STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to develop and revise comprehensive care plans for each resident that included the instructions needed to provide effective and person-centered care for three (#1, #3, and #8) residents out of 29 sample residents. Specifically, the facility failed to ensure: -Resident #1, #3, and #8, comprehensive care plan was revised and updated with a smoking plan for Resident #1, dementia care Resident #3, and wound care Resident #8. Findings include: I. Resident #1 A. Resident status Resident #1, age 72, was admitted on [DATE]. According to the February 2020 computerized physician orders [REDACTED]. The May 2020 minimum data set (MDS) assessment revealed the resident was cognitively impaired and no brief interview for mental status (BIMS) was obtained. He required one person assistance with hygiene needs, bed mobility and dressing. B. Record review Resident #1 care plan dated 3/25/2020 indicated the resident was to be supervised when smoking at all times and was not updated. It includes the staff were to remove the oxygen from the resident before he goes outside to smoke.This was updated on 7/26/2020. Many other instructions were implemented on 3/5/2020 but had not been revised. Residents #1's smoking assessments were done periodically on the following dates and revealed the following information: -Smoking assessment dated [DATE] reported that Resident #1 was a smoker; -Smoking assessment dated [DATE] reported the Resident #1 was an independent smoker; -Smoking assessment revealed resident dated 2/19/2020 indicated Resident #1 was an independent smoker. The care plan dated 3/25/2020 included the resident as a supervised smoker. However the following assessments were inaccurate to reflect the residents current smoking status. Resident #1's smoking assessment dated ,[DATE], 5/20, 6/2, and 6/24/2020 reported Resident #1 as an independent smoker The resident's care plan was revised on 7/15/2020 to include Resident #1 as a supervised smoker. C. After the resident returned for the hospital -A Baseline care plan was created for Resident#1 on 7/29/2020 the day he returned from the hospital. It included the resident needing one-on-one assistance with smoking. He was listed as a supervised smoker at this point. The smoking assessment date 8/5/2020 listed Resident #1 as a supervised smoker. II. Resident #3 A. Resident status Resident #3, aged 60, was admitted to the facility on [DATE]. According to the August 2020 CPOs, the resident's [DIAGNOSES REDACTED]. The 7/30/2020 MDS assessment documented Resident #3 required supervision for mobility. The resident was documented to wander one to three days and his wandering put him at significant risk of getting to a potentially dangerous place such as outside the facility. The MDS documented there was no discharge plans for Resident #3. B. Interviews The nursing home administrator (NHA), the director of operations was interviewed on 8/6/2020 at approximately 2:00 p.m. The director of operations said Resident #3 was going to remain in the facility indefinitely. They were no longer looking for placement for him. The social service director (SSD) was interviewed on 8/12/2020 at 11:15 a.m. The SSD said that he was newly employed and was not as familiar with the resident. He was aware he needed to have a one-on-one sitter. He said he was not actively looking for alternative placement. C. Record review The care plan revised on 4/22/2020 identified the resident was on a waiting list at a memory care unit to be transferred. The approaches documented to discuss the discharge planning process with the proxy decision maker. However, the care plan was not updated to reflect the changes that the resident was not being discharged to another facility. No additional documentation was found in the residents record to reflect the discharge goals/planning had changed for Resident #3. III. Resident #8 A. Resident status Resident #8, age 63, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/15/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required extensive assistance of two persons with bed mobility, transfers and dressing and extensive assistance with one person assistance for toilet use and personal hygiene. Skin said was marked no to unhealed pressure ulcers and marked yes to moisture associated skin damage (MASA). B. Record review Resident #8 potential for skin impairment care plan revised on 3/7/2020 revealed impairment of skin due to poor mobility and a history of pressure ulcers. The resident will have no skin breakdown through the next review target date of 8/3/2020. The resident will be encouraged to have frequent repositioning and offloading and will have a weekly skin assessment. -The care plan was not updated to include the stage two pressure wounds to the buttocks, treatment or interventions to prevent the development or worsening of the wound.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure two residents (#8 and #7) out of three residents reviewed for incontinence care, received the necessary assistance with activities of daily living (ADLs). Specifically, the facility failed to ensure Resident #8 and #7 received timely assistance with incontinent care. Cross-reference F686 ensure residents do not develop pressure injuries and F725 ensure sufficient staffing to care for the needs of residents Findings include: I. Facility policy The Perineal Care/ Incontinence Care policy, revised in February 2018, was provided by the director of nurses (DON) on 8/9/2020 at 9:01 p.m. It read in pertinent part; To provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition. Perineal care is to be offered every 2 hours and before and after meals if needed. II. Resident #8 A. Resident status Resident #8, age 63, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/15/2020 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. She required extensive assistance of two persons with bed mobility, transfers and dressing and extensive assistance with one person assistance for toilet use and personal hygiene. Skin was marked no to unhealed pressure ulcers and marked yes to moisture associated skin damage (MASA). B. Continuous observations and interview Resident #8 was observed on 8/4/2020 at 9:45 p.m. to have her call light on. Certified nurse aide (CNA) #8 answered the call light, and the resident said she had to have her brief changed as she had diarrhea. CNA did not assist the resident at that time and said she would be right back. -At 9:47 p.m. resident #17 entered resident #8 room. CNA #8 assisted resident #17 out of the room and back to his room. She shut the door to resident #8s room. Resident #8 reminded CNA #8 she needed a brief change and again the CNA said she would be right back. -At 10:14 p.m. the resident put her call light on. LPN #1

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) answered the light and the resident asked why the CNA did not not come back. LPN told the resident she would find the CNA and she would be right back. The resident said to the nurse she had diarrhea. LPN left the room and shut the residents door. -At 10:33 p.m. CNA #5 assisted the resident to change her brief. CNA donned gloves and cleaned the front of the peri area under the brief. The skin was bright red around the peri area and a foley (tube into the bladder) catheter was present. There was a strong odor of urine and feces. The resident rolled to her left side and CNA #5 took off the brief. The residents bottom was bright red and excoriated in a large area around her buttocks and inner thighs up to her sacral area. She had three open wounds on her left buttocks. Two open wounds were about the size of a dime and another one a little smaller. There were large amounts of feces on the wounds. CNA #5 cleaned the area with peri wipes and the resident grimaced and moaned with discomfort. CNA #5 changed gloves but did not wash his hands in between. He applied barrier cream that was in the resident bedside drawer to the residents bottom, buttock check area and thighs. The cream was applied to the three open wounds. CNA put a clean brief on the resident, cleaned up the area and washed his hands. Resident #8 was interviewed on 8/5/2020 at 11:00 a.m. She said it took a long time for the staff to answer the call light when she needed to be changed. (Cross-reference F725) She said she had been having diarrhea and needed assist to change her brief. C. Record review According to the August 2020 CPO, the resident had the following orders: -Change daily and as needed every day shift for MASD, ordered 8/9/2020. -Please offer to reposition every two hours as resident will allow. Chart compliance and refusals every two hours, ordered 8/9/2020. The care plan dated 3/1/2020 for the risk of alterations in gastro-intestinal said the resident was free from discomfort and complications. The interventions were to administer bowel management medications per physician orders. Monitor for effectiveness of the medication and document the number of and character of stools daily and as needed. Monitor for and report noted changes in bowel patterns to the physician. Monitor for episodes of constipation, provide medication as ordered and report to the physician. The care plan revised on 5/28/2020 for activities of daily living (ADL) self care performance deficit related to [MEDICAL CONDITION] said she had limited range of motion and limited mobility. The interventions were to maintain current level of function in bed and with mobility and transfers through the next review date on 8/3/2020. The resident required one staff participation to reposition and turn in bed. She required a mechanical aid (hoyer lift) of two persons for transfers. D. Interviews CNA #4 was interviewed on 8/11/2020 at 10:30 a.m. she said the residents that needed total assistance with personal care were changed before and after each meal. She said they would check the brief to see if that was soiled and then change it. The director of nurses (DON) was interviewed on 8/6/2020 at 5:30 p.m. She said residents were repositioned and toileted every two hours and before and after meals. She said the CNA would alert the nurse when there was a new skin issue and then the nurse would assess the skin. She said resident #8 had a moisture associated skin damage (MASD) and not a pressure ulcer. -On 8/10/2020 at 11:56 a.m. the DON clarified resident #8 had a pressure ulcer stage two on her bottom area, not a MASD (cross-reference F686). II. Resident #7 A. Resident status Resident #7, age 72, was admitted on [DATE]. According to the August 2020 CPO [DIAGNOSES REDACTED]. The 7/9/2020 MDS assessment revealed the resident had memory problems and had moderately imparimed decision making. The resident required extensive assistance with activities of daily living which included, toileting. She was at risk for pressure ulcers. She was always incontinent of urine and bowel. B. Record review The care plan last revised on 3/5/2020 identified the resident was at risk for skin breakdown, and that the resident was dependent on the staff to provide activities of daily living. Interventions were to assist the resident with peri care and hygiene needs as needed and to monitor the skin for breakdown related to incontinence episodes. C. Observations 8/6/2020 -At 10:00 a m., the resident was observed to sit in the geri chair in her room. -At 11:30 a.m., the resident was assisted to the dining room. -At 12:53 p.m., CNA #1 and CNA #4 were observed to assist Resident #7 into bed after lunch. The hoyer lift (machine used to lift) was used to transport the resident from the geri chair to the bed. Once the resident was in bed CNA #4 covered her up with a blanket and video called the resident's daughter so she could talk to the resident. No incontinence care was provided or offered. D. Interviews CNA #1 was interviewed on 8/9/2020 at p.m. The CNA said the resident was able to use her call light. The CNA #10 was interviewed on 8/13/2020 at approximately 2:00 p.m. The CNA said the resident was dependent on staff for all activities of daily living. The licensed practical nurse (LPN #1) was interviewed on 8/13/2020 at approximately 2:00 p.m. The LPN said the resident was dependent on staff for all activities of daily living which included incontinence care.
