STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. Building B. Wing	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interview, the facility failed to ensure immediate notification to the resident's representative of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); for one (#120) resident reviewed out of 33 sample residents. Specifically, the facility failed to make timely notification of Resident #120's change of condition to the resident's legal representative. Findings include: I. Facility policy The facility Change in a Resident's Condition or Status policy revised February 2021 was provided by the nursing home administrator on 8/29/23 at 5:30 p.m. It read in pertinent part: Our facility promptly notifies the resident, his or her attending physician and the resident representative of changes in the resident's medial/mental condition and or status. A 'significant change' of condition is a major decline or improvement in the resident's status that: Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions (is not 'self -limiting'). II. Resident #120 A. Resident status Resident #120, age 69, was admitted to the facility on [DATE] under hospice care and passed away on 8/28/22. According to the August 2022 computerized physician's orders (CPO), diagnoses included respiratory failure, history of stroke, and anxiety. The 6/1/22 minimum data set assessment (MDS) documented the resident had moderately impaired cognition and was on hospice care. B. Record review (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan, initiated 3/10/22 and last revised 7/12/22 revealed the resident was receiving hospice care; had impaired cognition; was dependent on staff for emotional, intellectual, physical and social needs; and wanted the facility to Inform my family of any significant changes in condition. Other interventions documented throughout the care plan included: Encourage ongoing family involvement. Communicate with me/my family/my caregivers regarding my capabilities and needs. Hospice social work visit (SW) notes dated 8/13/22 at 11:44 a.m. read in pertinent part: Resident experiencing memory deficit failure to recognize familiar persons/places, impaired decision-making, inability to recall events of the past 24 hours, failure to perform usual activities of daily living. Patient is alert and oriented to the person but forgetful and confused. -The note documented that the hospice SW left a voice message for the POA/resident representative to call the hospice social worker with any questions. Nurse's notes dated 8/23/22 at 3:02 a.m. read in part: Resident is receiving pain and anxiety medications as ordered by Hospice. Condition is declining slowly. He is getting more anxious and restless. Body is showing more weight loss. Nursing notes dated 8/24/22 at 10:33 p.m. read in pertinent part: (Resident) started declining and Hospice notified. (Resident) resting comfortably with no SOB (shortness of breath), distress or anxiety noted. Medications given as prescribed. -There were no progress notes to document that the resident's POA/representative was notified by the facility of the resident's change of condition, including increased anxiety, weight loss and decline. Nursing notes dated 8/26/22 at 1:14 a.m. read in pertinent part: Resident appears actively dying. (Resident) is unable to open his eyes and hard to swallow medications, comfort care provided, body repositioned, mouth care provided, safety maintained, will continue to monitor per care plan. -There were no nursing notes documenting that facility staff notified the POA/resident representative of the resident's change of conation. The resident's POA/resident representative was not notified of the resident's change of condition until hospice arrived to assess the resident hours later (see hospice note below). Hospice registered nurse (RN) visit notes dated 8/26/22 at 8:22 a.m. read in pertinent part: Patient's current mental status: deteriorating, not oriented to person place or time. Current status of the patient's appearance: deteriorating. Current status of the patient's pain/comfort: deteriorating. Patient had a major change in condition precipitated by an episode of extreme agitation and is no longer able to communicate. Beginning daily updates to evaluate change in condition. POA/resident representative notified with an update. C. Staff interviews The assistant director of nursing (ADON) was interviewed on 8/29/23 at 3:10 p.m. The ADON said that the nurse on duty was to notify the resident's family/ representative any time a resident experienced a change of condition and document the contact in the resident record. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social services director (SSD) was interviewed on 8/29/23 at 5:30 p.m. The SSD said the resident representative should always be notified as soon as possible when there was a change in a resident's condition unless the resident did not want others to be notified. The NHA and director of nursing (DON) were interviewed on 8/29/23 at 5:45 p.m. The DON said the hospice provider made notification to Resident #120's family when the resident had a change in condition. The DON was unable to find documentation of facility staff making any notification to the resident's POA when the resident first experienced a change of condition and acknowledged that facility nursing staff did not make notification of the resident's change of condition to the resident's POA.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on observations, interviews and record review, the facility failed to provide a clean, comfortable, homelike environment for residents. Specifically, the facility failed to ensure: -Resident rooms and unit hallways were clean, comfortable, free of urine odors and in good repair throughout the facility; and -Resident bed linens were in clean, stain-free condition. Findings include: I. Facility policy The Homelike Environment policy, revised February 2021, provided by the nursing home administrator (NHA) on 8/28/23, included in pertinent part: Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. The facility staff and management maximizes to the extent possible the characteristics of the facility that reflect a personalized, homelike setting to include: -clean, sanitary and orderly environment; -clean bed and bath linens that are in good condition; -pleasant, neutral scents. II. Observations and interviews On 8/23/23 starting at 8:45 a.m. the facility environment was observed, revealing the following conditions. -Resident room [ROOM NUMBER] was cluttered with boxes of the resident's personal items stacked in the corners and around the wall. Resident #48 said she was unhappy about all the boxes in her room and that she could not unpack and display her personal belongings. Resident #48 said staff do not help her get this done and no one is willing to help her create space for her personal belongings. -Resident room [ROOM NUMBER] was cluttered with the resident's belongings; items were packed on the furniture and piled in the corner. Resident #5 and Resident #1 said there was not enough space to store personal belongings so the items were left on the floor; and staff does not offer any solutions. