STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065285	A. Building B. Wing	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Heights Skilled Nursing and Rehabilitation	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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on interviews and record review, the facility failed to ensure one (#62) of one resident reviewed for verbal abuse out of 32 sample residents were kept free from abuse. Specifically, the facility failed to ensure Resident #62 was kept free from verbal abuse and threats by a staff member. Findings include: I. Facility policy and procedure The Abuse policy and procedure, undated, was provided by the nursing home administrator (NHA) on 10/16/23 at 10:30 a.m. It revealed, in pertinent part, (Facility) does not condone resident abuse and shall take every precaution possible to prevent resident abuse by anyone, including staff members, other residents, volunteers, staff of other agencies serving the resident, family members, legal guardians, sponsors, friends, or any other individuals. Every resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Resident abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment of a resident resulting in physical harm or pain, mental anguish, deprivation of goods or services that are necessary to attain or maintain physical, mental, or psychosocial well-being. Resident abuse may be verbal, sexual, physical, involuntary seclusion, mental abuse, neglect and/or misappropriation of resident property. Verbal abuse is defined as the use of oral, written, or gestured language that includes disparaging or derogatory terms to residents or their families, or within their hearing distance, regardless of their ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family again. II. Resident #62 status (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #62, age 80, was admitted and discharged on [DATE]. According to the October 2023 computerized physician orders (CPO), the diagnoses included dementia. According to the 10/4/23 admission nursing notes, the resident had cognitive impairment related to a diagnosis of dementia. The resident required supervision with all activities of daily living. A. Record review The 10/4/23 abuse investigation documented that at 6:00 p.m., registered nurse (RN) #5 received a report from the nurse from the previous shift. Resident #62 was sitting in a chair in the lobby, waiting for his son to come pick him up. RN #5 got into a verbal argument with Resident #62 and began threatening and yelling at the resident, saying I ' m calling the police and you may not live until the police get here. RN #5 was removed from contact with Resident #62 and notified the director of nursing (DON). Licensed practical nurse (LPN) #1, who was interviewed on 10/4/23, said she had her medication cart down in the lobby to keep an eye on Resident #62, who was upset with being admitted to the facility. She said she was waiting for his son to arrive to take him home. Resident #62 was sitting quietly in the recliner chair. She said RN #5 entered the facility for his shift and she informed him why they were in the lobby. She began to give him a report of the day, when he started complaining that he did not need to put up with this guy all night long. She said Resident #62 got upset and said, I can hear what you are saying, I know you are talking about me. She said RN #5 responded back to Resident #62 and said, You ' re right, we are (expletive) talking about you. Not only that, I ' m going to call the police on you. Yeah, you want to (expletive) hit me man, go ahead and hit me. I ' m calling the police and you may not live until the police get here! LPN #1 said she immediately told RN #5 to leave the area and get away from Resident #62. She said he continued swearing as he walked down the hallway, in front of other residents. Resident #62 was easily calmed down and forgot the incident by the time his son had arrived. B. Results of the facility's abuse investigation The conclusion of the abuse investigation documented that RN #5 did not interact appropriately and verbally threatened Resident #62, which was confirmed by witnesses and video surveillance. RN #5 was removed from the area, his employment was terminated and his actions reported to the Board of Nursing. III. Staff interviews The NHA and DON were interviewed on 10/19/23 at 1:57 p.m. The DON said that she was called on the night of 10/4/23 when the incident with RN #5 and Resident #62 happened. She said she interviewed the staff on duty and watched back the video surveillance. She said it was clear that RN #5 was yelling at Resident #62 and had threatened him. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA said the facility immediately suspended RN #5 and then decided upon a final action of termination. The NHA said the facility was able to substantiate the verbal abuse by RN #5 toward Resident #62.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46022 Based on observations, interviews, and record review, the facility failed to ensure two (#1 and #11) of four residents reviewed out of 32 sample residents for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities. Specifically, the facility failed to: -Ensure Resident #1 and #11 received showers; and, -Ensure Resident #1 and Resident #11's care plan addressed shower refusals and preferences. Findings include: I. Facility policy and procedure The Bath, Shower/Tub policy, revised Feburary 2018, was provided by the director of nursing (DON) on 10/18/23 at 5:13 p.m. It revealed in pertinent part, The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. II Resident #1 A. Resident status Resident #1, under the age of 65, was admitted on [DATE]. According to the September 2023 computerized physician orders (CPO) the diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (decreased movement of the right side following a stroke), cerebral palsy (weakness of the muscles), need of assistance with personal care and history of traumatic brain injury. The 8/4/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) with a score of nine out of 15. He required supervision of one person for bed mobility, toileting. He required supervision, set-up assistance for transfers, locomotion on and off the unit, eating. He required limited assistance of one person for dressing, personal hygiene. According to the MDS the resident did not have a shower in the review period. B. Observations On 10/16/23 at 9:59 a.m. Resident #1 was in his room. His hair appeared wet and greasy. Resident #1 had a body odor. On 10/17/23 at 8:54 a.m. Resident #1 was in his room. His hair appeared wet and greasy. Resident #1 had a body odor. