with [REDACTED]. F742 was cited at G level, actual harm and F657 was cited cited at E level, a pattern with the potential for more than minimal harm. Survey findings revealed the facility failed to accurately document and monitor resident behaviors on the South unit, failed to have an interdisciplinary team (IDT) that evaluated and discussed each resident on the South unit and failed to develop a person-centered approach to each resident and care plan new behavioral problems and concerns. Further, interviews revealed the facility failed to provide ongoing and specialized training to the staff working on the South unit. These failures contributed to the facility's inability to effectively care plan and manage unsafe behavior in an emergent situation and prevent physical abuse, as well as promote each resident's highest practicable level of physical, mental and psychosocial well-being C. Cross-reference F689 for failure to ensure resident safety from accidents, cited at K level, immediate jeopardy for serious harm, and EP 0007, EP 0009, EP 0037 and EP 039, failure to teach and train emergency preparedness. Survey findings revealed the facility experienced a fire in the South building dining room on 8/2/2020. Resident #1, severely cognitively impaired with behavioral disturbances that placed him at risk for harm, including daily resistance to cares, refused to evacuate the building. Staff left Resident #1 in his room behind a closed door after evacuating all the other residents from the building. The facility failed to identify and address Resident #1's known daily resistance to cares and failed to anticipate and plan for the difficulty in evacuating residents, including Resident #1, whose dementia and/or behaviors placed them at risk in an emergent situation such as fire. The facility further failed to provide sufficient emergency preparedness training and testing of staff after the 8/2/2020 fire and the unsuccessful evacuation of Resident #1 on the South secure unit. D. Cross-reference F584 for failure to maintain a safe, sanitary and homelike environment, cited at E level, a pattern with the potential for more than minimal harm and F924 for ineffective pest control, cited at D level, potential for more than minimal harm. Survey findings revealed the entire window and the middle two-thirds of the walls in Resident #1's room was covered with splatters in various shades of black, brown, pink and opaque material. Staff reported Resident #1 would frequently throw anything at the staff and at the walls in his room. She said he also frequently spit and yell at the staff and on the floor and his walls. She said staff would attempt to redirect him when he was throwing and spitting, but nothing really works, he'll just keep spitting and throwing things. Housekeeping staff said the walls, window and floor were covered in spit and everything Resident #1 threw at the wall, including food, drinks, and feces. Housekeeping staff were observed attempting to clean Resident #1's room using metal scrappers in an attempt to remove debris from the floor and the walls. Most of the debris was not removed easily; it appeared to have been on the walls and floor for some time. Observations further revealed standing water and mold in the South building basement. E. Cross-reference F679 for failure to provide activity programming to meet the interest and needs of each resident, cited at E level, a pattern with the potential for more than minimal harm. Survey findings revealed the facility failed to provide structured and meaningful activities to Residents #1, #2, #7 and #8, all of whom resided on the South secure unit and had displayed or were diagnosed with [REDACTED]. Record review revealed Resident #1, #2, #3, #4 and #5's quarterly/annual activity participation was not reviewed in a timely manner. Further, the unit lacked updated activity calendars to the and scheduled evening activities. Residents were observed unengaged in meaningful activities. F. Cross-reference F684 for failure to complete resident care (skin assessments) in a timely manner. The facility's failure to complete skin assessments timely, cited at a D level, potential for more than minimal harm. Cross-reference F686 for failure to provide adequate pressure ulcer care. The facility failed to provide treatment and services to prevent and heal pressure ulcers, cited at a D level, potential for more than minimal harm. III. Leadership interviews The nursing home administrator (NHA) and corporate regional consultant (CRC) were interviewed on 8/17/2020 at 9:00 a.m. The NHA said the facility currently had a QAPI committee which consisted of herself, the medical director, the director of nursing, the infection control nurse, the dietary manager human resources, the business office manager, the maintenance director, medical records, and a certified nurse aide if one is available. The NHA confirmed the QAPI committee had not identified and developed plans and corrective action for any of the deficiencies above in resident ' rights, resident ' safety, delivery of resident care and in promotion of residents ' quality of life. Rather, the NHA said the current issues the facility had identified were food and dining concerns, falls with fractures and residents wandering throughout the facility. The NHA said concerns from staff are generally brought up in morning meetings, and there was a concern from staff could fill out. The CRC said the corporation also provided a hotline telephone number that staff could use to report concerns. The CRC said she and the other corporate support for the facility would be inserting themselves into the facility to ensure everyone in the facility was on the same page. The CRC said QAPI would be one of the systems she and her team would be working on to ensure the facility was able to self-identify system failures, and hopefully implement systems to

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F 0865 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 18) correct any problems.