F 0686 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident observation, record review and interviews, the facility failed to ensure one Resident (#8) of three residents reviewed for pressure ulcers, received the treatment and services to prevent pressure ulcer development. The facility failed to prevent the development of three stage 2 pressure ulcers to Resident #8 ' s buttocks. The facility ' s failures contributed to the development of three stage II pressure ulcers to Resident #8's buttocks that were not consistently assessed and treated. The facility failed to provide incontinent care in a timely manner; accurately and consistently document Resident #8's wound on her bottom; ensure Resident #8's wound care was provided consistently and according to physician orders; and update the resident's care plan with newly identified skin integrity issues and interventions. Cross-reference F657 care plan timing and revision, F677 incontinence care and F725 sufficient staffing. Findings include: I. 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. II. Facility policies The Pressure Ulcer/Skin Breakdown clinical protocol, revised April 2018, was provided by the director of nurses (DON) on 8/13/2020 at 9:00 a.m. It read in pertinent part; The nursing staff and practitioners will assess and document an individual's significant risk factor for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcers. In addition, the nurse shall describe and document/report the following: -Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue; -Pain assessment; -Residents mobility status; -Current treatments, including support surfaces; and -All active diagnoses. The physician will assist the staff to identify the type and characteristics of an ulcer. The Perineal Care/Incontinence Care, policy revised February 2018 was provided by the DON on 8/9/2020 at 9:01 p.m. It read in pertinent part; To provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident ' s skin condition. Perineal care is to be offered every 2 hours and before and after meals if needed. III. Resident status Resident #8, age 63, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. -The [DIAGNOSES REDACTED]. She required extensive assistance of two persons with bed mobility, transfers and dressing and extensive assistance with one person assistance for toilet use and personal hygiene. Skin said was marked no to unhealed pressure ulcers and marked yes to moisture associated skin damage (MASA). IV. Continuous observations failure to provide incontinent care timely Resident #8 was observed on 8/4/2020 at 9:45 p.m. to have her call light on. Certified nurse aide (CNA) #8 answered the call light, and the resident said she had to have her brief changed as she had diarrhea. CNA did not assist the resident at that time and said she would be right back. -At 9:47 p.m. Resident #17 entered Resident #8 room. CNA #8 assisted Resident #17 out of the room and back to his room. She shut the door to Resident #8 ' s room. Resident #8 reminded CNA #8 she needed a brief change and again the CNA said she would be right back. -At 10:05 p.m. licensed practical nurse (LPN) #1 went into the room to check the residents blood pressure and then left the room. -At 10:14 p.m. the resident put her call light on. LPN #1 answered the light and the resident asked why the CNA did not not come back. LPN told the resident she would find the CNA and she would be right back. The resident said to the nurse she had diarrhea and wanted medication for that. LPN left the room and shut the residents door. -At 10:25 p.m. LPN #1 went into the residents room to tell her she had to call the physician to get an order for [REDACTED].#5 assisted the resident to change her brief. CNA donned gloves and cleaned the front of the peri area under the brief. The skin was bright red around the peri area and a foley (tube into the bladder) catheter was present. There was a strong odor of urine and feces. The resident rolled to her left side and CNA #5 took off the brief. There were large amounts of feces on her bottom. CNA #5 cleaned the area with peri wipes and the resident grimaced and moaned with discomfort. The residents bottom

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) was bright red and excoriated in a large area around her buttocks and inner thighs up to her sacral area. She had three open wounds on her left buttocks cheek. Two open wounds were about the size of a dime and another one a little smaller. CNA #5 changed gloves but did not wash his hands in between. He applied barrier cream that was in the resident bedside drawer to the residents bottom, buttock check area and thighs. The cream was applied to the three open wounds. CNA put a clean brief on the resident, cleaned up the area and washed his hands. V. Record review Potential for skin impairment care plan revised on 3/7/2020 revealed impairment of skin due to poor mobility and a history of pressure ulcers. The resident will have no skin breakdown through the next review target date of 8/3/2020. The resident will be encouraged to have frequent repositioning and offloading and will have a weekly skin assessment. The care plan was not updated to include the stage two pressure wounds to the buttocks, treatment or interventions to prevent the development or worsening of the wound. (see below) Treatment administration record (TAR) for July 2020 revealed an order dated 6/13/2020 to cleanse the wound with wound cleanser, apply powdered collagen medication and hydrogel medication to the wound bed. Apply a dry dressing one time a day for wound care. The order did not say where the wound was located and the order was discontinued on 7/9/2020. -On 7/10/2020 a new order read; wash coccyx with wound cleanser, apply skin prep to the wound daily and continue to apply barrier cream with incontinent episodes one time a day for skin breakdown prevention. Another order read wash left glut with wound cleanser, apply skin prep to the wound daily for gluteal trauma related to incontinence. Both orders were discontinued on 7/23/2020. -On 7/17/2020 a new order read; cleanse left buttock with wound cleanser, apply [MEDICATION NAME] medication to the wound bed, and cover with a foam dressing. Change daily and as needed every shift for MASD. -On 7/24/2020 a new order read; wash coccyx with wound cleanser, apply skin prep to peri-wound and barrier cream every shift and as needed for skin protection. There was an admission skin assessment completed on 7/16/2020 that revealed a new skin breakdown to the left buttocks which measured 1.5 centimeters (cm) x 1.8 cm. -Full skin assessment completed on 7/30/2020 showed the left buttocks measurement to be 2 cm x 1.2 cm. According to the August 2020 CPO, the resident had the following orders: -Cleanse left buttock and left gluteal fold with wound cleanser, apply [MEDICATION NAME] to wound bed, cover with [MEDICATION NAME] dressing, revised order date 8/9/2020. -Change daily and as needed every day shift for MASD, ordered 8/9/2020. -Please offer to reposition every two hours as resident will allow. Chart compliance and refusals every two hours, revised order date 8/9/2020. Weekly summary dated 8/2/2020 for the skin section had a check box marked no for any open skin issues and a narrative note in a box that read, Resident #8 had a condition on the peri area that extends to bilateral buttock with small open area on the left side buttocks. Another summary dated 8/9/2020 asked if there were any current pressure injuries and the box was marked no with a narrative note in the box that read, buttock/coccyx open area with treatment ongoing as ordered and left buttock open area with treatment ongoing as ordered. The skin assessment-non pressure ulcer form dated 8/5/2020 read in pertinent part; Cleanse with normal saline, apply Medi-honey to wound bed, apply skin prep to peri-wound cover with dry dressing. Change daily. A question box asking has the medical doctor (MD) classified the wound as unavoidable and that box was marked yes. If the box was marked yes, provide the date of the note specifying wound as unavoidable, and the date was 7/30/2020. -On 8/7/2020 skin assessment the box with the MD classified the wound unavoidable was marked no. Nurse practitioner note dated 7/16/2020 read there was a history of an unspecified open wound of buttock. No other information was given about the wound. VI. Interviews Licensed vocational nurse (LVN) #3 was interviewed on 8/13/2020 at 9:39 a.m. She said skin assessments were completed weekly by the floor nurse and the director of nurses (DON) did wound rounds with the doctor on Thursdays. LVN #1 was interviewed on 8/13/2020 at 10:12 a.m. She said when a resident developed a new skin issue an assessment was completed. She said the DON was notified and new orders for wound care were entered. She said the DON and the wound doctor staged the wounds once they looked at them. The DON was interviewed on 8/6/2020 at 5:30 p.m. She said Resident #8 had a moisture associated skin damage (MASD) and not a pressure ulcer. She said the MASD was on her bottom area and not a pressure area. VII. Follow-up The DON was interviewed again on 8/10/2020 at 11:56 a.m. The DON clarified Resident #8 had a pressure ulcer stage two on her bottom area not a MASD. The DON was interviewed for a third time on 8/13/2020 at 4:13 p.m. she said the nurses notified her of any new skin issues and the residents names were put on the list for the wound doctor to assess them. She said the facility just hired a new wound doctor. She said a weekly skin assessment was completed and the nurses document any changes. The care plan was updated to reflect the new wound.
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 observation, record review, and staff and resident interviews, the facility failed to provide adequate supervision to prevent smoking and non-smoking related accidents. Out of 26 sample residents, this facility failure affected five residents who smoked (#1, #2, #21, #22 and #25) and three residents (#15, #3, and #6) at risk for non-smoking related accidents. Specifically: SMOKING-RELATED ACCIDENTS Record review revealed on 7/26/2020, Resident #1 lit a cigarette in the smoking courtyard while his portable oxygen was running, supporting combustion and causing a fire and [MEDICAL CONDITION] the resident's face that required hospitalization . At the time, a housekeeping associate with no specific training was present to supervise the residents smoking in the courtyard. Following the 7/26/2020 incident, observations on 8/5, 8/6, and 8/11/2020 revealed continued failures of the facility to supervise residents as expected per facility policy, resident smoking assessment and/or care plan, or the facility's 8/3/2020 smoking list, in order to prevent smoking-related accidents. On 8/6/2020, observations revealed supervised smoker Resident #2 lighting a cigarette as she sat on a bench in the back of the smoking area out of staff's view; there were no staff or residents in the courtyard. Further, observations on 8/5/2020 revealed Resident #25, a supervised smoker, smoking independently and supervised smokers Residents #21 and #22 smoking without safety aprons they had been assessed to need. Then, on 8/11/2020, observations revealed Resident #2 smoking without a safety apron she was identified to need and Resident #21 in possession of cigarettes. Record review revealed inaccurate assessments of residents ' smoking abilities and insufficient training of staff on the hazards of smoking and smoking with oxygen. The facility's failures above created actual harm to Resident #1 and the likelihood of serious harm to Residents #2, #25, #22 and #21, all of whom required supervision to smoke safely. NON-SMOKING RELATED ACCIDENTS Further record review and observations revealed the facility failed to address other non-smoking accident hazards. Resident #3 failed to have the supervision - one on one sitter - he was care planned to receive due to his wandering and potential for elopement. Resident #15 failed to have a fall mat to prevent serious injury, Resident #6 failed to have a safety assessment for the use of a coffee machine in her room. Findings include: SMOKING ACCIDENTS I. Immediate jeopardy A. Findings of immediate jeopardy Record review revealed on 7/26/2020, Resident #1 lit a cigarette in the smoking courtyard while his portable oxygen was running, supporting combustion and causing a fire and [MEDICAL CONDITION] the resident's face that required hospitalization . At the time, a housekeeping associate with no specific training was present to supervise the residents smoking in the courtyard. Following the 7/26/2020 incident, observations on 8/5, 8/6, and 8/11/2020 revealed continued failures by the facility to supervise residents as expected per facility policy, assessment and/or care plan, or the facility's 8/3/2020 smoking list, to prevent smoking-related accidents. On 8/6/2020, observations revealed supervised smoker Resident #2 lighting a cigarette as she sat on a bench in the back of the smoking area out of staff's view; there were no staff or other residents in the courtyard. Observations on 8/5/2020 revealed supervised smoker Resident #25 smoking independently and supervised smokers Residents #21 and #22 smoking without the safety apron they had been assessed to need. Then, on 8/11/2020, observations revealed Resident #2 smoking without the safety apron she was identified to need and Resident #21 was found in possession of cigarettes. Record review and interviews revealed inaccurate assessments of residents ' smoking abilities and insufficient training of staff on the hazards of smoking and smoking with oxygen. The facility's failures created actual harm to Resident #1 and the likelihood of serious harm to Residents #2, #25, #22 and #21, all of whom required supervision to smoke safely, if the facility's failures were not corrected immediately. B. Imposition of immediate jeopardy On 8/11/2020 at 3:18 p.m., the nursing home administrator (NHA) was informed the facility's failures created an immediate jeopardy situation, contributing to actual harm for Resident #1 and the likelihood of serious harm for Resident #2, as well as other three other residents assessed as supervised smokers (#21, #22 and #25). C. Facility response to immediate jeopardy On 8/12/2020 at 5:25 p.m., the following abatement plan (draft #5) was submitted by the NHA to the Colorado Department of Public Health and Environment (CDPHE) to remove the immediate jeopardy situation. The abatement plan read: 1. All current smokers will be reassessed for safe smoking and their care plans updated as needed by the Director of Nursing (DON), Social Services Director (SSD) or designee by 08/11/2020. 2. Resident #1 was reassessed