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/18/23 at 10:37 a.m. Resident #1 was in his room. His hair appeared wet and greasy. Resident #1 had a body odor. C. Record review The director of nursing (DON) provided Resident #11's bathing log from 7/18/23 through 10/18/23 on 10/18/23. The July 2023 (7/18/23 to 7/31/23) shower documentation revealed Resident #1 refused a shower on 7/29/23. -It indicated Resident #1 did not receive a shower on six of six opportunities. The August 2023 shower documentation revealed Resident #1 received a shower on 8/9, 8/11 and 8/15/23. Resident #1 refused a shower on 8/19/23. -It indicated Resident #1 received a shower on three of 13 occasions. The September 2023 shower documentation revealed Resident #1 received a shower on 9/5 and 9/15/23. Resident #1 refused a shower on 9/4, 9/11, 9/13, 9/18, 9/20, 9/22, 9/25 and 9/27/23. -It indicated Resident #1 received a shower on two of 13 opportunities. The October 2023 (10/1/23 to 10/18/23) shower documentation revealed Resident #1 received a shower on 10/1, 10/2, 10/4, 10/6, 10/7, 10/8, 10/9, 10/12, 10/13, 10/15 and 10/16/23. -However, certified nurse aide (CNA) #8 was interviewed and said she did not provide Resident #1 a shower on 10/16/23 (see interviews below). -Review of the resident's medical record revealed there were no progress notes to indicate why the resident refused showers on multiple dates. A review of Resident #1's care plan did not indicate techniques to help encourage Resident #1 to bathe. III. Resident #11 A. Resident status Resident #11, under the age of 65, was admitted on [DATE] and readmitted on [DATE]. According to the October 2023 CPO the diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side (decreased movement of the right side of the body following a stroke), epilepsy (seizure disorder), gastro-esophageal reflux disease (GERD) and mood disorder. The 9/29/23 MDS assessment revealed the resident had moderate cognitive impairments with BIMS of 12 out of 15. She required supervision with one person assistance for bed mobility. She required limited assistance of one person for transfers, dressing and personal hygiene. She required physical help limited to transfer only for bathing. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observations On 10/16/23 at 2:25 p.m. Resident #11 was in the activity room. Resident #11 was wearing jeans and a red shirt. Resident #11 had a hat on. Resident #11's hair appeared greasy and wet. Resident #11 had body odor. On 10/16/23 at 1:20 p.m. Resident #11 was in the hallway wearing the same jeans and red shirt as 10/17/23. Resident #11 was wearing a hat and her hair was greasy and appeared wet. Resident #11 had body odor. C. Record review The activities of daily living (ADL) care plan, initiated on 10/18/21 and revised on 6/3/22, revealed Resident #11 required assistance with some ADLs. Resident #11 became frustrated easily with communicating her need for assistance with ADLs at times. The interventions included in pertinent part: allowing and encouraging Resident #11 to make her decisions of care, allowing sufficient time for her to complete tasks independently and bathing per resident's current preference. The activities care plan, initiated on 10/18/21 and revised on 8/14/23, revealed Resident #11 preferred a shower with female assistance. Resident #11 needed encouragement and reassurance for showering. The director of nursing (DON) provided Resident #11's bathing log from 7/18/23 through 10/18/23 on 10/18/23. The July 2023 (7/18/23 to 7/31/23) shower documentation revealed Resident #11 refused a shower on 7/28/23. -It indicated Resident #11 was not provided a shower out of four opportunities. The August 2023 shower documentation revealed Resident #11 received a shower on 8/11, 8/16, 8/18 and 8/29/23. -It indicated Resident #11 was provided a shower on three of nine opportunities. The September 2023 shower documentation revealed Resident #11 received a shower on 9/4, 9/5, 9/12, 9/15, 9/19, 9/22 and 9/26/23. -It indicated Resident #11 was provided a shower on six of eight opportunities. The October 2023 (10/1/23 to 10/18/23) shower documentation revealed Resident #11 received a shower on 10/1, 10/2, 10/4, 10/5, 10/6, 10/8, 10/11, 10/13, 10/14 and 10/15/23. -It indicated Resident #11 was provided a shower on two of five opportunities. IV. Staff interviews (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7 was interviewed on 10/18/23 at 4:01 p.m. CNA #7 said there were bath sheets in the nurses station that indicated each resident's preference for baths. CNA #7 said Resident #11 preferred to shower on Tuesday and Fridays on the evening shift. CNA #7 said Resident #1 preferred to shower Monday, Wednesday and Friday on the evening shift. CNA #8 was interviewed on 10/18/23 at 6:48 p.m. CNA #8 said she typically worked the evening shift. CNA #8 said Resident #11 occasionally refused showers. CNA #8 said Resident #11 responded well to a rewards system. CNA #8 said if Resident #11 refused a shower, she would reapproach the resident later and offer her a cigarette. CNA #8 said the cigarette helped encourage Resident #11 to shower. CNA #8 said Resident #1 occasionally refused showers. CNA #8 said she would attempt to help Resident #1 shower three times prior to documenting that he refused the shower. CNA #8 said she would also notify the nurse. CNA #8 said