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident room [ROOM NUMBER] had holes in the ceiling in the resident's bedroom. -Resident room [ROOM NUMBER] had boxes stacked on the resident's bed and around the bed. Resident #8 said she does not have enough room to unpack or store her personal belongings so she keeps them on her bed. -Resident room [ROOM NUMBER] had cluttered items, food stains on the wall, floor and bedside table; and particles that appeared to be dried food debris on the bedroom floor. -Resident room [ROOM NUMBER] had a strong urine odor that drifted out in the hall. There was no shelving or dresser space for the resident's personal items, so the resident's personal items were sitting on the floor around the resident's bed. -Resident rooms #27 and #28 were cluttered and disorganized, resident personal items were sitting on the floor around the resident's bed. -Resident room [ROOM NUMBER] had dirty bed linen with multiple yellow and brown stains. There was a soiled urinal hanging off a trashcan next to the resident's bed. The floor near the resident bed was soiled and stained with blackened debris and was sticky under foot. The bedside was soiled with dried liquid and food crumbs. -Resident room [ROOM NUMBER] had a strong smell of urine throughout the room. The smell was so strong it could be smelled from down the hall. -The floors in resident rooms #115, #116, #117, #124 were heavily stained with black marks, and had food and paper debris across the floors. -The south side of the building had dark stains on the walls around most of the doors. The overall condition of the hallway was unsanitary with food crumbs and staining visible on the floor. On 8/24/23 at 3:40 p.m., in resident room [ROOM NUMBER], Resident #46 and the resident's representative were visiting. The resident's representative was observed cleaning up the room and collecting food plates and covers from the resident's lunch and piling them into the lunch tray. -The resident's representative said the dirty dishes were left over from the lunch meal. It was frustrating that the facility staff frequently failed to collect the resident meal trays timely after the meal was done. The representative said she frequently had to take the dirty dishes back to the kitchen and had to pick up the resident's room during their visits because the staff did not tidy up the resident's room. -The resident representative said every time she came in to visit the resident's wheelchair was full of stuff; the resident's artificial leg was laying on the floor and the call light as if it were tossed there instead of placed neatly in the corner. V. Additional staff interviews (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The housekeeping supervisor (HSKS) was interviewed on 8/28/23 at 11:30 a.m. The HSKS said he just started his position a couple of days ago. The prior housekeeping team had been short staffed and had not been keeping up with cleaning duties. Members of the corporate office had been in the building recently and completed a walkthrough with the HSKS. They made a list of cleaning tasks and set a deadline for 9/15/23 to complete the list. The HSKS said there were a lot of areas that needed attention and his new team was working to get their cleaning priority list completed. The HSKS said nursing staff would have to assist with organizing and tidying up the residents' belongings as his team was focused on environmental cleaning. The NHA said they had concerns with the long standing housekeeping team, the facility recently hired a new HSKS and gave the team a list of items that needed to be addressed with a strict deadline to complete the cleaning tasks.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41032 Based on record review and interviews, the facility failed to ensure a written notice of bed hold was provided at the time of hospitalization to two (#121 and #122) of three residents reviewed out of 33 sample residents. Specifically, the facility failed to ensure Resident #121 and Resident #122 and their representative(s) were provided a bed hold notice informing them of their right for timely readmission after a therapeutic leave and appeal procedures for denial of readmission when sent to the hospital for mental health treatment. Findings include: I. Facility policy and procedure The Bed Hold policy and procedure, undated, was provided by the nursing home administrator (NHA) on 8/29/23 at 5:30 p.m. It revealed, in pertinent part, Residents and or representative are informed of the facility and state bed hold policy. All residents/representatives are provided written information regarding the facility bed-hold policies, which addresses holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents are provided written information about these policies at least twice: well in advance of any transfer and at the time of transfer or if the transfer was an emergency, within 24 hours. II. Interview A hospital representative was interviewed on 8/23/23 at 11:37 a.m. The hospital representative said neither Resident #121 or Resident #122 were provided a bed hold notice or given information regarding their right to return to the facility or appeal rights in the event of the facility refusing to readmit the residents when each of the residents were sent to the hospital on psychiatric hold for aggressive behaviors. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospital representative said the facility said they would readmit Resident #121 to the facility when the resident was psychiatrically stable and taking medication voluntarily. The facility said once the resident was assessed to be stable they would reassess the resident for readmission. The resident had been compliant with medication and treatment, was assessed to be stable on day 62 of hospitalization , and had returned to baseline behavior. The facility was notified. The facility said they would see the resident and assess the resident for readmission. On day 65, the resident was still awaiting the facility to reassess the resident for readmission. The hospital representative said the resident was asking and wanted to go home. On day 68, a facility liaison contacted the hospital to say they could not meet the resident's needs; despite that, no facility staff went to the hospital to assess the resident. On day 70, the facility told the hospital they would have to postpone assessing the resident due to other activities occurring at the facility. On day 78, 16 days after the resident was determined by hospital medical staff to be ready for readmission to the facility the facility staff assessed the resident for readmission. On day 83, 22 days after the resident was assessed to be back at baseline and taking prescribed medications, the resident and the resident's family became very frustrated with the facility's lack of attention to readmission. Not knowing what else to do, the resident and family began seeking alternative nursing facility placements. On day 84, another nursing facility accepted the resident for admission into care. The hospital representative said the facility came out on 5/5/23 and issued Resident #122 a discharge notice with appeal rights. This was the first document regarding placement and discharge provided to Resident #122. III. Resident #121 A. Resident status Resident #121, age 72, was admitted on [DATE] and was transferred to the hospital on 6/13/23. According to the June 2023 computerized physician orders (CPO), the diagnoses included schizophrenia, hypertension, and dysphagia (difficulty swallowing). The 6/13/23 discharge minimum data set (MDS) assessment revealed the resident had an unplanned discharge to an acute hospital with an anticipated return. The resident was unable to complete the brief interview for mental status. Staff assessment of the resident revealed the resident had short-term and long-term memory impairment, disorganized thinking, and required assistance in making decisions regarding tasks of daily life. The resident had delusions and displayed verbal behavioral symptoms. The resident did not reject care. The resident needed supervision level of care to complete activities of daily living and was independent while walking. The resident took daily antipsychotic medication. B. Record review Progress notes from 5/1/23 to 6/13/23 revealed Resident #121 started refusing medications on 6/1/23. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Notes dated 6/2/23 at 12:36 p.m. read in part: Resident has refused medication for two days. Resident stated she refused her medication because she believes the medication is causing her pain. The resident's physician was notified. -Notes dated 6/9/23 at 3:08 p.m. read: Resident has been refusing medication and nursing care. Resident stated that 'my medications are not helping'. MD (physician) was notified. Education was given, will continue monitoring and educating the resident. -Notes dated 6/13/23 at 11:00 a.m. read: Resident alert but showed agitated behavior, verbally abusive to everybody and refused to take medication. Emotional support was provided but it's useless. -Notes dated 6/13/23 at 12:30 p.m. read: Gave her scheduled Invega injection (antipsychotic medication for schizophrenia and mood support) under support of three peoples emotional support (a friend and two others gave verbal encouragement) . Her best friend (name) helped her with emotional support. Resident showed the same behavior. Keep on monitoring the resident, distanced from another resident to prevent feeling of insult. -Notes dated 6/13/23 at 5:30 p.m. read: Had emergency meeting. MD then gave order of transfer to hospital psychiatric unit. Arranged transportation for transfer. Resident refused to go to hospital, showed same behavior. Family tried to convince her through the phone and in person but were unsuccessful. The transportation team arranged for a 911 team to assist and the resident was transferred to the hospital at 4:52 p.m. Record review revealed the resident's medical record failed to contain a copy of a bed hold notice for 6/13/23 or that it had been provided to the resident/representative within 24 hours of the resident transfer to the hospital. Additionally, the record failed to document the reason why the resident was not permitted to return to the facility after the hospital assessed the resident to be back at psychiatric baseline of prior function to the event that caused the resident to be sent for psychiatric treatment in the first place (see interview above). There was no physician documentation in the resident record to indicate that the facility was unable to meet the resident's physical or psychiatric care needs. IV. Resident #122 A. Resident status Resident #122, age 67, was admitted on [DATE] and was transferred to the hospital on 4/28/23. According to the June 2023 computerized physician orders (CPO), the diagnoses included diabetes, chronic obstructive pulmonary disease (COPD) and substance use disorder. The 4/28/23 discharge minimum data set (MDS) assessment revealed the resident had an unplanned discharge to an acute hospital with a return not anticipated. The 1/29/23 MDS quarterly assessment documented that the resident had moderately impaired cognition with a BIMS score of 10 out of 15. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Both the discharge and quarterly MDS assessment documented the resident had no behaviors and did not reject care. The resident was independent with most ADLs but needed supervision level of care while bathing. The resident was not on any psychotropic medications. B. Record review Progress notes failed to document the reason for the resident's discharge to the hospital but documented the resident was admitted to the hospital and on leave. Record review revealed the resident medical record failed to contain a copy of a bed hold notice for 4/28/23 or that it had been provided to the resident/representative within 24 hours of the resident's transfer to the hospital. Notes dated 5/10/23 at 11:04 a.m. read: Topic: Discharge plan: On 5/5/23 at noon this writer (NHA) visited Resident #122 at (hospital name) hospital and informed him that due to his homicidal ideation and violence directed towards other residents at the facility as well as his statement that he had access to a gun, (facility name) would no longer be able to care for him. This writer offered to help find appropriate placement for (resident name). The ED (emergency department) social worker stated that they had a discharge plan in place. V. Staff interviews The NHA was interviewed on 8/27/23 at 11:45 a.m. The NHA said the facility provided bed hold notice upon admission and upon transfer of the resident to the hospital but the facility did not provide either Resident #121 or Resident #122 a bed hold notice. The NHA said the facility intended to hold the resident beds and readmit the residents once they were deemed to be psychiatrically stable. Once Resident #122 reported intent to harm other residents in the facility, the facility made a decision they were unable to readmit Resident #122 due to a belief that the resident posed a threat to himself and to other residents. The NHA said the facility should have provided the notice to each resident within 24 hours of transfer to the hospital. The social services director (SSD) was interviewed on 8/28/23 at 2:00 p.m. The SSD said she was the discharge planner and usually worked with residents when they were transferring to another facility or being discharged for nonpayment. The SSD said she was not involved in emergency discharges and was not sure who was responsible for issuing the bed hold notices to residents being transferred out to the hospital but believed it would have been the discharging nurse's responsibility. The SSD said discharge notices were provided by the NHA.

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care by qualified persons according to each resident's written plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, interviews, and record review, the facility failed to provide services by qualified persons for one (#64) out of 35 sample residents. Specifically, the facility failed to ensure Resident #64 was assessed by a registered nurse (RN) after a fall. Findings include: I. Resident status Resident #64, under age 65, was admitted on [DATE]. According to the August 2023 computerized physician orders (CPO), diagnoses included anxiety disorder, depression, presence of right artificial hip joint, osteoporosis, chronic obstructive pulmonary disease (COPD), fracture of an unspecified part of the neck, pain in the right leg, unsteadiness on feet, repeated falls, and acute respiratory failure with hypoxia (insufficient oxygen in the tissue to sustain bodily function) According to the 6/30/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required limited assistance for activities of daily living, bed mobility, transfers, grooming, and toilet use. The MDS revealed the resident had two or more falls since admission. II. Record review The comprehensive care plan initiated 6/23/23 and revised 7/18/23, identified the resident was at risk for falls. Interventions include encouraging the resident to use her call device for assistance, ensuring the resident is wearing appropriate footwear, and falling matt next to her bed for injury prevention. Progress note dated 6/24/23 at 11:17 a.m. written by licensed practical nurse (LPN) #2, documented that the physical therapist reported that Resident #64 had a witnessed fall while walking to the bathroom without her walker. The note documented that a physical therapist (PT) assisted the resident from the floor and took the resident to the bathroom without first having the registered nurse (RN) on duty assess the resident for injuries. The progress note documented that an assessment was conducted the resident's range of motion (ROM) was within a normal level, had redness on both knees with no other observed injuries. The resident denied pain or discomfort. Immediate action taken was to remind the resident to use her walker with ambulation. -The progress note did not identify who completed the assessment after the fall. (continued on next page)

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F 0659 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress note dated 7/28/23 at 2:33 p.m., written by LPN #3, documented that Resident #64 was found on the floor by therapy staff in the smoking area. The resident stated she fell while attempting to assist another resident. -The therapy staff helped the resident back into her wheelchair without first having the RN on duty assess the resident for injuries. A full review of the resident's medical record was conducted on 8/29/23 at 11:15 a.m. The resident's medical record did not reveal documentation that the resident was assessed by an RN following the fall either resident's fall on 6/24/23 or 7/28/23. III. Staff interviews LPN #2 was interviewed on 8/29/23 at 11:45 a.m. The LPN said when a resident fell she would go to the location of the fall and ensure that the resident was safe then call for a RN to complete the assessment before anyone assisting the resident from the floor. The LPN said it was outside her scope of practice to assess a resident after a fall. The director of nursing (DON) was interviewed on 8/29/23 at 2:21 p.m. The DON said the staff should get the RN on duty immediately to assess the resident's condition to ensure moving the resident would not cause further injury, additionally; No one should move the resident off the ground without the RN completing an assessment and giving staff the approval to move the resident. An LPN was not able to conduct an assessment because it was outside of an LPN's scope of practice. The DON said she confirmed with the physical therapist who discovered Resident #64's falls and who had also assisted the resident up off the floor. The PT confirmed that the RN was not notified and that the RN did not assess the resident before the resident was assisted up off the floor. The DON said she educated the PT that the RN always needs to assess the resident prior to a lift assist off the floor after a fall and also had a conversation with the director of rehabilitation (DOR) to provide education to the therapy department that they must call the RN to assess the resident before assisting the resident up for the floor to avoid further injury to the resident.