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) upon admission to the community and a new smoking assessment was complete on 8/5/20 to determine residents' smoking privileges. Additionally, a wander guard was placed on the portable oxygen tank of the resident to alarm the door if he attempted to enter the smoking patio with the oxygen tank still on. Care plan was reviewed to reflect his current status, and smoking capabilities. Performance improvement plan was completed immediately following the incident. Wander guard was placed on the top of the tank where the strap connects to the tank. 3. Resident #2 was immediately brought into the community upon learning that she was smoking. A physical assessment was completed for the resident to determine if there was an incident regarding her physical body. Resident was then re-assessed to determine her smoking capabilities inclusive of any adaptive equipment needs. A wander guard was added to the residents wheel to alert staff if and when she is attempting to enter the smoking area. 4. Resident(s) who are assessed to be independent with smoking will be allowed to smoke independently; however, for safety reasons supervised resident smoking materials will be kept at the nursing station in a locked case. 5. All residents who are utilizing portable oxygen will be educated on the importance of removing oxygen during the times they desire to smoke and will be considered supervised in the event that the portable tank is changed and the wander guard will be placed in the same location on the exchanged tank. However, residents who utilize o2 (oxygen) concentrators will remain independent if assessment determines they have independent smoking capabilities. Staff smoking supervisors will be educated on appropriate safety measures regarding oxygen and proper storage locations. Staff smoking supervisors will be educated on removing oxygen off residents prior to entering the smoking area. 6. Facility has created a supervised smoking checklist to assure accuracy of who is a supervised smoker while also highlighting any adaptive equipment that is to be utilized if needed and will update this list if there is a significant change or quarterly at minimum. SSD or DON will train all supervising staff on supervised smoking checklists prior to providing smoking supervision. All staff will be trained to the Smoking policy, smoking rules, supervised smokers, and adaptive equipment by 8/17/20. Facility will provide all adaptive equipment as needed to assure safe smoking practices for all residents. 7. The facility has created smoking rules that highlight appropriate smoking conduct to support a safe smoking environment which will be presented to residents who smoke upon admission. For residents who are current smokers, smoking rules were completed 8/11/20 be by SSD and DON. 8. The facility has revised the smoking policy to best support a safe smoking environment. 9. Oxygen door signs will be checked daily by the Plant Maintenance Director or designee to assure No oxygen signage is posted inside the smoking door and in the smoking area. On the weekend it will be the responsibility of the Charge nurse on duty. 10. A meeting will be held with smoking residents to discuss any changes or concerns with the facilities smoking policy and procedures quarterly and as needed. Meeting will be led by the SSD and DON. Meeting 1: 11/13/2020 Meeting 2: 2/12/2021 Meeting 3: 5/14/2021 Meeting 4: 8/13/2021 11. All staff will be educated on the facility safe smoking practices prior the start of their shift by the DON, or SSD starting 08/12/2020: a. Provision and posting of No-Smoking signs for residents who utilize oxygen and the designated smoking area b. The facility designated smoking areas c. Supervised Smoking Checklist d. Smoking rules e. Use of smoking blanket f. Supervision will be provided by facility staff who have been trained on all safety measures to prevent/minimize the risk of resident accidents or incidents during the smoking times and for those residents who require supervision. g. The provision and application of adaptive equipment for supervised residents while smoking 12. The plan will be presented to the QAPI Committee Meeting by 08/14/2020 D. Removal of the immediate jeopardy On 8/12/2020 at 5:25 p.m., the NHA was notified the immediate jeopardy had been removed based on staff interview and review of the facility's abatement plan. However, deficient practice remained at G level (actual harm) based on Resident #1's smoking injury 7/26/20 as well as systemic failures in the smoking procedures identified during survey 8/4/2020 - 8/13/2020. II. Smoking population and smoking policy A. Smoking population Review of the facility census list provided by the NHA on 8/6/2020, revealed 17 out of 59 facility residents smoked. Eleven of the 17 residents were determined to be independent smokers. This meant the residents kept and carried their own smoking materials and were allowed to go outside to smoke when they wanted to do so. Six residents were determined supervised smokers as of 8/3/2020, including Residents #1, #2, 21, #22, and #25. There were specific smoking times when the residents were to be supervised by staff when smoking. Two of the 17 residents used oxygen routinely, Resident #1 (supervised smoker) and Resident #26 (independent smoker). B. Facility Smoking Policy The policy read, in pertinent part, The facility will assess each smokers ' level of support and supervision by completing a smoking assessment. The facility may impose a smoking restriction on residents at any time if it is determined the resident cannot smoke safely with the available levels of support and supervision. Residents are encouraged to wear smoking aprons, and in addition, they will have the direct supervision of a staff member, worker at all times while smoking . Residents may not have or keep cigarettes, lighters fluids, including butane gas, or any other forms of gas or fluids at any time. III. Residents #1, #2, #25, #22, and #21 A. Failure to supervise Resident #1 to prevent a smoking-related accident 1. Resident status Resident #1, age 72, admitted to the facility on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The CPO documented the resident had an order for [REDACTED]. The resident was unable to complete the brief interview for mental status (BIMS) evaluation for assessment of cognition. The 2/21/2020 MDS documented the resident had moderate cognitive impairment as evidenced by a BIMS score of ten out of 15. Record review revealed Resident #1 smoked cigarettes. 2. Incident 7/26/2020 Review of progress notes dated 7/26/2020 at 9:30 a.m. and incident audit report received on 8/10/2020 at 1:00 p.m. documented Resident #1 caught himself on fire while smoking with oxygen. Licensed practical nurse (LPN) #2 wrote the resident had soot all around his nasal area and partial burn to his mustache and lower lip, possible 1st to 2nd degree burn possibly experienced a second-degree burn on his lips and face. When asked what happened, the resident replied, I forgot to ask the staff to take off my oxygen container. When asked where he got his cigarette, he said he had his own cigarettes and motioned with his head pointing at his cigarette tucked in between the cushion on the right side of his wheelchair. A call to Resident #1's wife revealed her caregiver brought Resident #1 groceries on 7/22/2020 and brought him cigarettes as well. The resident received Tylenol and a cold compress for his face. He was transferred to the hospital per physician orders. Housekeeping associate #1 (HSK#1) was interviewed on 8/5/2020 at 10:00 a.m. She said she was supervising the residents in the smoking courtyard on 7/26/2020. She said she was outside in the smoking area that day at approximately 9:30 a.m. near Resident #1. She turned around from the flowerbed and noticed the resident's lip and beard were on fire. She said she removed the hose from the resident's nose and tossed the oxygen. Resident # 21 was interviewed on 8/5/2020 at 11 a.m. She said she was outside smoking with about five other smokers on 7/26/2020. She said she heard a loud pop. She then saw Resident #1 on fire. She said she did not notice where the resident had gotten his cigarettes. Resident #27 was interviewed on 8/9/2020 at approximately 10:00 p.m. The resident said he was present during the incident with Resident #1 on 7/26/2020. He said he was sitting on the bench and the housekeeping associate #1 was standing near him. He said Resident #1 was smoking with oxygen on and he saw the flames under his nose. He said the housekeeping associate ran over and put the fire out with her hands. Resident # 20 was interviewed on 8/10/2020 at 3:40 p.m. He said he was out in the smoking area on the day Resident #1 caught himself on fire. He said he did not notice the oxygen on the resident's face. He said he saw the resident light a cigarette and saw his face catch on fire. He said the staff member who was out in the area immediately took the oxygen from the resident and put out the fire on his face. He said he went into the facility to get a nurse for the resident. He said he saw the paramedics come a few minutes later and take the resident from the facility. 3. Facility failure to protect Resident #1 from an accident while smoking a. Failure to ensure Resident #1's smoking abilities were accurately assessed to meet his need for supervision. Record review revealed conflicting information on Resident #1's smoking abilities. Specifically, smoking assessments dated 2/18, 2/19, 5/19, 5/20, 6/2 and 6/24/2020, documented Resident #1 was an independent smoker, which indicated he had his own smoking materials. However, his care plan during much of this same period, dated 3/25/2020 and revised 7/15/2020, documented he was to be supervised when smoking at all times. There was no evidence in Resident #1's record to explain this discrepancy; the resident's care plan provided no explanation why the resident was a supervised smoker and what interventions this triggered. In an interview on 8/13/2020 at 12:33 p.m., the NHA said he was not aware that the resident's care plan did not match his smoking assessments. Moreover, his most recent smoking assessment prior to the 7/26/2020 incident, dated 6/24/2020, documented he had no cognitive loss. This was inaccurate as his 5/21/2020 MDS documented the resident was unable to complete a BIMS due to cognitive impairment. Indeed, review of a facility quality improvement (QAPI) root cause analysis of the 7/26/2020 incident provided by the NHA on 8/17/2020 revealed the QAPI found Resident #1's smoking assessments were inconsistent. Meeting notes read: Resident #1 had a BIMS of 5 and a [DIAGNOSES REDACTED]. His being deemed an independent smoker may not have been appropriate. b. Failure to ensure the facility's Smoking Policy was followed. (1) Although the facility policy read, Residents may not have or keep cigarettes, lighters fluids at any time, review of Resident #1's most

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) recent smoking assessment dated [DATE] documented resident had control of his own smoking materials. Resident #1's statement after the 7/26/2020 incident, that he had his own cigarettes, pointing to one on the cushion in his wheelchair, revealed this was the case on 7/26/2020, even though his care plan read he was a supervised smoker. There was no evidence the supervising staff was aware the resident had his own cigarettes or questioned where the resident had obtained his cigarettes until after the incident. (2) Although facility policy read, No oxygen is allowed in designated smoking areas at any time, interview with the NHA revealed no signage was in place to direct residents, visitors, and staff that oxygen is flammable and must be removed before entering the smoking area until after the incident on 7/26/2020. Further, there was no evidence the supervising staff observed and attempted to turn off and remove Resident #1's portable oxygen when he entered the smoking courtyard. c. Failure to ensure staff members supervising residents who required supervision when smoking were trained in how to perform their duties. The NHA was interviewed on 8/13/2020 at 12:33 p.m. The NHA said his employment started at the facility in November 2019. He said he was not sure if any training had been completed with the staff on the smoking policy during his administration, prior to the incident from 7/26/2020. He said he himself had not completed any training on smoking with the staff. He said housekeeping associate #1 who was supervising the residents during the incident on 7/26/2020 did not have training on the smoking policy. He further stated the new maintenance man had not been trained on the smoking policy or smoking areas. 4. Actions taken after 7/27/2020 incident a. Individual-focused actions According to the 7/26/2020 QAPI meeting notes provided by the facility on 8/17/2020, corrective action for Resident #1 included the resident was to be a supervised smoker and his smoking materials stored by the facility to which he would have access during supervised smoking times. A wander guard would be placed on the resident's portable oxygen tank to alert the staff if the resident was trying to go out to the smoking area with his oxygen on. Resident #1's smoking assessment dated [DATE] read he was a supervised smoker. Physician orders, revised on 8/6/2020 read the resident was to be offered three smoke breaks per day. The orders included the resident was to be outside at opposite times of other smokers. Another order beginning 8/6/2020 read to place an alarm on the resident's portable oxygen tank to alert staff if the resident tried to go outside by himself. b. Systemic actions According to the 7/26/2020 QAPI meeting notes, systemic action included an audit of all residents that smoked to ensure the residents have an accurate smoking assessment within the last quarter, an accurate/appropriate smoking care plan, wear supplemental oxygen, and to determine if a resident is independent or supervised with smoking. . Smoking materials for cognitive impairments/supervised smokers will be kept secure by the facility staff and will not be allowed to be stored in the resident's possession. The facility issued a Supervised Smoking Policy dated 7/26/2020 that directed to staff supervising smokers in the smoking area to: -look at all residents to ensure they are safe -ensure oxygen has been removed for all residents and, if not, immediately remove it, and -make sure that smoking residents who are required to wear an apron, or other devices, are wearing items during smoking. -not leave supervised smokers in the smoking area A Smoker's Meeting was held 7/30/2020 to discuss adjustments to smoking at the facility. The NHA, in his interview on 8/13/2020 at 12:34 p.m., said staff called him the day of the incident involving Resident #1. He said he immediately did a complete assessment on all of the residents, focusing on the supervised smokers and taking all of the smoking materials away from them. He said he was not involved with the smoking policy prior to this incident, stating the social service director (SSD) was to review the smoking policy every six months. B. Resident #2, #25, #21, and #22 - Continued failure to supervise residents to prevent smoking-related accidents and failure to consistently implement post 7/26/2020 systemic actions set forth above. Following the 7/26/2020 incident, observations on 8/5, 8/6, and 8/11/2020 revealed continued failure of the facility to supervise residents as expected per facility policy, assessment and/or care plan or the facility's 8/3/2020 smoking list, in order to prevent smoking-related accidents. Specifically, observations revealed supervised smokers smoking without supervision, without safety aprons, and in possession of their own smoking materials. 