Resident #8 did not receive a shower on 10/16/23 or 10/17/23. Registered nurse (RN) #4 was interviewed on 10/19/23 at 10:55 a.m. RN #4 said CNAs were responsible for assisting residents with showers. RN #4 said a bath aide was scheduled on the day shift. RN #4 said the scheduled evening CNAs were responsible for assisting with showers on their assigned unit. RN #4 said the CNAs were responsible for notifying the nurse when a resident refused a shower. RN #4 said she was not aware that Resident #1 refused showers. RN #4 said Resident #11 had a history of refusing showers and is quite particular. RN #4 said Resident #11 preferred certain staff members to assist her with showers. The DON was interviewed on 10/19/23 at 1:19 p.m. The DON said the bath aides were responsible for assisting residents with showers. The DON said if a bath aide was not scheduled the CNAs were responsible for assisting residents with showers. The DON said the CNAs should attempt to encourage residents to shower three times prior to documenting the refusal. The DON said Resident #1 refused showers frequently. The DON said Resident #1 needed a lot of convincing to shower and preferred certain staff members. The DON said the residents care plan needed to be updated to include Resident #1's shower refusals and ways to encourage Resident #1 to shower. The DON said Resident #1 often had body odor. The DON said Resident #11 refused showers occasionally. The DON said Resident #11 preferred certain staff members to help her shower. The DON said Resident #11 often had body odor. The DON said Resident #11 responded well to positive reinforcement. The DON said Resident #11's care plan needed to be updated. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the MDS documentation changed on 10/1/23. The DON said the CNAs could have been documenting showers incorrectly as there were a lot of changes. The DON acknowledged that CNA #8 said she did not provide Resident #1 a shower on 10/16/23, despite it being documented in the resident's medical record. The DON said she would provide education to the CNAs on proper shower documentation with the new changes that were implemented.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on interviews and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for one (#51) of two reviewed for change of condition out of 32 sample residents. Specifically, the facility failed to ensure: -A cardiology appointment was scheduled for Resident #51 with a diagnosis of heart failure; and, -The physician was notified when Resident #51 had chest pain. Findings include: I. Resident #51 status Resident #51, age 72, was admitted on [DATE]. According to the October 2023 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disease (COPD), chronic kidney disease stage four and obstructive and reflux uropathy (obstructive urinary flow). The 10/11/23 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview of mental status (BIMS) score of 13 out of 15. He was independent with all activities of daily living. A. Record review Resident #51 was admitted to the hospital from the facility on 6/17/23 for shortness of breath and was discharged from the hospital back to the facility on [DATE]. The hospital discharge instructions recommended a follow-up with cardiology due to a new diagnosis of heart failure with an ejection fraction of less than 40%. The discharge papers instructed the primary care physician (PCP) be notified of signs and symptoms of chest pain or shortness of breath. A nurse's note entered on 7/9/23 at 11:34 p.m. revealed the resident had dry heaves, sweating, nausea, sharp chest pain described as greater than 10 out 10 and shortness of breath. His vital signs were respirations of 26 (normal rate is 12 to 18), heart rate of 68, oxygen saturation of 93% out of 100% and blood pressure of 202/94 (normal range is less than 120 and less than 80). The note documented the nurse remained with the resident for 20 to 30 minutes and the chest pain had decreased to seven to eight out of 10 and the resident wanted to go bed. -There was not any documentation to show that the nurse notified the physician of the residents chest pain and shortness of breath. II. Staff interviews (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 10/18/23 at 5:25 p.m. She said she looked through all of the documentation on Resident #51's chart and could not locate where the physician was notified of the residents complaint of chest pain and shortness of breath. She said she would have called the physician if she were the nurse responsible for that resident that night. The physician was interviewed on 10/19/23 at 9:27 a.m. He said he does not recall being informed of any chest pain events in July 2023 for Resident #51. He said he would not want a nurse to make the decision without contacting a physician if a resident complained of chest pain. He said he would expect a phone call. The DON was interviewed again on 10/19/23 at 1:53 p.m. She said Resident #51 had not been seen by a cardiologist for an ischemic workup as recommended by the discharge instructions from his hospital stay that ended on 7/5/23 and the physicians note dated 7/6/23. She said the resident was not having a heart attack and he was seen by cardiology on 7/24/23 to be cleared for fistula surgery. She said he did not come back from hospital with a heart failure diagnosis and that he had atrial fibrillation from pneumonia and end-stage kidney failure. She said she did not believe the cardiac recommendations were for cardiac problems. -However, the hospital discharge instructions indicated the resident was to be seen by cardiology due to a new diagnosis of heart failure (see above). The assistant director of nursing (ADON) was interviewed on 10/19/23 at 5:27 p.m. She said she remembered the night that Resident #51 was outside dry heaving and complaining of chest pain. She said she did not call the doctor and she did not have a good reason for not doing so. She said she it was not in her scope of practice as a licensed practical nurse (LPN) to determine if the resident was having a heart attack and she would have expected her staff to call the physician for direction.