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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** 47150 Based on observations, record review, and interviews, the facility failed to ensure resident were free from accidents and hazards situations for one (#25) of three residents reviewed out of 35 sample residents. Specifically, the facility failed to ensure: -Resident #25 had the ability to access the call light to call for staff assistance during showering; and, -Staff responded to resident #25 when the resident had been in the shower room for over 45 minutes coughing and unable to get to the call light for staff assistance. Findings include: I. Facility policies and procedures The safety and supervision of residents policy, revised 7/2017, was provided on 8/29/23 at 5:30 p.m. by the nursing home administrator (NHA). It read in pertinent part: The facility strives to make the environment as free from accident hazards as possible. The residents' safety supervision and assistance to prevent accidents are the facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes and the facility-wide commitment to safety at all levels of the organization. -Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. II. Resident #25 A. Resident status Resident #25, under the age of 65, was admitted on [DATE]. According to the August 2023 computerized physician orders (CPO), the diagnosis included, severe obesity, major depressive disorder, obstructive sleep apnea, chronic pain syndrome, dependent on supplemental oxygen, According to the 8/4/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent with activities of daily living (ADLS), transfers, toileting, and bed mobility, and required supervision and oversight encouragement or cueing with one person's physical assistance with dressing. B. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's comprehensive care plan last revised on 9/14/17 documented Resident #25 had limited ability to perform activity of daily living (ADL), and self-care performance deficit due to obesity and activity intolerance. Interventions for bathing included the resident needing assistance getting into and out of the shower room due to the use of an oversized wheelchair. Ensure the call light is within the resident's reach and encourage her to use the call light to call for assistance. -The care plan was not revised to include new interventions to ensure the resident did not get stuck in the shower room unable to access the call light to call for staff assistance during showers. The progress note dated 8/24/23 documented Resident #25 had an episode of nose bleeding while in the shower room. Resident stated she was coughing and triggered nose bleeding. The resident was assisted back to her room and placed cold compress over the bridge of her nose and the nosebleed stopped. Nasal saline gel was applied to the resident nostril. The resident oxygen level was 84 percent. Oxygen was applied via nasal cannula and the resident's oxygen level increased and was stable at 98 percent. C. Observations On 8/24/23 at approximately 11:00 a.m., an uncontrollable loud coughing was heard coming from a bathroom/shower room on the south side of the building. The cough continued for over 39 minutes which prompted an investigation to see if someone needed assistance; who was coughing; and where the cough was coming from At 11:36 a.m., the investigation revealed that Resident #25 was in the showroom and unable to reach the call light to summon staff assistance. Upon finding the location where the coughing was coming from it was discovered that three dietary staff including the dietary manager were meeting in an office located next door to where the coughing sound was coming from. The door to the dietary off was open. The three dietary staff were approached and asked if they knew who was in the room next door to their office; they did not know who was in the room next door coughing. The coughing could be clearly from inside of the dietary office as the office door and the shower room door were five feet apart and sharing a common wall between the two rooms An unknown male dietary staff went to the room where the coughing was coming from knocked on the door and tried to enter. The dietary staff could not gain access to the shower room because Resident #25's wheelchair was blocking the door. The dietary staff was able to crack the door to speak to the resident. The resident had labored breathing but was able to tell staff she was stuck and needed assistance from nursing staff and help to get out of the shower room. The dietary staff alerted nursing staff registered nurse (RN) #1 arrived at the scene and attended to the resident. Resident #25 continued coughing and had shortness of breath and a bloody nose during the observation. In addition to aggressive persistent cough, and having a bloody nose the resident had facial redness and signs of respiratory distress. RN #1 cleaned the blood from the nosebleed and began assessing the resident for signs and symptoms of illness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At 11:45 a.m., the resident was assisted out of the shower room by RN #1. Resident #25 had to stand up with the nurses assistance while another staff folded up the resident's wheelchair because it would not fit through the door fully opened with the resident seated in the chair. Once the chair was in the hall the RN and staff physically assisted the resident to walk to the chair. The resident was fatigued and unable to walk with the staff assistance. RN #1 then escorted the resident to her room for further assessment and care. Observations about the physical layout of the shower room revealed a narrow entry door. The wheelchair was wider than the entrance of the bathroom and could not fit without having the resident stand up, fold her wheelchair closed then push the wheelchair through the doorway, open her chair back up and sit down in the wheelchair,or have staff assist her in the process of getting into the room. The room contained a sink toilet and roll in shower. The call light was placed in a narrow pathway in a tight corner where the resident's wheelchair