1. Resident #2 Resident #2, age 69, admitted to the facility on [DATE]. According to the August 2020 CPO, her [DIAGNOSES REDACTED]. She required supervision and set up help for locomotion on the unit. She required a wheelchair for locomotion. Record review revealed Resident #2's smoking assessment, dated 7/26/2020, read the resident did not require a safety apron while smoking and a progress note from 7/27/2020 revealed the resident was offered a safety apron and refused. However, the 8/3/2020 smoking list identified the resident was to wear a safety apron when smoking. In addition, her care plan, updated 7/29/2020, read the resident's cigarettes and lighter were to be kept in a secure location. On 8/5/2020 at 3:06 p.m. and again on 8/6/2020 at 11:03 a.m., observations revealed Resident #2 smoking outside with staff present. She was not wearing a safety apron either time. On 8/6/2020 at 5:34 p.m., observations revealed Resident #2, without a safety apron, sitting on the bench in the back of the smoking courtyard out of staff view. It was dinnertime and no staff or other residents were in the courtyard. The resident had a cigarette in her mouth. She reached into her pocket and pulled out a lighter. She lit her cigarette and started smoking. On 8/11/2020 at 1:45 p.m., the assistant director of nursing (ADON) provided an incident report regarding this incident. The report revealed Resident #2 was found smoking alone in the courtyard without an apron. The resident was a supervised smoker. The action taken by the facility included removal of cigarettes and lighters and a skin assessment for injuries. The resident could not tell staff where she got her cigarette and lighter. With the consent of the resident's family, staff searched the resident's room for cigarettes. The investigation did not reveal how the resident obtained the cigarette or lighter. On 8/11/2020 at 3:01 p.m., observations revealed Resident #2 smoking outside in the courtyard. Staff was present, but the resident was not wearing a safety apron. The director of nursing (DON), interviewed on 8/6/2020 at 6:30 p.m., said Resident #2 was only allowed to smoke during designated smoking times because she was a supervised smoker. She said they had gone over the smoking policy with the resident and attempted a smoking contract, which the resident refused to sign. 2. Resident #25 Record review revealed Resident #25's 5/21/20 smoking assessment documented he was independent with smoking; however, the facility smoking list dated 8/3/2020, listed him as a supervised smoker. On 8/5/2020 at 2:15 p.m., observations revealed Resident #25 received a cigarette from registered nurse (RN) #1 at the nurses ' station. He then left and went out to the smoking courtyard by himself to smoke. No staff was present to supervise him. On 8/6/2020 at 4:46 p.m., observations again revealed Resident #25 smoking a cigarette in the courtyard with no staff present to supervise him. 3. Resident #21 Record review revealed Resident #21 was assessed on 7/26/2020 as a supervised smoker. Per the assessment, her care plan and the 8/3/2020 smoking list, she was to wear a safety apron. Further, per her assessment and care plan, her cigarettes were to be kept by the staff. On 8/5/2020 at approximately 3:15 p.m., observations revealed Resident #21 smoking outside in the smoking courtyard during one of the designated smoking times. She did not have an apron on. On 8/11/2020 approximately 4:00 p.m., the resident was observed in her room. She had a zipper pouch around her waist. Inside the open zipper pouch was a pack of cigarettes. 4. Resident #22 Record review revealed Resident #22 was assessed on 7/26/2020 as a supervised smoker and was to wear an apron while smoking. On 8/5/2020 at approximately 3:15 p.m., observations revealed the resident was outside smoking. He did not have a safety apron on while he smoked. 4. Staff interviews on supervised smoking Interviews revealed conflicting understanding of the procedures for supervised smoking and the observations above revealed the procedures articulated were not consistently followed. Certified nurse aide (CNA) #2 was interviewed on 8/11/2020 at 11:50 a.m. She said she has had to supervise the smokers before. She said she gathers all the residents in the common area, puts the aprons on, and reminds them if they don't wear one, they cannot smoke. She said she then gathers their cigarettes and a lighter from the box in the nurses ' station and takes the residents outside. She said each resident can have two cigarettes and can enter the building when they are done smoking. She said she cannot enter the building until all the supervised smokers have finished smoking. She said if a resident missed the designated smoking time, he or she has to wait until the next time to smoke. She said she received training about smoking safety and a demonstration on how to use the fire extinguisher. She said portable oxygen canisters had to be left at the nurse's station before a resident could go outside to smoke. RN #3 was interviewed on 8/11/2020 at 4:01 p.m. She said all the cigarettes and lighters for supervised smokers were kept in the locked nurses ' station and given to staff at supervised smoking times. She said the supervising staff was to light the cigarettes for the supervised residents and hold onto their second cigarette until they were done with their first one. Licensed vocational nurse (LVN) #2 was interviewed on 8/12/2020 at 2:50 p.m. She said the safety aprons for smokers were kept in the nurses ' station. She said the residents had a right to refuse the apron and still go outside to smoke. She said the lighter was given to the supervising staff member to light the cigarettes for the residents. NON-SMOKING RELATED ACCIDENTS Record review, observations and interviews revealed the facility failed to address other non-smoking-related accident hazards. A. Failure to prevent Resident #3 from wandering outside the facility 1. Resident status Resident #3, aged 60, admitted to the facility on [DATE]. According to the August 2020 CPOs, the resident's [DIAGNOSES REDACTED]. The 7/30/2020 MDS documented

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) Resident #3 required supervision for mobility. The resident was documented to wander 1 to 3 days and his wandering put him at significant risk of getting to a potentially dangerous place such as outside the facility. 2. Failure to implement supervision for wandering a. Record review The 4/23/2020 care plan documented the approaches for managing Resident #3's wandering included one-on-one for safety and care needs related to wandering. b. Observations 8/4/2020 and staff interviews 8/4 and 8/6/2020 On 8/4/2020 at 9:15 p.m., observations revealed the resident wandering the hallway. He did not have a one-on-one sitter with him. RN #1, who was in charge of the resident's care, was interviewed at 9:30 p.m. She said Resident #3 did not have a sitter. She said staff keep their eye on the resident when he is out of his room and wandering the hallways. She also said he had a wander guard bracelet. On 8/6/2020 at approximately 2:00 p.m., the NHA and the director of operations (DOO) were interviewed. The NHA acknowledged a sitter for Resident #3 was not scheduled on the evening of 8/4/2020. The NHA said the facility's goal was to have four CNAs, a sitter, and two licensed nurses on the evening shift. The DOO and the NHA gave assurances a sitter would be in place for Resident #3 from now on. The director of operations said Resident #3 was going to remain in the facility indefinitely; the facility was no longer looking for alternative placement for him. c. Observations and interview 8/9/2020 After the meeting on 8/6/2020 (see above) with the NHA and DOO and their assurance that the plan of correction would be met with a sitter for Resident #3, observations revealed the resident continued to be without a sitter. On 8/9/2020 at 9:15 p.m., Resident #3 was in his room; he did not have a sitter with him in his room. At the time, RN #1 was across the hall assisting another resident to bed. On 8/9/2020 at approximately 9:30 p.m., RN #1 was interviewed. She said the resident had a sitter up until 8:30 p.m. She said had been sitting with him; however, the resident across the hall had asked to go to bed, so she was helping her. On 8/9/2020 at approximately 9:30 p.m., RN #2 was interviewed. RN #2 said he worked on 8/8/2020 on the 6:00 p.m. to 6:00 a.m. shift. He said no sitter had been scheduled for Resident #3 on 8/8/2020. He said he had removed himself from the working the floor to sit with the resident, although he said he was not always with the resident. He said the floor he was assigned to work was an easier assignment and the CNA on his floor kept an eye on his residents. B. Failure to place a fall mat to prevent injury to Resident #15 1. Resident status Resident #15, age 97, admitted to the facility on [DATE]. According to the August 2020 CPO, her [DIAGNOSES REDACTED]. The 5/28/2020 MDS assessment revealed the resident had cognitive impairment with a brief interview for mental status score of 6 out of 15. She required extensive two-person assistance with transfers and bed mobility. She required a wheelchair for locomotion. The resident's care plan, updated on 5/22/2020, documented the use of a fall mat and the bed to be in the lowest position when the resident was in bed. A fall investigation from 7/30/2020 was received from the DON on 8/13/2020 at 10:00 a.m. It documented the resident slid out of her chair in the hallway. The nurse assessed the resident and three staff assisted the resident back into her chair. An interdisciplinary team (IDT) note dated 8/4/2020 discussed the resident's fall from 7/30/2020. Fall risks included weakness, dementia, and confusion. Interventions included a fall mat and physical therapy screen. 2. Observations On 8/5/2020 at 3:00 p.m., observations revealed Resident #15 sleeping in bed. A fall mat was not on the floor at the bedside. On 8/6/2020 at 11:00 a.m., observations revealed Resident #15 sleeping in bed. A fall mat was not on the floor at the bedside. On 8/6/2020 at 2:24 p.m., observations revealed Resident #15 being transferred to bed. The certified nurse aide (CNA) #1 and the director of nursing (DON) communicated to the resident that they were going to lay her down. After the transfer and completion of care, no fall mat was placed on the floor at the bedside. On 8/9/2020 at 9:40 p.m., observations revealed Resident #15 sleeping in bed. A fall mat was not on the floor at the bedside. On 8/12/2020 at 10:00 a.m., observations revealed Resident #15 sleeping in bed. A fall mat was not on the floor at the bedside. 3. Staff Interviews On 8/12/2020 at 10:14 a.m., CNA #1 was interviewed. She said Resident #15 was lying down after me
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills to ensure the residents received the care and services they required as determined by resident assessments and individual plans of care. Specifically, the facility failed to consistently provide adequate nursing staff which considered the acuity and [DIAGNOSES REDACTED]. As a result of inadequate staffing, the facility had delayed call light response, failed to provide assistance with activities of daily living (ADLs) incontinent care, lack of pressure ulcer interventions to prevent pressure ulcers, to clear dinner trays from dining areas and resident rooms, and an adequate infection control program. Cross-reference F-677, Maintain activities of daily living for dependent residents; Cross-reference F-686, Treatment, prevent pressure ulcers;and; Cross-reference F-880, Infection control program; Cross-reference F-689, Accident hazard; Cross-reference F-732 Post daily staffing; and, Cross-reference F-835, Administration. Findings include: I. Resident census and conditions According to the 8/11/2020 Resident Census and Conditions of Residents report, the resident census was 59. However, the census and condition failed to show three residents as the census and condition showed 56 residents. The following care needs were as identified: -37 residents needed assistance of one or two staff with bathing and 15 residents were dependent. Four residents were independent. -35 residents needed assistance of one or two staff members for toilet use and six residents were dependent. 15 residents were independent. -38 residents needed assistance of one or two staff members for dressing and six were dependent. Ten residents were independent. -32 residents needed assistance of one or two staff members and seven were dependent for transfers. 17 residents were independent -11 residents needed assistance of one or two staff members with eating and three were dependent. 42 residents were independent. II. Staffing requirements for each station According to the desired staffing pattern documentation provided by the director of nursing on 8/10/2020: The licensed nurses were scheduled for 12 hour shifts. Maple: One licensed nurse from 6:00 a.m. to 6:00 p.m. Willow/ Oak One licensed nurse from 6:00 p.m. to 6:00 a.m. The certified nurse aides (CNA) were also scheduled for 12 hour shifts, however, eight hour shifts were utilized if needed. The staffing pattern on the master schedule was 12 hour shifts. The 6:00 a.m. to 6:00 p.m. was to have five CNAs and one CNA for the 1:1 sitter. The 6:00 p.m to 6:00 a.m. was to have four CNAs and one CNA for the 1:1 sitter. III. Observations On 8/4/4/2020 at 9:10 p.m., the 6:00 p.m., to 6:00 a.m. shift had two CNAs working and two licensed nurses. There was no 1:1 sitter for Resident #3. On 8/9/2020 at 9:11 p.m., the 6:00 a.m. to 6:00 p.m. shift had two CNAs and two licensed nurses. The 1:1 sitter for Resident #3 left the building at 8:30 p.m. Observations were conducted on 8/9/2020 at 9:08 p.m. Resident #13 was heard calling for staff help and his call light was on. The call light board was observed and his call light had been on for 55 minutes. CNA #5 answered his call light at 9:10 p.m. On 8/9/2020 at 9:10 p.m. Call light for room [ROOM NUMBER] on the call light monitor was observed to be going off. The call light monitor indicated that the duration of the light for room [ROOM NUMBER] was 64 minutes prior to 9:10p.m. observation. The resident from room # 114 could be heard calling out for help. At 9:35 p.m., CNA#4 was observed to enter room [ROOM NUMBER] to answer the light. On 8/9/2020 at 10:05 p.m. it was observed a resident was taking out the trash for the staff. He indicated to the surveyor that he always took the trash out just to help out the CNAs. IV. Resident council The resident council minutes for 6/11/2020 showed call lights not being answered timely was expressed as a concern. V. Resident Interviews Resident #10 was interviewed on 8/4/2020 at 9:15 p.m. He said the dishes were piled up on the cart every night and the dishes were still in the kitchen dirty until morning. Resident #13 was interviewed on 8/5/2020 at 2:00 p.m. He said the facility was short staffed on the weekends and night shift. He said he has had to wait up to an hour for help after using his call light. He said sometimes staff don't answer his call light at night. Resident #6 was interviewed on 8/5/2020 at 2:42 p.m. Resident #6 said she has had to wait 45 minutes for staff assistance after using her call light. She said a 45 minute wait time was common at night because sometimes there was only one CNA. She said long wait times were also common on weekends. She said the facility did not have enough staff on nights and weekends. She said staff are visibly frustrated on weekends. She said she had been incontinent many times while waiting for staff assistance. Resident #13 was reinterviewed on 8/10/2020 at 11:42 a.m. He said he had to wait over an hour for help last night. HE said he was yelling for help and had his light on and still no one came. He said he was having trouble breathing and no one came to check on him. Resident # 18 was interviewed on 8/10/2020 at 11:45 a.m. She said there was not enough dining staff and she had to wait a long time to get her food during meal times. She said the meals were often late and the food was cold. She said she had to wait a long time to get her medications and the call lights were answered anywhere from half an hour to two hours.