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38185 Based on observations, record review and interviews, the facility failed to ensure one (#14) of eight out of 32 sample residents received adequate supervision to prevent accidents. Specifically, the facility failed to ensure Resident #14 received the supervision he required to prevent falls. Findings include: I. Resident #14 Resident #14, age under 65, was admitted on [DATE]. According to the October 2023 computerized physician orders (CPO), the diagnoses included Huntington's Disease, Parkinson's disease, vascular dementia without behavioral disturbance, chorea (a neurological disorder characterized by spasmodic involuntary movements of the limbs or facial muscles), muscle weakness, depression, repeated falls, lack of coordination, functional urinary incontinence and unsteadiness on feet. The 9/29/23 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status score of nine out of 15. He required extensive assistance of one person with bed mobility, transfers, eating and personal hygiene and total dependence of one person with toileting and dressing. It indicated the resident had two or more falls since the prior assessment. A. Resident interview and observations Resident #14 was interviewed on 10/16/23 at 1:45 p.m. He said he had experienced a lot of falls. He said at first he had a difficult time accepting he could not do certain things, but that lately his falls were because the facility staff took a long time to help him. He said he needed help with almost everything. On 10/16/23 at 3:22 p.m. Resident #14 could be heard calling out for help from the hallway before rounding the corner to the nursing station. Two staff members were observed sitting in the nursing station, looking down at their cell phones. Resident #14's room was directly across from the nursing station and could be heard calling out for help. The call light was activated. Resident #14 was observed on the floor, with his left leg tangled in the wheelchair with a urine puddle on the ground. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon notifying an unidentified staff member that Resident #14 was on the ground, tangled in his wheelchair, the staff member said, um ok. She finished looking at something on her cell phone, placed her cell phone down and entered the resident's room. She said to the resident she needed to get gloves and other items and would be back to help him off the ground. She returned with a nurse to assist. On 10/17/23 at 1:31 p.m. Resident #14's call light had been activated, along with two other call lights. Resident #14 was observed calling out for help. Staff members were observed sitting at the nursing station, not getting up to attend to any of the call lights. Activity assistant (AA) #1 was observed entering each of the rooms of the activated call lights. AA #1 informed licensed practical nurse (LPN) #3 that three call lights had been activated, staff were sitting in the nursing station and all three residents required incontinence care. B. Record review The cognitive care plan, initiated on 7/24/23 and revised on 10/13/23, documented the resident had impaired cognitive function related to a diagnosis of dementia. The interventions included administering medications as ordered, asking yes or no questions to determine the resident's needs, communicating with the resident regarding his capabilities and needs and keeping the resident's routine consistent to decrease confusion. The communication care plan, initiated on 8/15/22 and revised on 10/13/23, documented that the resident had potential for complications due to impaired communication exhibited by unclear speech and difficult to understand. The resident had effects of chorea on vocalization. The interventions included allowing the resident time to respond, express himself and understand others; asking the resident for clarification as needed; providing the resident with appropriate adaptive equipment and observing any changes to his communication. The activities of daily living (ADL) care plan, initiated on 8/15/22 and revised on 2/21/23, documented that the resident had severe chorea that impacted his ability for self-care. He was able to feed himself with finger foods, but was unable to use utensils safety or effectively. It indicated the resident had impaired vision, was forgetful and his speech was unclear at times. The interventions included offering and assisting the resident with transfers and bed mobility; and offering and providing assistance with grooming, oral/dental care, personal hygiene, meals and incontinence care. The fall risk care plan, initiated on 8/15/22 and revised on 4/21/23, documented that the resident was at risk for injuries from falls due to decreased coordination and a history of falls. The resident had uncontrolled tremors. It indicated that the resident chose to transfer without assistance. The interventions included providing safety devices, assistive equipment, dycem under the cushion to prevent slipping, therapy for transfer training; providing verbal reminders not to transfer without assistance; encouraging the resident to call for help when needed; keeping the call light within reach and responding promptly; providing a low bed for safety; providing anti-rollbacks for the wheelchair; and removing the foot pedals from the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Fall incident 2/13/23 According to the 2/13/23 interdisciplinary (IDT) team fall committee progress note, the resident sustained an unwitnessed fall while self-transferring from the recliner to his wheelchair to go to dinner. The resident lost his balance and fell to the ground. The resident sustained a laceration to the top of the right side of his head. There was minimal bleeding and no swelling noted. The interventions included offering the resident a helmet for safety and continuing to encourage the resident to ask for assistance with transfers. 