F 0914 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide bedrooms that don't allow residents to see each other when privacy is needed.** Based on observations and interviews, the facility failed to ensure residents were provided full visual privacy in their rooms for one of one residents reviewed for functional window blinds out of 10 sample residents. Specifically, the facility failed to ensure Resident #1 had functional window blinds or window privacy film to ensure the resident had visual privacy. Findings include: I. Observations On 8/4/2020 at 2:45 p.m. Resident #1 window was observed with no window covering such as blinds, or window film to ensure the resident had visual privacy. On 8/5/2020 at 4:35 p.m. Resident #1 window was observed with no window coverings such as blinds or window privacy film, to ensure the resident had visual privacy. On 8/6/2020 at 10:00 a.m. Resident #1 window was observed with no window coverings such as blinds or window privacy film, to ensure the resident had visual privacy. II. Record review The maintenance work orders were reviewed on 8/5/2020 and revealed the following dates requested to add window privacy film to Resident #1 window: -12/5/2017: film on window; -6/21/2017: film on window; and, -10/8/2019: film on window. No additional maintenance requests for window privacy film or requests for window blinds were provided by the facility. III. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 8/5/2020 at 12:40 p.m. She said she had worked on the South Hall with Resident #1 for over a year. She said the resident had window blinds at one point, but it had been months since he had them. The CNA said in the past the resident would pull down the blinds that were hanging in his room. The NHA was interviewed on 8/6/2020 at 10:41 a.m. She said the resident had window blinds in the past, but he would frequently pull the blinds down. The NHA said they had also tried window film, but the resident would remove the film as well. The NHA said the facility had recently tried window privacy film on the outside window, but it had not been improperly installed so it was no longer hanging. CNA #5 was interviewed a second time on 8/5/2020 at 10:50 a.m. She said the resident had not had window privacy film in months. The NHA was interviewed a second time on 8/17/2020 at 9:00 a.m. She said the maintenance department had installed window privacy film on the outside of Resident #1's window. The NHA said the resident was able to see outside of his room through the window privacy film. The NHA said you could not see through the window during the day because the film had a mirror effect, but she was unsure if the window privacy film offered privacy to the resident at night due to the lighting from inside the facility that allowed the resident to be seen and possibly be visible even with the window privacy film installed.
F 0925 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.** Based on observations, record review, and interviews, the facility failed to maintain an effective pest control program so the facility was free of pests and rodents. Specifically, the facility failed to implement interventions to keep the facility free of flies. Findings include: I. Facility policy and procedure The Pest Control policy and procedure, last revised May 2008, provided by the nursing home administrator (NHA) on 8/10/2020 at approximately 5:00 p.m., read in pertinent part: Our facility shall maintain an effective pest control program. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents. II. Observations On 8/5/2020 at 4:35 p.m. Resident #1 was observed laying in his bed in his room, multiple flies were observed in the resident room, coming through the resident's open window which had no screen. Cross-reference F584 for homelike environment for failure to provide a homelike by ensuring Resident #1 had a window screen to ensure flies did not enter his room. On 8/6/2020 at 10:20 a.m. Resident #1 was observed sitting in his room on the bed eating a cookie. Multiple flies were observed in the residents room. Flies were observed landing on the cookie the resident was eating. On 8/6/2020 at 1:15 p.m., Resident #6 was observed finishing her lunch. There were several flies observed flying in her room. Flies were observed landing on the resident's water pitcher, as well as landing on her lunch. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 8/6/2020 at 1:15 p.m. She said there were several farms in the area and that was where all of the flies in the building were coming from. The NHA was interviewed on 8/6/2020 at 10:41 p.m. She said the facility had purchased forced air wall curtains that needed to be installed and that should help with the fly problem in the facility. The regional maintenance supervisor (RMS) was interviewed on 8/6/2020 at 12:21 p.m. He said without a window screen on Resident #1's window, there was nothing preventing flies and other pests from entering the building. He said he would install a screen and monitor the window to ensure the screen stayed in place. The NHA was interviewed a second time on 8/17/2020 at 9:00 a.m. She said while the electricians were in the facility installing new lighting fixtures, they had wired and installed the forced air wall curtains in order to help with the number of flies in the buildings.