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 6) She said that she noticed the facility brought in extra staff while the surveyors were in the building, however, when the surveyors were not in the building it went back to low staffing. She said she and her roommate felt ignored by the staff. She said that she had to get in her wheelchair by herself on several occasions and go find a nurse when she needed something. Resident #5 was interviewed on 8/12/2020 at approximately 10:00 a.m. The resident said she felt bad for the staff, as they worked hard and they never had enough staff, so they were constantly running to get things done. She said the staff were overworked. Resident #9 was interviewed on 8/13/2020 at 3:00 p.m. She said she gets very frustrated with all the new staff who work the facility. She says they do not know how to care for her and she has to tell them her preferences for care all the time. She said it would be nice to have consistency and staff that she can trust to care for her. Resident #12 was interviewed on 8/12/2020 at 4:11 p.m. The resident said she was tired of having a high turnover rate with the CNAS. She said that she used to know the staff by name and they knew her, but now they do not know her. She said the staff were always in a hurry and her call light was not answered timely. She said the facility never had enough help. VI. Staff turnover inadequacies The facility had experienced a significant staff turnover with the department heads. The turnover was as follows for department heads and start dates: Director of nurses (DON) 6/24/2020; Assistant director of nurses (ADON) 6/30/2020; Medical records director 7/8/2020; Social service director 6/15/2020; Activity director #1 8/6/2020; Activity director #2 7/23/2020; Dietary manager 7/12/2020; Maintenance director 8/5/2020; and, Housekeeping supervisor August 2020. VII. Staff Interviews ACNA #2 was interviewed on 8/9/2020 at 10:00 p.m. She said it was difficult to answer call lights. ACNA #1 was observed talking to the assistant director of nursing (ADON) on 8/10/2020 at 2:15 p.m. ACNA #1 said she was being given so many different tasks from different nurses she did not know what to get done. She said she was frustrated and needed direction. The ADON said that she was the lead on the floor and what she told her to complete should be done. CNA #10 was interviewed on 8/12/2020 at approximately 4:00 p.m. The CNA said there was never the five CNAs on her shift, as the schedule mandated. She said that when there were not enough CNAs, then they were running. The regional therapy director (RTD) was interviewed on 8/13/2020 at 3:15 p.m. He said the facility was still accepting admission. The staffing coordinator was interviewed on 8/12/2020 at 12:02 p.m. The staffing coordinator said she worked with the master schedule. She said that her responsibility was if there was a call off then she was responsible to work the shift if she was not able to cover it. She said she knew there were open positions. However, she was not sure of how many open positions there were. The director of nurses (DON) was interviewed on 8/10/2020 at 4:44 p.m. The DON said she was recently hired, and she said that she knows the facility has staffing challenges. She said that they were currently hiring and seeking employment. She said that agency staff were being used to fill the gaps. She was aware the facility worked shorthanded. She said she agreed two CNAs for 55 residents was too much, and the plan was to have five CNAs for 6:00 a.m. to 6:00 p.m. She said four for 6:00 p.m. to 6:00 a.m. The DON said she had heard complaints from residents. She said she tells the residents to give them time, but understands their frustration as they get tired of hearing that. The DON was interviewed a second time on 8/12/2020 at 12:25 p.m. The DON said the facility recently reached out to colleges and schools to help get staff. She said office manager, housekeeping, and kitchen staff help with all care, to answer call lights, get water, pass room trays and to assist the resident as they can. The kitchen was fully staffed and they were cross trained with a six hour online course to assist the residents with meals. The nursing home administrator and the clinical consultant were interviewed on 8/13/2020 at 12:33 p.m. The NHA said he had developed a performance improvement plan to improve the staffing in the building. He said the facility expanded the nursing agencies which were used. He said when there was a call off, he expected the staffing coordinator to fill the position. He was not noticed if the facility was not fully staffed. He said there were staffing shortages everywhere and it was a challenge to get staff. The NHA confirmed that the facility had a great amount of turn over in the department heads. He said it was tough day to day to keep staff during a pandemic. He said the facility was working on developing incentives such as raffles, and bonuses. He said they were also working on the onboarding process and exit interviews. VIII. Failure to clear meal trays from dining areas and resident rooms. A. Observations A pile of dinner trays was observed in the kitchenette on 8/4/2020 at 9:23 p.m. The chapel dining room was observed on 8/9/2020 at 9:11 p.m. There were nine remaining dinner trays scattered on the tables in the chapel dining area. The trays still had food on them and many were uncovered. Dirty cups were stacked on a cart along with one dinner tray. There was an empty cart next to the drink cart, stacked with dirty cups. The drink cart and beverages were still in the dining area. There was an open undated gallon of milk, an open undated half gallon of lactose free milk, two dated pitchers of juice, one undated pitcher of juice and one undated pitcher of iced tea. The ice in the beverage bin was all melted. On 8/4/2020 at 9:05 p.m. a cart of dirty dishes was piled up and sat in the kitchen area by the nurses station. Several rooms had food trays on the bedside tables. On 8/9/2020 at 9:19 p.m. agency certified nurse aide (ACNA) #2 was observed removing two meal trays from room [ROOM NUMBER] and picked up a third as she walked to the kitchenette. B. Staff interviews ACNA #2 was interviewed on 8/9/2020 at 10:00 p.m. She said this was the first night she came on shift and there were dinner trays still in the dining area. ACNA #2 was interviewed on 8/9/2020 at 10:00 p.m. She said this was the first night she came on shift and there were dinner trays still in the dining area. Certified nurse aide (CNA) #2 was interviewed on 8/10/2020 at 3:52 p.m. She said CNA's help with tray pick up after meals. She said they had an empty cart they put the dinner trays on to be returned to the kitchen. She said they wipe down the tables after meals and help the residents clean up if needed. She said they had a bin in the kitchenette for dirty dishes from room trays. She said she clearing the meal trays after meals was important to prevent spreading illness. Registered nurse #3 was interviewed on 8/10/2020 at 3:58 p.m. She said clearing meal trays from rooms and the dining area was important to prevent food spoilage and foodborne illness. She said meal trays should be cleared after the resident finished their meal. She said clearing meal trays was also important to prevent spills which can contribute to falls. The registered dietitian was interviewed on 8/10/2020 at 2:15 p.m. She said CNAs were supposed to clear the trays from rooms and the chapel dining area. She could not say why the trays and drink cart were not cleared. The regional dietary manager (RDM) was interviewed on 8/10/2020 at 2:52 p.m. She said CNAs should pick up the trays after meals and return them to the kitchen. She said one of the dietary aides that evening was new and might not have known to pick up any remaining dishes before leaving for the night. The dietary manager (DM) was interviewed on 8/10/2020 at 3:11 p.m. She said CNAs were supposed to clear the trays from the dining areas and rooms and return them to the kitchen. ACNA #1 was interviewed on 8/10/2020 at 3:11 p.m. She said after meals she helps clear the meal trays and returns them to the kitchen. CNA #1 was interviewed on 8/10/2020 at 3:47 p.m. She said CNAs clear the meal trays. She said the dirty trays go onto a cart and the trash gets taken out. She said the cart is returned to the kitchen after meals. She said CNAs had a two hour window after meals to clear trays and return them to the kitchen. She said clearing meal trays is important to prevent foodborne illness. C. Follow-up The DON and the ADON were interviewed on 8/10/2020 at 4:44 p.m. The DON said an inservice was completed which directed the CNAs to remove the meal trays from the rooms, and the dietary staff would remove the meal trays from the dining room. If the dietary staff were not available then the CNAs would remove the trays.
F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Post nurse staffing information every day.** Based on observations, record review and interviews; the facility failed to ensure nurse staff was posted on a daily basis and the posted requirements were met. Specifically, the facility failed to ensure: -The nurse staff was posted on a daily basis; and, -The total number of registered nurses (RN), licensed practical nurses (LPN) and certified nurse aides (CNA) were listed. Cross-reference F725 failed to ensure sufficient staffing to properly care for resident needs I. Record review The staff posting records dated from 8/1/2020 to 8/11/2020 had the facility name and daily census of 55 listed, which was the same census number for all 11 days. The hours worked for each discipline, the licensed practical nurse (LPN) and the certified nurse aide (CNA) were different day by day even though the census number was the same. -On the day and night shift there were between 12 and 24 hours listed for LPNs -On the day shift there were between 40, 48 and 56 hours listed for CNAs. The evening shift hours were between 12, 16, 18 and 20 hours. And the night shift hours 16, 24, 32 and 36. -On 8/5/2020 there showed no CNA hours between 6:00 p.m. to 10:00 p.m. II. Observations and interviews Nursing home administrator in training (NHAT) was interviewed on 8/13/2020 at 3:30 p.m. He said the numbers next to the discipline RN, LPN and CNA on the staff posting form were the number of hours needed to work for that day for that discipline. On 8/13/2020 at 1:13 p.m. observations showed no staff posting list by the front door. The nursing home administrator (NHA) had the posting in his office with a date in the posting frame 8/11/2020. He said he would change the posting out to reflect the current date of 8/13/2020. Additionally, the posting did not include the correct date and the total number of each staff.

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	065285	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	**4001 HOME ST CASTLE ROCK, CO 80108**

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F 0732 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 7)

F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide programs that addressed dementia care for two (#3 and #17) of five of the 28 sampled residents. Specifically, the facility failed to comprehensively assess and effectively identify person-centered approaches for dementia care for Residents #3 and #17. Findings include: I. Resident census and conditions The 8/11/2020 resident census and condition form documented 59 total residents with 23 residents (39%) with dementia and 41residents with behavioral healthcare needs (70%). The facility did not have a secure unit but did have a wander guard system in place. II. Facility Policy The policy Dementia-Clinical Protocol, updated March 2018, was received from the NHA on 8/12/2020. It read in pertinent part, The IDT (interdisciplinary team) will review the past and current physical, functional, and psychosocial status of each individual with dementia to formulate an accurate overall picture of the individual's condition, related complications, and functional impairments. Using several sources, including the resident (if appropriate), family and information from prior records, the following information will be collected and documented in the resident's record; Life experiences (previous careers, hobbies, areas of interest); Personal preferences (food, music, daily routine); Overall health and medical conditions, including the presence of pain; Cognitive status and related abilities; Mood behavior patterns, including how the resident typically expresses physical, emotional and psychosocial needs, including distress; and current medications. III. Resident #3 A. Resident status Resident #3, aged 60, was admitted to the facility on [DATE]. According to the August 2020 CPOs, the resident's [DIAGNOSES REDACTED]. The 7/30/2020 MDS assessment documented Resident #3 required supervision for mobility. The resident was documented to wander one to three days and his wandering put him at significant risk of getting to a potentially dangerous place such as outside the facility. The MDS documented there was no discharge plans for Resident #3. B.Observations 8/4/2020 -At 9:15 p.m., observations revealed the resident wandering the hallway. The resident had a wander guard bracelet on. 8/5/2020 -At 12:10 p.m., the resident was lying in bed awake, he had a sitter with him, although the sitter was not interacting with the resident. -At 4:00 p.m., the resident was sitting on the edge of the bed. The resident had no interaction with the sitter. The resident had no activity materials. The soft instrumental music was playing, however, it was not very loud, so it was difficult to hear. 8/6/2020 -At approximately 9:00 a.m., the resident was having his vital signs taken. When the vitals were taken by the CNA, the CNA did not explain to the resident what was happening before beginning. The CNA was observed to place the pulse oximeter onto the resident ' s finger without notifying the resident. The resident was sitting on the edge of the bed. 8/11/2020 -At 10:00 a.m., the resident was observed to be sleeping in bed. The sitter was sitting in a chair in the room with the door closed. -At 12:43 p.m., the resident was observed to continue to sleep. His noon meal tray was on the bedside table, and had not been touched. The CNA #2 said she the resident had been sleeping since she has been sitting with him. She said she started to sit with him at 11:00 a.m. 8/12/2020 -At approximately 4:00 p.m., an agency staff member was sitting with the resident. The resident was lying in bed sleeping. Soft instrumental music was playing. -At approximately 5:00 p.m., the resident was up and walking in the hallway with the agency staff member. 