2. Fall incident 3/3/23 The 3/3/34 nursing progress note documented the resident was found on the floor twice, within a few minutes of each other. The resident was unable to verbalize what caused the fall. The resident did not sustain any injuries. -It did not include any new interventions. 3. Fall incident 4/3/23 The 4/3/23 nursing progress note documented that at 1:00 p.m., the resident was seen by staff and another resident transferring himself from the wheelchair to the recliner. He made it to the arm of the chair and slid to the floor. He said he did not hit his head. The resident did not sustain any injuries. The interventions included reminding the resident to call for help when he is ready to transfer back to his wheelchair. The 4/4/23 post fall evaluation documented to continually encourage the resident to ask for assistance and that the current interventions were in place to promote safety when the resident falls rather than reducing falls. It indicated that the resident's falls were unavoidable. The 4/5/23 nurse practitioner progress note documented the falls with the resident were unfortunately unavoidable due to his diagnosis of Huntington's disease and severe chorea movements. -However, according to the observations, the resident not only vocalized needing assistance but had also activated his call light with staff close by at the nursing station. The staff did not respond to the call light or the yelling out for help until prompted. The resident was on the floor with evidence of an incontinence episode. 4. Fall incident 4/20/23 The 4/20/23 nursing progress notes documented the nurse was notified that the resident landed on his bottom during a self-transfer from the wheelchair to the recliner in the front lobby, lost his footing and fell . The resident did not sustain an injury. -It did not include any additional interventions. The 4/21/23 IDT fall committee progress note documented the resident was educated again on asking for help when transferring. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Fall incident 5/7/23 The 5/7/23 nursing progress note documented that the resident was found on the floor. He said he was transferring himself from the wheelchair to the bed and slid off his chair. The resident did not sustain any injuries. The interventions included frequent visual monitoring for the resident's needs and safety and ensuring the call light is within reach at all times. -However based on the observations, the resident's needs were not addressed timely after the resident had activated his call light and called out for help. 6. Fall incident 7/11/23 The 7/11/23 nursing progress note documented that the resident was on the phone, talking excitedly, and popped out of his wheelchair and landed on the floor. The resident did not sustain an injury. -No new interventions were in place. 7. Fall incident 8/13/23 The 8/13/23 nursing progress note documented at 1:00 p.m. the resident was found sitting on the floor in front of his wheelchair. The resident said he tried to transfer himself and landed on the ground. The resident did not sustain an injury. The resident was strongly encouraged to always call when he would like to be transferred. 8. Fall incident 9/6/23 The 9/6/23 nursing progress note documented the resident was found on the floor, on his buttocks with his legs extended in front of him, with the wheelchair facing the opposite direction. The certified nurse aide (CNA) said she was assisting the resident at the sink prior to bed. She attempted to help the resident sit back in the wheelchair, but because of the foot pedals, the wheelchair moved backwards. The resident was lowered to the floor by the CNA. 9. Fall incident 9/24/23 The 9/24/23 situation, background, assessment and recommendations (SBAR) documented that the resident sustained a fall. -It did not provide any additional details. The 9/25/23 IDT fall committee progress note documented the resident was found on the floor next to his bed, reaching for his IPad. The resident did not sustain an injury. The intervention included therapy evaluating the resident's room. 10. Fall incident 10/15/23 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/15/23 nursing progress note documented that the resident fell from the low bed to the floor and then crawled out to the doorway. The resident was assisted with incontinence care upon his request. The resident did not sustain an injury. 11. Fall incident 10/16/23 The 10/16/23 nursing progress note documented that the CNA told the nurse that the resident was found on the floor, in his room, in front of his wheelchair. The resident was soiled with urine. The resident said he slipped from the cushion on his wheelchair because of the urine. The resident did not sustain an injury. II. Staff interviews CNA #2 was interviewed on 10/19/23 at 11:30 a.m. She said Resident #14 required assistance with all ADLs. She said the resident was incontinent and required assistance with incontinence care. She said the resident was able to activate his call light when it was within reach, but that sometimes he would call out for assistance. She said the resident had a difficult time communicating and was difficult to understand at times. She said Resident #14 had sustained a lot of falls. She said the resident usually fell because he wanted to get up out of bed or needed incontinence care and he did not want to wait any longer. She said it depended on the day and what was happening if she was able to assist him timely. She said the resident often did not like to wait for an extended period of time and would attempt to transfer himself. She said she did not think the involuntary movements from his disease were the cause of most of his falls. The director of nursing (DON) was interviewed on 10/19/23 at 1:57 p.m. She said Resident #14 required total assistance with ADLs. She said he had sustained a lot of falls. She said the resident had difficulty accepting the change in his level of care and would self-transfer, which caused the falls. She said the resident was able to activate his call light and would sometimes yell out for help. She said the resident was in the room directly across from the nursing station so staff could assist the resident quickly. The DON said she was not aware of the two observations made on 10/16/23 and 10/17/23, during the survey process. She said the staff should not be sitting in the nursing station on their cell phones. She said if they had down time, then they should be rounding and checking on the residents. She said the staff were aware that Resident #14 would yell for assistance and that should have alerted them to check on him.