could not fit due to the size of the wheelchair. The shower room was not spacious enough for the resident to be able to freely maneuver around in her wheelchair. D. Interviews RN #1 was interviewed on 8/24/23 at 2:30 p.m. The RN said it was brought to her attention that a resident needed assistance in the front shower room. The RN said the resident (#25) went to the shower room to shower but started coughing and became weak and unable to reach the call light or call for assistance. The RN said with the help of other staff she was able to assist the resident out of the shower room, because the resident was too weak and out of breath to get out of the shower room on her own. The RN said she assessed the resident and noticed the resident had oxygen desaturating (a condition when the body's saturations (oxygen levels) are dropping) and was assessed to have an oxygen saturation (a crucial measure of how well the lungs are working) of 84 percent (a normal level of oxygen saturation is usually 95 percent or higher; reading between 90 and 92 percent are considered low oxygen level, also called hypoxemia - inadequate levels of oxygen in body tissues and blood. A reading this low means you might need supplemental oxygen or that there may be challenges that affect how your lungs function. A result below 90 percent indicates that a person should seek medical attention). Resident #25 was interviewed on 8/29/23 at 9:30 a.m. The resident said she usually used the front southside shower room by her own choice and had to fold up and push her wheelchair thru the door because of the doors narrow size. On the day she got stuck in the shower room she entered at approximately at 10:20 a.m. and was getting ready to take a shower when she suddenly developed an uncontrollable cough and then became short of breath, fatigued and weak in both legs, resident #25 said she was unable to stand and walk to the call light that was out of reach because her wheelchair was too wide to fit down into the pathway by the toilet where the shower rooms call light was placed in the corner of the room. Resident #25 said she was also too short of breath to yell for help. Resident #25 said she was in the shower room coughing with her nose bleeding for over an hour and thirty minutes before staff arrived to help her. She felt trapped in the bathroom. RN #1 was interviewed on 8/28/23 at 4:32 p.m. RN #1 said since the bathroom incident with Resident #25 just happened one time she did not think there should be any changes to the resident's care plan. She said the resident should be able to continue showering in that same bathroom without additional supervision. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #2 was interviewed on 8/29/23 at 11:30 a.m. The LPN said the resident was now taking baths in the back bathroom located near the nursing station. LPN #2 said staff should provide supervision for the resident during showers. The LPN said she was unsure if the resident's care plan was updated to include the new shower routine. The LPN said she believed the resident's care plan should be updated so staff were aware that the resident neede to be checked on during showering, to avoid another incident from happening. Certified nurse aide (CNA) #6 was interviewed on 8/29/23 at 11:40 a.m. CNA #6 said the resident was independent with showers and was able to get herself in and out of the bathroom without any assistance from staff. The CNA said she was unaware of any changes to the resident's shower routine. The NHA interviewed on 8/29/23 at 12:12 p.m. The NHA said the facility maintenance team had modified the call light system in the front bathroom to allow easy access for a resident to reach the cord without having to get down the narrow pathway by the toilet to reach the call light. -When checked and tested with the NHA the modified call light would not alarm because the angle of the call light's pull cord did not facilitate activation. The manner in which the call light was modified only allowed for the cord to be pulled sideways and the call light cord needed to be pulled straight in a downward motion to activate the call light. The NHA acknowledged the call light was not functional for resident use and said he would alert the maintenance staff to come up with a different solution. The director of nursing (DON) was interviewed on 8/29/23 at 2:30 p.m. The DON said the dietary staff whose office was next door to the shower room, where Resident #25 was discovered, should have checked on the resident to see if she was ok when they heard the resident coughing excessively and or called for nursing assistance, The DON said she thought the dietary staff probably thought since they were not nursing staff it was not their responsibility to check on residents. The DON said she would make sure that all staff including the dietary staff were educated of the responsibility to ensure all residents were safe and received care when needed. The DON said Resident #25 was independent with showering and they did not want to take that away for the resident; however, the staff should be aware to check on the resident routinely when she was in the shower room and the resident's comprehensive care plan should be updated to reflect interventions for the resident's shower routine to ensure staff were aware of the need to check on the resident for safety. The DON said the facility would provide education to all the departments on potential accident hazards, demonstrate competency on how to identify and report accident hazards and try to prevent potential and avoidable accidents and hazardous situations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 8/29/23 at 5:30 p.m. The NHA said the maintenance department had located a remote door bell that could be placed in the area of the residents shower for easier access to call for staff assistance. The remote alarm end would be placed at the nurse station to alert nursing staff when a resident was in the front shower room and needed assistance. The system still needed to be tested to make sure the distance and placement of the ringer was functional; they would need to have a monitoring system