8/13/2020 -At 9:00 a.m., the CNA #9 was sitting with the resident. The resident was sleeping in bed. The door was closed. -At 11:00 a.m., the CNA #9 was sitting with the resident. The resident was sleeping in bed. The door was closed. The CNA #9 had a computer in front of her. -At 3:06 p.m., CNA #10 was observed to be sitting with the resident. The resident was lying in bed awake, the door was closed. She was looking at her phone and not interacting with the resident. The room did have soft instrumental music playing. C.Record review The behavior care plan last revised on 4/22/2020 identified the resident received an antipsychotic for [MEDICAL CONDITION] and had the ptotel to display unprovoked verbally and physically aggressive behavior toward others. The care plan identified the resident displayed episodes of sitting and laying on the floor despite education, redirection and encouragement to sit or lay in a chair or bed. Pertinent interventions included, redirect and assist resident away from confrontational situations, assist the resident to a quieter calmer area of the living environment to decrease stimulation, keep in light of sight while out of room, approach the resin calmly and redirect to alternative location and explain why behavior was inappropriate. The August 2020 CPO included: -[MEDICATION NAME] 15 mg by mouth one time a day with a start date of 12/11/19 for associated [DIAGNOSES REDACTED]. The nursing and behavior progress notes showed the behaviors which were being tracked, included, unprovoked verbally and physically aggressive behavior toward others, smearing feces and urinating in inappropriate places, and sitting and laying on the floor despite education, redirection and encouragement to sit/lay in a chair or bed. The tracking system showed the specific behaviors were being tracked, however there was no indication of what behavior the resident exhibited, as it was initialed by staff as occurring, however, no specifics of what type of behavior was exhibited by the resident. Further review of the record showed the resident ' s last activity assessment was 2/2/2020. The activity care plan revised on 2/14/2020 identified the resident was dependent on staff for meeting his emotional, intellectual, physical and social needs related to cognitive deficits. Pertinent interventions included, all staf to converse with Resident #3 while providing care, assist with community activities, monitor for need of 1:1 bedside/in room visits and activities if unable to attend our to froom events, offer materials and assist with materials, provide calendar, preferred activities are reading, card games, cars, airplanes and being outside. The one-to-one program documentation for August 2020 revealed documentation on 8/6, 8/7/2020 and it documented, engaged with CNA (certified nurse aide). -There was no amount of time indicated for which the CNA had spent with the resident On 8/13/2020 the one-to-one program documented, walks, listens to music and exposed to sensory items. -There was no amount of time indicated for which the CNA had spent with the resident. Additionally, the desired resident response was blank. The activity participation record for August 2020 showed the resident was independent in listening to music, and received assistance with outdoor visits. An undated document which the director of nurses (DON) provided on 8/13/2020 at approximately 2:00 p.m The DON said this document was provided during training back in May 2020. It revealed the resident liked: -To listen to Led Zeppelin or old rock; -To sing with a microphone; -Go outside; -Look at picture books; -Share stories; -Get a coke; and, -Games such as connect four or battleship. However, as observations showed above there was no picture books or games in the room, no meaningful interaction with the one-on-one sitter, and no old rock or Led Zeppelin playing on the stereo. D.Interviews Registered nurse (RN) #2 was interviewed on 8/9/2020 at approximately 9:30 p.m. The RN said the resident had a wander guard in place. He said that on his shift, he remained in his room the majority of the time. The SSD and the director of nurses (DON) were interviewed on 8/12/2020 at 11:15 a.m. The SSD said he was recently employed and he was not as familiar with the resident. He said Resident #3 had a history of [REDACTED]. He said the resident spent the majority of his time in his room with music playing. He said he also enjoyed walking. He said he had not been involved with the sitter, and had not provided any training to staff since his employment in June 2020. The SSD said Resident #3 was currently receiving [MEDICATION NAME] for behaviors, and the behaviors were tracked. The activities director #2 (AD) #2 was interviewed on 8/12/2020 at approximately 1:00 p.m. The AD #2 said she had just started and was not familiar with Resident #3. She said that the resident was on a one-on-one program. The SSD was interviewed a second time on 8/12/2020 at approximately 2:00 p.m. The SSD said that after reviewing the record the resident received the [MEDICATION NAME] for the associated [DIAGNOSES REDACTED].#9 was interviewed on 8/13/2020 at approximately 9:00 a.m. The CNA said that she was told that he will become combative at times, during personal care. She said he did not want to receive help with pulling up his pants. She said she was aware he liked to walk and she would take him for a walk when she could. Otherwise, no other specific training was provided. CNA #10 was interviewed on 8/13/2020 at 3:06 p.m. The CNA said that she had dementia training on the computer based program. She said that she was told not to get too close to the resident. She said she did not receive anything more specific of special needs for Resident #3. IV. Resident #17 ' s status Resident #17, age 84, was admitted on [DATE]. According to the August 2020 computerized physician orders [REDACTED]. The 7/23/2020 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems with severely impaired cognitive skills for daily decision-making. He required extensive assistance of one person with transfers, dressing, toilet use and personal hygiene. One person for supervision and oversight with encouragement for meals. A. Observations and resident interviews Resident #17 was observed on 8/4/2020 at 9:47 p.m. trying to open doors to the locked utility closets in the hallway and then he entered resident room [ROOM NUMBER]. He walked out of room [ROOM NUMBER] and entered Resident #8 ' s room. He rummaged through the resident ' s personal belongings on the shelves. Resident #8 used her call light to alert the staff and told Resident #17 to get out of her room. The resident

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F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 8) continued to touch her things and until the certified nurse aide (CNA) #4 redirected Resident #17 to his room. She was in the room with him a short time then left him in there and shut the door when she left. Resident #8 was interviewed on 8/4/2020 at 9:52 p.m. She said she was upset when Resident #17 entered her room. She yelled at him when he was in there to get out. She had to use the call light and yell for staff to come get him out of her room because he touches all of her things. B. Record review The care plan for wandering risk dated 7/23/2020 said the resident will have no episodes of elopement. The interventions were to document any wandering behaviors and/or exit seeking behaviors in behavior book or progress notes and to notify the family and the physician as needed. Encourage the resident to attend activities frequently throughout the day and check placement of the wanderguard per facility protocol. Review of the comprehensive care plan on 8/13/2020 revealed that the facility failed to identify and address interventions specific to person-centered support for dementia to include the resident ' s frequent wandering into other resident rooms and rummaging through their personal items. Nurse note dated 7/23/2020 00:04 a.m. read in pertinent part; Staff was able to get the resident to go to bed, he had been resistant to go to bed (the note does not say how long the staff tried to assist the resident to bed or how they assisted him). Resident #17 was also resistant to personal cares, and eating. Resident ambulates throughout the building on his own. His gait was slow and steady. He was alert to himself only and he had no short term memory. He was difficult to redirect, going into different resident rooms, break rooms, and he attempted to go outside. He stayed close to the nurses station, or went into the nurses station. He was pleasant, but very confused and wanted the facility to call a cab for him to go home. The nurse informed him this was his home, he stated to the nurse I don't believe you. Monitoring continues. Nurse note dated 7/30/2020 at 7:50 p.m. read; Resident stayed in his room most of the shift. Refused meals and showers. (The resident said,) Just leave me alone. Nurse attempted to get him up with no availability. C. Staff interviews CNA # 4 was interviewed on 8/12/2020 at 4:05 p.m. She said Resident #17 stayed in his room most of the day. She said he wandered at nighttime. She said she was not trained on dementia care at the facility and no specific training for Resident #17. She said it was important to redirect residents and refocus the ones with dementia for what she had learned in the past. She said she redirected him back to his own room when he was found in another resident ' s room. She said he would usually lay down and sleep when she took him to his room. Social service director (SSD) was interviewed on 8/13/2020 at 10:39 a.m. He said he just started at the facility and he had not yet had any training on dementia specifically. He said there were no specific assessments used for dementia residents. He said he talked to resident families to get the most information about the resident on cares and how to interact with them. The director of nurses (DON) was interviewed on 8/13/2020 at 10:42 a.m. She said she read the policies on dementia when she started a month ago. She said the care plan was updated for each resident on each one specifically to their needs.
F 0835 **Level of harm** - Actual harm **Residents Affected** - Few	**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, interview and record review, the facility failed to be administered in a manner that enabled it to use its resources effectively and efficiently to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically: The record review and interviews with staff showed the facility failed to provide adequate supervision to prevent smoking accidents. The investigation revealed an ineffective system in implementing a facility policy on smoking. These failures contributed to an immediate jeopardy situation and a resident experiencing harm level of injury related to smoking with oxygen which resulted in [MEDICAL CONDITION] his face. Cross-reference F689: The facility failed to ensure resident safety with accident hazards. The facility's failure to identify and address smoking related accidents resulted in the facility having an immediate jeopardy. The facility's failure to protect residents from accident hazards was cited at a K level. Cross-reference F725: The facility failed to have adequate nurse staffing. The facility was cited at cited at a F level widespread for more than minimal harm. Additional failures included, lack of leadership to address sufficient nurse staffing, which as resulted in inadequate staffing, the facility had delayed call light response, failed to provide assistance with activities of daily living (ADLs), lack of pressure ulcer interventions to prevent pressure ulcers, and an adequate infection control program. Findings include: I. Current findings in area of quality of care-Failure to ensure facility policy was implemented to identify, prevent, six supervised smoking residents (Residents #1, #2, 21, #22, #24, and #25). A. Facility policy The facility read in pertinent parts, will assess each stated smokers ' level of support and supervision by completing a smoking assessment. The facility may impose smoking restrictions on residents at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. Residents are encouraged to wear smoking aprons, and in addition, they will have the indirect supervision of a staff member, worker at all times while smoking Residents may not have or keep cigarettes, lighters fluids including butane gas, or any other forms of gas or fluids at any time. B. Cross-reference F689K. Facility administration failed to have a system/plan to ensure residents who used oxygen and who had access to the designated smoking areas were monitored, assessed and to implement smoking interventions, and to ensure the smoking policy was followed. These failures created situations that resulted in an immediate jeopardy situation. - Observation, record review, and interviews with staff, and residents demonstrated the facility did not have an effective system in place to implement preventive safety measures for residents who were to be supervised with smoking. -Smoking assessments were not completed accurately to ensure the most effective interventions were in place. The care plans did not match the assessments and interventions. -Smoking paraphernalia was not stored with staff and safely secured. -Staff were not adequately trained to ensure they knew the importance of smoking safety which included, but not limited to the use of oxygen. C. Interviews The NHA was interviewed on 8/13/2020 at 12:33 p.m. The NHA said he was called the morning of 7/26/2020 in regards to Resident #1 smoking with oxygen and as a result received [MEDICAL CONDITION] the oxygen exploding with the lit cigarette. The NHA said smoking assessments were completed on all of the residents who smoked. He said he was not involved with any of the assessments, and he was not aware some of the previous assessments were not accurately completed and that the care plans were not accurate or followed in regards to the smoking interventions. The NHA said his employment started at the facility November 2019. He said the facility did have a smoking policy, however, he was not sure if any training had been completed with the staff during his administration prior to the incident from 7/26/2020. He said he himself had not completed any training on smoking with the staff. He said the director of housekeeping who was out supervising the residents during the incident on 7/26/2020 did not have training on the smoking. II. Current findings in area of quality of care Facility administration failed to consistently provide adequate nursing staff which considered the acuity and [DIAGNOSES REDACTED]. A. Cross-referenced citations As a result of inadequate staffing, the facility had delayed call light response, failed to provide assistance with activities of daily living (ADLs), lack of pressure ulcer interventions to prevent pressure ulcers, and an adequate infection control program. Cross-reference F-677, Maintain activities of daily living for dependent residents; Cross-reference F-686, Treatment, prevent pressure ulcers;and, Cross-reference F-880, Infection control program. B. Staff turnover inadequacies The facility had experienced a significant staff turnover with the department heads. The turnover was as follows for staff member and start dates: Director of nurses (DON) 6/24/2020; Assistant director of nurses (ADON) 6/30/2020; Medical records director 7/8/2020; Social service director 6/15/2020; Activity director #1 8/6/2020; Activity director #2 7/23/2020; Dietary manager 7/12/2020; Maintenance director 8/5/2020; and, Housekeeping supervisor August 2020. C. Interviews The DON and the ADON was interviewed on 8/13/2020 at approximately 11:00 a.m. The DON said she had started to work at the facility approximately five weeks ago. She said that since working at the facility the staffing has been a challenge. She said that the facility did not staff according to accuity, however, she was activity working on a plan to staff to accuity. The DON was aware that the facility worked without the appropriate amount of staff at times. The NHA was interviewed on 8/13/2020 at 12:33 p.m. The NHA said he was aware of the turnover in both his department heads, and the front line nurse staffing. He said a performance improvement plan had been written and he was using multiple agencies to help cover open shifts. He said they were also holding raffles, and starting a bonus program. He said if he received a complaint from a resident, he told them they were doing everything they could. He said he was not notified when the staffing was not adequate. The NHA said stability of staff was tough day to day during the pandemic. He said that the facility was going to start focusing on the onboarding process of the staff and complete exit interviews. III. Previous survey dated 6/5/2020 A. Previous F835 The facility was cited F835 on 6/5/2020 for the administration failing to have an effective system in implementing facility policy on the following areas nutrition, hydration and in maintaining acceptable nutritional parameters to ensure adequate nutrition, scope of H. The