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, staff interviews, and record review, the facility failed to consistently provide urostomy care, treatment and services to minimize the risk of urinary tract infections for one (#7) of two residents reviewed for urinary devices out of 32 sample residents. Specifically, the facility failed to ensure Resident #7 had orders for urostomy care. Findings include: I. Professional reference According to the American Cancer Society (10/16/19) at https://www.cancer.org/cancer/managing-cancer/treatment-types/surgery/ostomies/urostomy/management.html accessed on 10/30/23, it read in pertinent part, During the day most people need to empty the pouch about as often as they used the bathroom before they had urostomy surgery or other bladder problems-for many people, this might mean every 2 to 4 hours, or more often if you drink a lot of fluids. Different pouching systems are made to last different lengths of time. Some are changed every day, some every 3 days or so, and some just once a week. It depends on type of pouch you use. Your pouch should be changed on a schedule that fits your routine. And it's best to have a regular changing schedule so problems don't develop. In other words, don't wait for it to leak to change it. Before changing your pouch, clean your hands well and put all your supplies on a clean surface. Clean pouches decrease the chances of germs (bacteria) getting into your urinary system. Bacteria can multiply quickly even in the tiniest drop of urine. These germs may travel up the ureters and cause a kidney infection. Bacteria can also cause foul-smelling urine. II. Resident #7 A. Resident status Resident #7, age 74, was admitted on [DATE]. According to the October 2023 computerized physician orders (CPO), diagnoses included malignant neoplasm of the prostate (prostate cancer), chronic kidney disease and unspecified injury of the right kidney. The 9/20/23 admission minimum data set (MDS) assessment revealed the resident had intact cognition and scored a 15 out of 15 on the brief interview for mental status (BIMS). The resident showed no signs of delusions or psychosis and had no aggressive behaviors. The resident did not reject care or assistance. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident upon admission was able to complete some activities of daily living independently and some with only set up assistance from staff. The resident needed extensive assistance from staff for bed mobility, transferring, toileting, dressing and with personal hygiene. The resident was continent of bowel and preferred to use a bedpan. The resident had a urostomy and was not placed on a toileting program. B. Resident observation Resident #7 was observed on 10/16/23 at 10:56 a.m. The resident had a urostomy connected to a foley bag. C. Record review Review of the resident's medical record revealed the resident was admitted on [DATE] with a urostomy (ileal conduit in right upper quadrant with catheter drainage bag). At the time of admission there were not any orders entered for care of the stoma or urostomy. Review of the resident's October 2023 physician's orders, medication and treatment administration record (MAR/TAR) and comprehensive care plan revealed: -No orders for routine stoma or urostomy care, maintenance or monitoring of the resident urostomy, and; -No documentation of urostomy care provided. A nursing progress note, dated 8/25/23 at 5:15 a.m., revealed the urostomy was leaking and was changed with the last remaining urostomy bag. The care plan, initiated on 8/29/23 and revised on 9/20/23, had a focus for the urostomy and listed goals of no signs or symptoms or urinary infection and free from catheter-related trauma. The interventions listed were to monitor/document for pain/discomfort due to catheter and monitor/record/report to physician signs and symptoms of a urinary tract infection such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. III. Staff interview The director of nursing (DON) was interviewed on 10/19/23 at 1:53 p.m. The DON said orders for urostomies should be entered upon admission to the facility and should include orders for the care. Licensed practical nurse (LPN) #3 was interviewed on 10/18/23 at 2:19 p.m. She said orders should be placed upon admission for residents with urinary devices. She said the orders should include the care and maintenance of those devices.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 46022 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months, and provide regular in-service education based on the outcome of these reviews for five of eight staff reviewed. Specifically, the facility had not completed annual performance reviews for certified nurse aide (CNA) #4, CNA #2, CNA #5, CNA #6 and activities aide (AA) #1. Findings include: I. Record review A request for CNA #4 (hired 1/20/21), CNA #2 (hired 9/22/2020), CNA #5 (hired 11/23/16), CNA #6 (hired 11/11/21) and AA #1 (hired 10/8/21) annual performance review on 10/19/23. -The human resources director (HRD) said CNA #4, CNA #2, CNA #5, CNA #6 and AA #1 did not have an annual performance review. AA #1 was a CNA and worked as a bath aide (see interview). CNA #4, CNA #2, CNA #5, CNA #6 and AA #1 had not completed annual inservice education based on the outcome of their reviews. II. Staff interviews AA #1 was interviewed on 10/16/23 at 10:04 a.m. AA #1 said she was a CNA and worked as a bath aide once a week. The director of nursing (DON) was interviewed on 10/19/23 at 1:10 p.m. The DON said staff training was done via a website. The DON said the facility was not completing annual reviews for CNAs. The staffing coordinator (SC) was interviewed on 10/19/23 at 2:06 p.m. The SC said she was responsible for helping ensure all CNAs received annual training. The SC said the facility used to complete annual competencies, but no longer completed them regularly. The SC said she was unsure why the facility no longer did annual competencies. The SC said it was important to complete annual competencies to help determine what training the staff needed. The HRD was interviewed on 10/19/23 at 4:23 p.m. The HRD said annual competencies have not been completed. The NHA and the DON were interviewed on 10/19/23 at 4:50 p.m. The DON said annual competencies have not been completed. The NHA said annual competencies needed to be completed and they would start completing them.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47960 Based on observations and interviews, the facility failed to ensure two out of three medication carts stored medications in accordance with accepted professional standards. Specifically, the facility failed to ensure the medication carts were locked when the nurse was not at the cart or in direct line of sight. Findings include: I. Facility policy and procedure The Medication Storage policy and procedure was requested on 10/19/23 from the nursing home administrator (NHA), however, it was not provided. II. Observations On 10/16/23 at 9:41 a.m. the medication cart was left unlocked while licensed practical nurse (LPN) #1 went into a residents room. She was not in direct line of sight of the cart which was across and up the hall from the room she entered and there were not any licensed nursing staff observed within direct line of sight. Residents were walking in the hall and one unidentified male resident frequently waited at the cart requesting medication. LPN #1 returned to the cart four minutes later and realized she left the cart unlocked. She put her keys back in her pocket and continued to prepare another medication. At 10:24 a.m. the medication cart in the main room on the 300 hall was unlocked and there were not any licensed nursing staff observed within direct line of sight. Several residents were in the hall including a female resident who was known to wander. After two minutes, registered nurse (RN) #1 opened the door from inside a residents room. She was notified that the medication cart was unlocked and she proceeded to lock it. At 1:41 p.m. the medication cart on the 300 hall was unlocked and there were not any licensed nursing staff observed within direct line of sight. A male resident was wandering in the hall during this time. RN #1 was assigned to the medication cart, however she could not be located. III. Staff interviews RN #1 was interviewed on 10/16/23 at 10:26 a.m. She said the medication cart should not ever be left unlocked. She said it the nursing staff kept the medication cart locked when unattended and out of direct line of sight. She said she could not believe she forgot to lock the cart because she never usually leaves the medication cart unlocked. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3 was interviewed on 10/18/23 at 2:19 p.m. She said the medication carts should always be locked. She said the facility was home to many residents with memory deficits and wandering behaviors. She said the danger of an unlocked medication cart was that the residents could get into medications that were not safe for them and take something they should not. This could lead to possible overdose or harm, even if it was an over-the-counter medication. The director of nursing (DON) was interviewed on 10/19/23 at 1:53 p.m. The DON said medication carts should be locked at all times. She said it was not acceptable for staff to leave them unlocked. She said the facility was home to many dementia residents so if the medication carts were left unlocked those residents could get into medications that were not meant for them.

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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** 47151 Based on observations, record review and staff interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to ensure control measures for monitoring and preventing Legionella and waterborne pathogens growth were included in the facility's water management plan. Findings include: I. Professional reference The Center for Disease Control and Prevention (CDC) recommendations for Legionella, last reviewed on 3/25/21, was retrieved on 10/22/23 at https://www.cdc.gov/legionella/wmp/healthcare-facilities/healthcare-wmp-faq.html under Heathcare Water Mangement read in pertinent part: Healthcare facilities, such as hospitals and nursing homes, usually serve the populations at highest risk for Legionnaires' disease. These include older people and those who have certain risk factors, such as being a current or former smoker, having a chronic disease, or having a weakened immune system. Also, healthcare facilities can have large complex water systems that promote Legionella (the bacterium that causes legionnaires' disease) growth if not properly maintained. For these reasons, the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) consider it essential that hospitals and nursing homes have a water management program that is effective in limiting legionella and other opportunistic pathogens of premise plumbing (waterborne pathogens, for short) from growing and spreading in their facility. Legionella and other waterborne pathogens occur naturally in the environment, in bodies of water like lakes, [NAME], and streams. Although municipalities treat their water with disinfectants like chlorine that can kill these pathogens, a number of factors may allow these pathogens to enter a building's water distribution system, such as construction (including renovations