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F 0835 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 9) plan of correction indicated a consulting nursing home administrator (CNHA) was to be used to provide consultation and oversight. B. Interview The NHA was interviewed on 8/13/2020 at 12:33 p.m. The NHA said the CNHA was used to bounce ideas off of, and had one-on-one with the CNHA one time a week. He said he was positive that the direction he was receiving was heading in the right direction.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on observations, record review and interviews the facility failed to ensure accuracy of records for six residents (#2, #6, #9, #14, #15, #16) out of 29 sample residents. The facility failed to: -Use a current set of vital signs on the daily COVID 19 monitoring forms; and -Monitor medication administration records for accuracy. Findings include: I. Failed to use a current set of vital signs on COVID 19 monitoring forms II. Professional Reference The Colorado Department of Public Health and Environment issued a Health Alert Network Broadcast on July 31, 2020. It read in pertinent part, All residents in residential care facilities should continue to be assessed for symptoms of COVID-19 at least daily. Retrieved 8/20/2020 from https://www.colorado.gov/pacific/sites/default/files/ 020%20Health%20Alert%20Network%20Update%20-%20%20COVID-19%20.pdf. III. Facility policy The policy Coronavirus/COVID-19 was received from the director of nursing (DON) on 8/13/2020. It read in pertinent part, Every disease is different. The local, state and federal authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment, and skilled nursing facility response related to the specific disease threat. Revisions will be made upon the regulatory requirements and the structure and staffing specific to the facility. A. Record review Covid-19 monitoring forms were reviewed for six of the 29 sampled residents (#2, #6, #9, #14, #15, #16). Covid-19 monitoring forms for Resident #2 revealed: -The 8/2 and 8/1/2020 monitoring forms documented the vital signs were recorded on 7/31/2020. -The 7/29/2020 monitoring form documented vital signs were recorded on 7/28/2020. Covid-19 monitoring forms for Resident #6 revealed: -The 8/6/2020 monitoring form documented the vital signs were recorded on 8/5/2020. -The 8/3/2020 monitoring form documented the vital signs were recorded on 8/2/2020. -The 7/27/2020 monitoring form documented vital signs were recorded on 7/26/2020. -The 7/23/2020 monitoring form documented vital signs were recorded on 7/22/2020. -The 7/20/2020 monitoring form documented vital signs were recorded on 7/19/2020. -The 7/15, 7/16, and 7/17/2020 monitoring form documented vital signs were recorded on 7/14/2020. -The 7/13/2020 monitoring form documented vital signs were recorded on 7/11/2020. -The 7/7 and 7/8/2020 monitoring form documented vital signs were recorded on 7/6/2020. Covid-19 monitoring forms for Resident #9 revealed: -The 8/1/2020 monitoring form documented the vital signs were recorded on 7/31/2020. -The 6/19/2020 monitoring form documented the vital signs were recorded on 6/18/2020. -The 6/17/2020 monitoring form documented vital signs were recorded on 6/16/2020. -The 6/5/2020 monitoring form documented vital signs were recorded on 6/4/2020. Covid-19 monitoring forms for Resident #14 revealed: -The 8/11, 8/10, and 8/9/2020 monitoring form documented the vital signs were recorded on 8/8/2020. -The 8/8, 8/6, 8/5, and 7/30/2020 monitoring form documented the vital signs were recorded on 7/19/2020 (pulse), 7/25/2020 (temperature), 7/26/2020 (pulse), 7/27/2020 (respirations, oxygen saturation). -The 7/22, 7/21, and 7/20/2020 monitoring form documented vital signs were recorded on 7/19/2020. -The 7/16, 7/15, and 7/14/2020 monitoring form documented vital signs were recorded on 7/10/2020. -The 7/9, 7/8, and 7/6/2020 monitoring form documented vital signs were recorded on 7/4/2020. -The 7/2, 7/1, and 6/30/2020 monitoring form documented vital signs were recorded on 6/29/2020. Covid-19 monitoring forms for Resident #15 revealed: -The 8/1 and 8/2/2020 monitoring form documented the vital signs; respirations, oxygen saturation, and temperature were recorded on 7/30/2020. -The 7/19/2020 monitoring form documented the vital signs; respirations, oxygen saturation, temperature were recorded on 7/18/2020. -The 7/8/2020 monitoring form documented the vital signs; respirations, oxygen saturation, temperature were recorded on 7/7/2020. Covid-19 monitoring forms for Resident #16 revealed: -The 8/1/2020 monitoring form documented the vital signs were recorded on 7/31/2020. -The 7/1/2020 monitoring form documented the vital signs were recorded on 6/30/2020. IV. Anti-anxiety medication monitoring for a resident not taking anti-anxiety medication. A. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 8/12/2020 at 11:50 a.m. She said she does take resident vital signs. She said she writes them down and gives them to the nurse to enter into the computer. She said if a resident refuses, she notifies the nurse and the nurse will attempt to get the vital signs. She said some of the dementia residents do not like the blood pressure cuff and will scream when it starts to tighten. She said she will take all the vitals the residents allow her to get. She said vitals were taken twice a day. Licensed practical nurse (LPN) #3 was interviewed on 8/12/2020 at 2:50 p.m. She said vital signs were taken once a shift, so twice a day. She said vital signs were recorded on the treat record and refusals from residents should be documented there as well. She said previous vital signs should not be used on a Covid-19 monitoring form. She said the vitals on the monitoring form should be from the same day. She said accuracy of vital signs was important to catch potential signs and symptoms of illness. The director of nursing (DON) was interviewed on 8/13/2020 at 10:40 a.m. She said vital signs should be taken once a shift and documented on the treatment record. She said resident refusals should be documented there too. She said past vital signs should not be documented on the Covid-19 monitoring forms. She said the vitals signs documented on the form should be from the same date as the form. V. Accuracy of Medication Administration Record [REDACTED]. The orders revealed Resident #14 was being monitored for side effects of anti-anxiety medication. The orders documented the resident had never been prescribed said anti-anxiety medication. B. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 8/12/2020 at 2:50 p.m. She said if a resident is not taking an anti-anxiety medication there was no need for them to be monitored for side effects. The DON was interviewed on 8/13/2020 at 10:40 a.m. She said anti-anxiety medication tracking should be discontinued when the medication was discontinued. She said the resident was going to begin taking an anti-anxiety medication but the physician started her on something else. She said the Medication Administration Record [REDACTED]. She said the physicians input their own orders and medications for residents. She said she would double-check their orders to ensure accuracy.
F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a plan that describes the process for conducting QAPI and QAA activities.** Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to, accident hazard, pressure ulcers, infection control, dementia care and staffing issues. Findings include: I. Cross-reference citations Cross-reference F689: The facility failed to ensure resident safety with accident hazards. The facility's failure to identify and address smoking related accidents resulted in the facility having an immediate jeopardy. The facility's failure to protect residents from accident hazards was cited at a K level. Cross-reference F686: The facility failed to prevent the development of three stage III pressure sores. The facility's failure to identify and prevent the pressure ulcer was cited at a harm G level. Cross-reference F744: The facility failed to effectively identify person-centered approaches for dementia care. The facility was cited at a D level. Cross-reference F880: The facility failed to implement an effective infection control program. The facitliy was cited at a F level widespread for more than minimal harm. Cross-reference F725: The facility failed to have adequate nurse staffing. The facility was cited at a F level widespread for more than minimal harm. II. Repeat deficiencies Review of the facility's regulatory record revealed it failed to operate a QA program in a manner to prevent repeat deficiencies. F689 During the 5/5/2020 abbreviated survey, F 689 was cited at an immediate temporary level. During the abbreviated survey on 8/13/2020 the facility was cited at an immediate jeopardy level K which was an increase in the scope and severity. F744 During the 5/5/2020 abbreviated survey, F 744, was cited at a D level. The facility was currently cited at a D level for a potential for more than minimal harm on 8/13/2020. F880 During the 5/5/2020 abbreviated survey, the facility was previously cited at widespread potential for more than minimal harm on 5/5/2020 at an F and currently cited at an F. Staff interviews The nursing home administrator (NHA) was interviewed on 8/13/2020 at 12:33 p.m. The NHA said he was aware of the turnover in both his department heads, and the front line nurse staffing. He said a performance improvement plan had been written and he was using multiple agencies to help cover open shifts. The NHA confirmed that the facility had a great amount of turn over in the department heads. He said it was tough day-to-day to keep staff during a pandemic. He said the facility was working on developing incentives such as raffles, and bonuses. He said they were also working on the onboarding process and exit interviews. The medical

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	065285	A. BUILDING _____ B. WING _____	08/13/2020

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CASTLE ROCK CARE CENTER	4001 HOME ST CASTLE ROCK, CO 80108

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F 0865 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 10) director (MD) was interviewed on 8/13/2020 at 2:25 p.m. The MD said he attended the QAPI monthly. He said the committee focused on the corrections put into place for the past citations. He said he reviewed infections and ensured education was provided for COVID-19. He said he was made aware of the immediate jeopardy in relation to the supervised smoking issues and he had some additional suggestions to keep residents safe. He said he collaborated with the team. The NHA, clinical nurse consultant, and the DON were interviewed on 8/13/2020 at 4:16 p.m. The NHA said the quality assurance meeting was held monthly. The entire interdisciplinary team attended the meeting. The meeting had an agenda which was followed. The DON was newly hired and only attended one QAPI meeting, which was completed shortly after her start date. The NHA said some of the areas of concern come from the past citations, resident council, complaints and incidents. He said that performance improvement plans were written for the previous cited deficiencies. The NHA said infection control was reviewed in QAPI. He said they had identified handwashing needing to improve, and education was needed daily and they might need more different types of education, as everyone learned differently. He said the QAPI talked about the infections and infection control issues, but they did not track them. The NHA said pressure ulcers were discussed in every QAPI with the medical director and the IDT team. He said the pressure ulcers were tracked and the goal was to reduce pressure injury. The DON said the facility recently contracted with a new wound physician, as the pressure ulcers were not being staged. He said the resident care was his first priority and having additional staff would help with the care issues. The NHA said he was cited on dementia care in May 2020. He said he had hired two new activity directors, and purchased music and encouraged licensed staff to help with individual programs. He said staff had been trained on dementia care, however, the staff needed additional training. He said he needed more guidance on dementia care. The clinical nurse consultant said she was working to build a team, and resident safety was highest priority.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the possible development and transmission of Coronavirus (COVID-19). Specifically, the facility failed to: -Follow proper protocol for use of personal protection to ensure compliance with recommended standards for respiratory hygiene and cough etiquette were provided to residents; -Ensure staff performed hand hygiene in-between caring for multiple residents; and -Failure to ensure EPA registered cleaners were used to clean communal surfaces. -Offer hand hygiene to residents before meals; and -Ensure a complete and thorough screening process for employees and visitors; Findings include: I. Failure to offer hand hygiene to residents before meals A. Facility Policy B. Observations 8/5/2020 Observations of the noon meal from 12:25 p.m. to 12:50 p.m. -At 12:25 p.m., the lunch cart arrived on the unit. -At 12:27 p.m., certified nurse aide #7 (CNA #7) was observed to deliver a lunch tray to the resident in room [ROOM NUMBER]. He did not offer hand hygiene to the resident. -At 12:29 p.m. , CNA#7 delivered a lunch tray to the resident in room [ROOM NUMBER]. He did not offer hand hygiene to the resident. -At 12:33 p.m., CNA#7 delivered a lunch tray to the resident in room [ROOM NUMBER]. He did not offer hand hygiene to the resident. -At 12:37 p.m., CNA#7 delivered a lunch tray to the second resident in room [ROOM NUMBER]. He did not offer hand hygiene to the resident. -At 12:45 p.m., CNA#7 delivered the lunch tray to the resident in room [ROOM NUMBER]. He did not offer hand hygiene to the resident. Lunch Observations were conducted on 8/6/2020 from 11:56 a.m. thru 12:40 p.m. -At 12:09 p.m. an unidentified CNAd delivered lunch to a male resident. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 12:14 p.m., an unidentified CNA delivered a room tray to Resident #15. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 12:30 p.m. a CNA delivered a room tray to Resident #16. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. Dinner observations were conducted on 8/6/2020 between 5:00 p.m. thru 5:45 p.m. -At 5:07 p.m., the first meal was delivered to a male resident by the director of nurses (DON). She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 5:11 p.m., the DON delivered a meal to another male resident. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 5:13 p.m., CNA #4 delivered a meal to a female resident. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 5:17 p.m., the nursing home administrator (NHA) delivered a meal to Resident #15. He set the plate, silverware, and napkin on the table in front of the resident. He did not offer to assist the resident with hand hygiene. -At 5:19 p.m., CNA #4 delivered a meal to another female resident. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. -At 5:23 p.m., the DON delivered a meal to Resident #16. She set the plate, silverware, and napkin on the table in front of the resident. She did not offer to assist the resident with hand hygiene. C. Staff interviews CNA #1 was interviewed on 8/10/2020 at 3:47 p.m. She said she had been trained to offer hand hygiene before meals. She said she assisted residents with soap and water if they were in their rooms and provided hand sanitizer to those in the dining area. CNA #2 was interviewed on 8/10/2020 at 3:52 p.m. She said she had been trained to assist residents with hand hygiene in their rooms using soap and water and if she was assisting in the dining room she provided residents hand sanitizer before their meal. She said hand hygiene was important to prevent the spread of illness at the facility. Registered nurse (RN) #3 was interviewed on 8/10/2020 at 3:56 p.m. She said hand hygiene should be offered to residents before they eat, after activities, when soiled, and as often as needed. She said hand hygiene was important because it prevents the spread of illness. The assistant director of nursing (ADON) was interviewed on 8/10/2020 at 4:15 p.m. She said she did an in-service training for the staff regarding hand hygiene. She said the staff could use a washcloth to wash the resident's hands if nothing else was available. She said she would pay closer attention to the staff when it pertained to hand hygiene. She included she would get the hand hygiene policy and give a copy of it to each staff member. The DON was interviewed on 8/10/2020 at 4:45 p.m. She said hand hygiene was to be offered to residents before meals. She said staff should assist residents perform hand hygiene if the residents could not complete it themselves. II. Cleaning of communal areas A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (Update April 12, 2020), retrieved from: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html#infection_control, Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for [DIAGNOSES REDACTED]-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed. 1. Tables and chairs A. Observations The activities assistant (AA) was observed on 8/6/2020 at 2:56 p.m. She was wiping down the tables and chairs in the activity room, preparing for an activity. She was using the disposable personal washcloths to wipe down the tables and chairs. The washcloth packaging instructed the clothes were for cleaning the perineal area and not intended for the treatment, mitigation, or prevention of disease. C. Staff interviews CNA #2 was interviewed on 8/13/2020 at 11:50 a.m. She said surfaces and vitals equipment should be wiped down with the germicidal wipes, not the disposable personal washcloths. The AA was interviewed on 8/13/2020 at 1:15 p.m. She said she received training from the DON and was to only use germicidal wipes on surfaces before activities, not the personal washcloths. The ADON and DON were interviewed on 8/10/2020 at 4:44 p.m. They said the germicidal wipes should be used when wiping down surfaces that residents will be utilizing. 2. Water dispenser A. Observations Resident #10 was observed on 8/6/2020 at 10:30 a.m. to take a cup from the cup holder near the water dispenser located in the common area. Too many cups came out of the holder so the resident put them all back into the top of the cup holder after he touched them all with his hands. He used the one cup to fill water from the dispenser. The dispenser was not sanitized after the use. On 8/9/2020 between 9:50 p.m., and 10:18 p.m., three different residents were observed dispensing water into their own water containers. The dispenser was not sanitized in between each resident's use. B. Interview CNA #1 was interviewed on 8/10/2020 at 3:47 p.m. She said she was not sure who was responsible for wiping down the water dispensers after they had been used. She said they should be wiped down after each use. She said she had seen housekeeping wiping them down but was not sure how often they did it. RN #3 was interviewed on 8/10/2020 at 3:56 p.m. She said the water dispensers should be wiped down daily and after a resident used it. She said everyone was responsible for wiping it down if they witnessed it being used. The ADON and DON were interviewed on 8/10/2020 at 4:44 p.m. They said the water dispenser should be sanitized by housekeeping every day and between uses. C. Follow- up On 8/10/2020 at approximately

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 11) 12:00 p.m., the water dispensers were removed from the common areas. III. Face masks use A. Professional reference The Center for Disease Control (CDC), Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (4/30/2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#minimize, (Update April 13, 2020) Patients may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room. Screening for symptoms and appropriate triage, evaluation, and isolation of individuals who report symptoms should still occur. B. Observations Observations on 8/4/2020 of residents not wearing face masks; - At 9:04 p.m., Resident #10 was observed in the lobby, not wearing a face mask. - At 9:10 p.m. Resident #17 was observed pacing the hallways, not wearing a mask. He passed by several staff members. None of them offered to help him don a face mask. - At 9:16 p.m., two female residents were observed in the common area, not wearing masks. Staff passing them in the common area did not stop and offer assistance with donning a face mask. Observations on 8/5/2020 of residents not wearing a face mask; -At 4:04 p.m., a male resident was sitting in the common area without a face mask. -At 3:55 p.m., Resident #23 was observed in Resident #6's room, not wearing a face mask. Resident #23 was also within six feet of Resident #6. -At 3:57 p.m., two male residents in the common room were not wearing face masks. The staff did not offer assistance donning a face mask. -At 3:59 p.m., two female residents walking in the hallway were not wearing face masks. The staff did not offer assistance donning a face mask. -At 4:04 p.m., a male resident in the common area was not wearing a face mask. Observations on 8/5/2020 of residents not wearing a face mask; -At 2:00 p.m., a male resident entered the building from the smoking courtyard, not wearing a mask. A female resident entered the building from the smoking courtyard, not wearing a facemask. The female resident was receiving assistance from a staff member. The staff member did offer the resident a face mask. C. Resident interviews Resident #13 was interviewed on 8/5/2020 at 2:02 p.m. He said staff had never offered him a face mask when they came in to provide him care. D. Staff interviews CNA #1 was interviewed on 8/10/2020 at 3:47 p.m. She said the staff were supposed to offer masks and donning assistance to residents. She said some residents simply refused to wear face masks. She said if they refuse the masks the staff was to encourage social distancing. She said some residents forgot about wearing a mask and needed reminders. She said face masks for the residents were kept on the nurse's medication cart and in the nurse's station. CNA #2 was interviewed on 8/12/2020 at 1150 a.m. She said she trades out resident fabric face masks each shift or when it is soiled. She said the fabric masks go through the facility laundry. RN #3 was interviewed on 8/10/2020 at 3:56 p.m. RN #3 said the staff were to encourage residents to use face masks. She said some residents refuse to wear a face mask. She said if a resident refuses staff was to remind them of the importance of face masks and encouraged to stay in their room if they do not wish to wear a face mask. She said staff also educated residents about social distancing and that the tape on the floor was measured six feet apart. The ADON and DON were interviewed on 8/10/2020 at 4:44 p.m. The DON said the staff were to offer residents face masks every shift and document in the treatment record if the resident refused or accepted. IV. Screening process Facility Policy The facility screening process was provided by NHA on 8/13/2020 at 9:14 a.m. The process was as follows: 1. Sanitize hands when you enter the building. 2. Be screened by a nurse or screener at the front door. (Do not screen yourself) 3. Have your temperature taken. If higher than 99.6 you cannot enter the facility. 4. Be screened on both sheets. There is one you sign and the other has more symptoms to screen. 5. Use the pen from the clean jar and put it in a used jar when finished. 6. Take your mask from a set of bags for the appropriate day of week. 7. Take your goggles from the clean bag of goggles in front of the desk. 8. If there are no goggles, then use a face shield or use the mask that has a face shield attached to it. 9. When screening lab tech or hospice RN only, please have then sign the PBJ (orange) binder and screen them using the form that is in the front of that binder. It includes who they work for and their positions. 10.Once screening is complete, give the star color of the day for their name badge to show they have been screened. 11.When finished with your shift, put your mask in the bag of the day. Put your goggles in the dirty bag in front of the receptionist desk. 12.Sanitize your hands. B. Observations On 8/4/2020 at 9:04 p.m., a pharmacy delivery employee was observed to approach the front door of the facility. CNA #8 answered the door. She asked the pharmacy employee if he knew where to go and let him walk into the building. She did not screen the pharmacy employee or encourage the use of hand hygiene before he entered the resident area. -At 9:08 p.m. RN #1 met surveyors in the lobby of the facility. She showed surveyors into the facility without a screening or encouraging hand hygiene. -At 9:20 p.m. RN #1 asked surveyors to wait at the nurse's station while she retrieved the thermometer and screening forms. C. Staff interviews The nursing home administrator (NHA) was interviewed on 8/4/2020 at approximately 9:45 p.m. The NHA was informed of the lack of screening. The NHA said everyone needed to be screened when entering the building. He said he would provide training to RN #1. CNA #1 was interviewed on 8/10/2020 at 3:47 p.m. She said the front door was always locked so all staff had to call for assistance. She said a nurse always takes her temperature and she fills out the screening form questions. RN #3 was interviewed on 8/10/2020 at 3:56 p.m. She said a nurse or trained staff member is at the front doors to screen in staff and visitors. She said the screening staff takes temperatures and the staff fills out the screening form questions. She said she received screening training when the outbreak started and has had to screen in staff and visitors. She said the screening process was important to prevent illness from entering the facility. The ADON and DON were interviewed on 8/10/2020 at 4:44 p.m. They said staff needed to ask the questions and fill in the form when screening visitors and staff. They said all who enter the building should be screened. V. Observations to follow droplet precautions with proper personal protective equipment (PPE) A. Professional reference for PPE The Centers for Disease Control (CDC) Key Strategies to Prepare for Coronavirus COVID-19 in Long Term Care Facilities, dated April 2020, read in pertinent part: If COVID-19 was identified in the facility, have health care providers (HCP) wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off. This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop. Certified nurse aide (CNA) #8 was observed on 8/4/2020 at 9:00 p.m. to answer the front door. She had a surgical face mask on her mouth but her nose was not covered. She wore no eye protection. -At 9:24 p.m. CNA #8 entered Resident #3 ' s room. She had a face shield on and the surgical mask still did not cover her nose. LPN #3 was observed on 8/6/2020 at 5:25 p.m., in Resident #28 ' s room to collect blood. She wore her eye protection on top of her head and not on her eyes. On 8/13/2020 at 3:06 p.m., CNA #10 was observed to sit approximately four feet from Resident #3. She had her face mask hanging off of one of her ears. The mask was not covering her mouth or or nose. VIII. Handwashing A. Professional reference Hand washing According to the Centers for Disease and Prevention (CDC) Hand Hygiene in Healthcare Settings, last up updated 1/31/2020, retrieved from https://www.cdc.gov/handhygiene/providers/index.html, included the following recommendations: Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores. When using alcohol-based hand sanitizer, put the product on hands and rub hands together. Cover all surfaces until hands feel dry. This should take around 20 seconds. When cleaning hands with soap and water, wet hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times. B. Observations 8/5/2020 -At 12:29 p.m., CNA #7 delivered a lunch tray to the resident in room [ROOM NUMBER]. He did not perform hand hygiene after leaving the residents room. -At 12:33 p.m., CNA #7 delivered a lunch tray to the resident in room [ROOM NUMBER]. He did not perform hand hygiene either before entering the room or after. -At 12:37 p.m., CNA#7 delivered a lunch tray to the second resident in room [ROOM NUMBER]. He did not perform hand hygiene either before entering the room or after. -At 12:45 p.m., CNA#7 delivered the lunch tray to the resident in room [ROOM NUMBER]. He did not perform hand hygiene either before entering the room or after. Assistant director of nurses (ADON) was observed on 8/11/2020 at 2:12 p.m. The ADON was observed to pick up a lunch tray from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASTLE ROCK CARE CENTER	**4001 HOME ST CASTLE ROCK, CO 80108**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 12) isolation room [ROOM NUMBER]. She donned a gown, gloves, eye protection and a surgical mask. She came out of the room with her eye protection and surgical mask on. She had the tray in her bare hands and put two cups, silverware and a plate on the tray cart in the hallway. The tray cart had all the residents' dishes on there (isolation and non isolation room trays). C. Interviews Regional dietary manager (RDM) was interviewed on 8/11/2020 at 4:35 p.m., she said the isolation room trays were all paper products and they were to be thrown away after use. The DON was interviewed on 8/11/2020 at 5:10 p.m., she said all PPE gear to include gown, gloves, eye protection and a mask was worn in the isolation rooms. She said handwashing should occur after each task and in between residents. VI. Housekeeping Housekeeper observations on 8/11/2020 begining at 12:45 p.m. room [ROOM NUMBER] -At 12:46 p.m., housekeeper #2 (HSK#2) took a spray bottle from the cleaning cart and sprayed bleach solution in the bathroom on the toilet, the sink and the towel rack. She was then observed to wipe the bleach solution at 12:50 p.m. She brought the bottle back to the cart. She did not change gloves or perform hand hygiene. She did not wait the 10 minute dwell time. -At 12:48 p.m., HSK#2 emptied the room trash and swept the floor in the room. She came back to the cart with a broom. She did not change gloves or perform hand hygiene. -At 12:50 p.m., HSK #2 took a rag from the cart and wiped down the bathroom area including the toilet and the sink. She did not change her gloves or perform hand hygiene. -At 12:52 p.m., HSK#2 wiped down the living area of the residents room such as tables, lamps and television. She used the same rag she had used for the bathroom. -At 12:53p.m., HSK#2 wiped down the bathroom area again using the same rag. She did not change her gloves or perform hand hygiene. -At 12:55 p.m HSK#2 retrieved the mop and a clean mop head from the cart. -At 12:56 p.m., HSK#2 mopped the bathroom. -At 12:59 p.m., HSK #2 brought the mop back to the cart and disposed of the mop head in a bag. She did not change her gloves or perform hand hygiene. Interview The director of plant operations (DOPO) was interviewed on 8/13/2020 at 11:44 a.m. He said the housekeeper supervisor should be training the housekeepers, however a new housekeeper supervisor just started employment at the facility and he was training her. He said the housekeepers made their own bleach cleaning solution with 10 parts water and one part bleach. He said the dwell time on that product was 10 minutes. Another cleaner used was called true shot cleaner and the dwell time was one minute. He included the housekeepers should be changing their gloves and performing hand hygiene between each task they perform.