and installation of new equipment). Vibrations and changes in water pressure can dislodge biofilm and release legionella or other waterborne pathogens. Biofilm is a slimy layer in pipes in which pathogens can live; it can give pathogens a safe harbor from disinfectants. Water management programs identify hazardous conditions and take steps to minimize the growth and spread of legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for legionella growth (77-113 Fahrenheit). -Preventing water stagnation. -Ensuring adequate disinfection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Maintaining premise plumbing, equipment, and fixtures to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for legionella. Members of a building water management program team work together to: -Identify ways to minimize growth and spread of legionella and other waterborne pathogens. -Conduct routine checks of control measures to monitor areas at risk. -Take corrective action if a problem is found. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions. Programs should include predetermined responses to correct hazardous conditions if the team detects them. II. Facility policy and procedure The Legionella Water Management Program policy and procedure, undated, was provided by the nursing home administrator (NHA) on 10/17/23 at 3:00 p.m. It revealed in pertinent part, Legionalla an grow in many parts of of the building water systems that are continually wet, and certain devices can then spread contaminated water droplets. Examples include but are not restricted to: water heaters, water filters, electronic and manual faucets, showerheads and hoses, ice machines, pipes, valves and fittings, cooling towers, medical devices (such as CPAP machines) and evaporative coolers. If a control limit is not being met, you need to take corrective actions to get the conditions back to within an acceptable range. If three is any time there is a suspected case of Legionnaires disease associated with your building you should decontaminate the building water system if necessary and review the water management program and review it if necessary. Control measures and limits will be established for each control point. You will need to monitor to ensure your control measures are performing as designed. A list of interventions known to eliminate legionella: prevention is the best intervention, ten to one bleach solution, heating water to above 160 degrees and water movement (stagnant water allows Legionalla to grow). -The interventions included in the Legionella Water Management Program did not include additional details on how or where to administer and monitor a ten to one bleach solution, how to monitor heating water to above 160 degrees fahrenheit at the source and throughout the flow of water through the facility or how to determine the effectiveness of these interventions. The Legionella Water Management Program did not include specific facility locations monitored such as water heaters, water filters, electronic and manual faucets, showerheads and hoses, ice machines, pipes, valves and fittings, cooling towers, medical devices (such as CPAP machines) and evaporative coolers. III. Record review (continued on next page)

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

(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	The weekly water systems testing and monitoring spreadsheet was provided by the NHA on 10/19/23 at 10:20 a.m. The spreadsheet documented monthly and weekly monitoring from 10/1/22 to 10/31/23. The monthly monitoring included an inspection of the eyewash stations. The weekly monitoring included testing and monitoring of the water management plan for Legionella with a corresponding completion date. -The water systems testing and monitoring spreadsheet did not include specific locations monitored in the facility such as water heaters, water filters, electronic and manual faucets, showerheads and hoses, ice machines, pipes, valves and fittings, cooling towers, medical devices (such as CPAP machines) and evaporative coolers. The spreadsheet did not indicate how many eyewash stations were inspected. IV. Staff interviews The NHA, the maintenance supervisor and regional maintenance supervisor (RMS) were interviewed on 10/19/23 at 10:00 a.m. The RMS said there was a document in the electronic building and asset management system that contained specifics on which facility locations to monitor. The RMS said the water management plan was for the facilities in their corporation, but each facility might have different items or locations specifically to monitor. The RMS said he could enter the specific facility locations to monitor into the electronic building and asset management system and add to the water management binder the steps to take if the facility had to turn up the temperature on boilers. The MS said the facility halls had separate boilers and one boiler could be adjusted if a single hall was found to have an issue. The MS said water for certain sections can be closed off to control which hallway was monitored. The NHA said if if there was possible contamination the facility water temperature could be increased. The NHA said if the water temperature was increased, the facility would implement the same plan used when the facility previously repaired facility pipes. The residents did not use the water and staff were notified of the changes. The NHA said the unused resident room on the other side of the building were part of the facility monitoring and the goal was to someday use those rooms again. The RMS said the MS checked sections of pipes that were rarely or not used, swamp coolers and the shower room on the closed hall for any signs of Legionella. The RMS if there were signs of Legionella contamination when the facility tested then Ecolab conducted tests at the facility. V. Facility follow-up The RMS added specific facility locations in addtion to the eyewash stations that were monitored to the electronic building and asset management system on 10/19/23 at 11:00 a.m.