to make sure the batteries were tested for and changed routinely to ensure the system was fully functional. In the meantime they were encouraging resident #25 to use the shower room closer to the nurses station for her personal safety until a function and accessible call light system was installed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on resident observations, record review, and staff interviews, the facility failed to ensure residents received respiratory treatment as ordered for one (#46) of one resident reviewed for supplemental oxygen use out of 35 sample residents. Specifically, the facility failed to acquire a physician's order before administering oxygen to Resident #46. Findings include: I. Facility policy The Oxygen Administration policy, dated April 14, 2023, was provided on 8/29/23 at 5:30 p.m. by the nursing home administrator (NHA). It read in pertinent part: Oxygen is administered and stored to residents who need it, consistent with professional standards of practice, comprehensive person-centered care plan, and the resident's goals and preferences. The policy explanation and guidelines included: 1. Oxygen will be administered under orders of a physician, except in case of emergency. In such cases, Oxygen shall be administered and orders for Oxygen shall be obtained as soon as practicable when the situation is under control. 2. Staff shall document the initial and ongoing assessment of the resident's condition warranting Oxygen and the response to Oxygen therapy. 3. The resident's care plan shall identify the interventions for oxygen therapy, based on the resident's assessment and orders. II. Resident #46 A. Resident status Resident #46, over age 65, was admitted on [DATE] and readmitted on [DATE]. According to the August 2023 computerized physician orders (CPO), diagnoses included acute respiratory failure with hypoxia (insufficient amount of oxygen in the body), chronic systolic congestive heart failure, ischemic heart disease, chronic pain, and myocardial infarction (heart attack). According to the 8/4/23 minimum data set (MDS) assessment, the resident was cognitively intact with a brief interview for mental status (BIMS) score of thirteen out of 15. The resident required extensive assistance for bed mobility, grooming, toileting, and transfers. The resident was not assessed to be on oxygen therapy. B. Record review (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan initiated on 7/31/23 revealed that the resident had signs and symptoms of respiratory distress and acute respiratory failure with hypoxia. The care focus included the following interventions: monitor and report to the medical director (MD) any signs and symptoms of respiratory distress, increased heart rate, restlessness, confusion, or cough. Oxygen settings via nasal prongs/mask. -The care plan did not include parameters for the prescribed liter flow of oxygen therapy, duration of treatment or the specific method by which the oxygen would be delivered; it gave two methods: nasal cannula (prong) and mask. The August 2023 CPO did not include a physician's order for oxygen therapy, that included the oxygen liter flow, duration of treatment, or method of delivery. The 8/1/23, through 8/6/23 skilled nursing progress notes, documented the resident was receiving oxygen therapy via nasal cannula at two (2) liters per minute (LPM). C. Observations On 8/23/23 at 11:27 a.m., Resident #46 was observed. Resident #46 lying down in bed receiving oxygen therapy by nasal cannula. The resident's oxygen concentrator was set to 3 LPM. On 8/23/23 at 4:14 p.m., Resident #46 was observed. Resident #46 was sleeping in his bed receiving oxygen therapy by nasal cannula. The oxygen concentrator was set at 3 LPM. On 8/24/23 at 4:38 p.m., Resident #46 was observed. Resident #46 was awake in bed receiving oxygen therapy by nasal cannula. The concentrator was set at 3 LPM. On 8/28/23 at 11:28 a.m., Resident #46 was observed. A staff member assisted the resident from his wheelchair to his bed and applied a nasal cannula tubing to the resident's nostrils. The tubing was connected to an oxygen concentrator which was set to 3 LPM of oxygen. D. Staff interviews Licensed Practical Nurse (LPN) #1 was interviewed on 8/29/23 at 9:10 a.m. LPN #1 said oxygen was considered a medication and needed to be administered according to a physician's order. The LPN said there was a physician's order in place for the resident to receive oxygen therapy at 2 LPM to 3 LPM via nasal cannula; however, when the LPN looked into the resident's CPO, the LPN could not locate the physician's order for the resident's oxygen therapy. The LPN said the resident needed oxygen therapy to avoid a possible negative outcome such as a hypoxia which could lead to confusion, bluish skin, and changes in breathing and heart rate. The LPN said, however, the nurses needed a physician's order to follow for oxygen therapy and should not be given oxygen therapy without a physician's order. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 8/29/23 at 1:45 p.m. The DON said oxygen was considered a medication and required a physician's order in order to be administered. The DON said there should be an order for resident #46's oxygen therapy. The DON said a negative outcome of the resident not receiving oxygen therapy was that the resident could end up in respiratory distress, but the nurses need to follow the physician's orders for the specific LPM and method of delivery. The DON said in cases of extreme emergencies where oxygen therapy was needed she expected nursing staff to apply the oxygen and notify the resident's physician that there was a change in the resident condition and request a physician's order for oxygen therapy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record reviews, and interviews, the facility failed to ensure that drugs/biologicals were stored and disposed properly upon expiration. Specifically, the facility failed to dispose of expired Cephalexin (antibiotic medication) and Levemir injection pen (insulin medication device). Findings include: I. Professional reference According to the Food and Drug Administration (FDA), FDA, Keflex (Cephalexin) Oral Suspension, Highlights of Prescribing Information (2018), retrieved from https://www.accessdata.fda.gov/drugsatfda_docs/label/, d+[DATE]s013lbl.pdf, on [DATE], advised refrigerate Cephalexin after mixing. Medication may be kept for 14 days without significant loss of potency. According to Novo Nordisk, manufacturer recommendations, Taking Levemir (2022), retrieved from https://www.mynovoinsulin.com/insulin-products/levemir/taking-levemir.html, on [DATE], Dispose of the Levemir pen after 42 days, even if there is insulin left in the pen. II. Facility policy The facility medication labeling and storage policy, revised February 2023, was provided by the nursing home administrator (NHA) on [DATE] at 5:30 p.m. It read in pertinent part, The nursing staff is responsible for maintaining storage and preparation areas in a clean, safe and sanitary manner. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Opened or accessed multidose vials are outdated and discarded within 28 days, unless manufacturer specifies shorter or longer duration. -The policy did not provide direction to nursing staff for determining discard dates for single patient use of insulin pens, including Levemir. III. Observations and interviews On [DATE] at 3:45 p.m. medication storage room was observed with registered nurse (RN) #1. The medication storage refrigerator contained two bottles of Cephalexin suspension labeled for Resident #57 with expiration label instruction to discard after [DATE]. Registered Nurse (RN) #1 was interviewed on [DATE] at 3:45 p.m. RN #1 said the Cephalexin suspension for Resident #57 with a written expiration on the bottle to discard [DATE] should be removed from the refrigerator and discarded. The RN took the medication out of the refrigerator to discard. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:50 a.m., the south hall medication cart was observed with certified nursing assistant with medication administration authority (CNA) #1. A Levemir insulin injection pen was observed in the cart. The Levemir insulin pen was labeled with an open date that was difficult to read and appeared to be labeled as being opened/first used on [DATE]. -The insulin injection had been opened and had been in use for 50 days well over the manufacturer recommendations for use to administer to a patient (see professional reference above). CNA #1 with medication administration authority was interviewed on [DATE] at 11:50 a.m. CNA #1 was unsure what date on the Levemir insulin pen was, as the writing on the label was difficult to read. CNA #1 said the open date written on the label of the insulin injection pen could have been [DATE] but it was not clearly written and therefore the insulin should be disposed of; because all insulin pens should be disposed of 28 days after opening. IV. Other interviews The director of nursing (DON) was interviewed on [DATE] at 12:55 p.m. The DON said that a refrigerated liquid medication (ie Cephalexin) with a discard by date of [DATE] should have been discarded on the last day of [DATE]. The DON said that the Levemir insulin pen should be discarded 28 days after opening.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48458 Based on observation, interviews and record review the facility failed to store food in a sanitary manner in one of two residents' snack refrigerators. Specifically, the facility failed to ensure proper unit refrigerator temperatures were maintained in the south hall for resident snack refrigerators that contained ready to eat perishable foods intended for resident consumption. Findings include: I. Professional reference The Colorado Retail Food Regulations, effective 1/1/19 and retrieved 9/5/23 from https://cdphe.colorado.gov/environment/food-regulations read in pertinent part, Except during preparation, cooking, or cooling, time and temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less. Equipment for cooling and heating food, and holding cold and hot food, shall be sufficient in number and capacity to provide food temperatures as specified. The FDA (Food and Drug Administration) food code reviewed 3/27/23 and retrieved 9/5/23 from https://www.fda.gov/food/fda-food-code/food-code-2022 read in pertinent part, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone (41 degrees to 135 degrees F) for too long. II. Facility policy The facility policy for food from outside sources was reviewed, revised 7/28/23, was provided by the nursing home administrator (NHA) on 8/23/23 at 10:00 a.m. It read, in pertinent part, To assure foods are safe, to prevent foodborne illness, to assure safety for swallowing and chewing, and to add quality of life for residents, questionable food may be removed until safety is determined. Food includes any edible food stuff, including snacks, candy, beverages, or anything made for human consumption. Cold foods must be stored at 41 degrees or lower. If food is above 41 degrees and temperature is documented for less than one hour, the food may be served. If food is higher than 41 degrees and exceeds one hour, the food is advised to be discarded. III. Observation and record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065290	A. Building B. Wing	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestmoor Care Center	895 S Monaco Pkwy Denver, CO 80224

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/24/23 at 5:10 p.m., the resident snack refrigerator for the south hallway was observed. The thermometer inside the shared unit snack refrigerator had a high out of range temperature reading of 46 degrees F. The refrigerator temperature log for August 2023 was taped to the refrigerator, and contained a. m. and p.m. columns for recording refrigerator temperatures; the a.m. columns were completed, and the p.m. columns did not have any entries for any days of August 2023. The recorded temperatures for August, 2023 were as follows: -On 8/1/23, the temperature was 46 degrees F; -On 8/2/23, the temperature was 46 degrees F; -On 8/3/23, the temperature was 46 degrees F; -On 8/4/23, the temperature was 46 degrees F; -On 8/5/23, the temperature was 44 degrees F; -On 8/6/23, the temperature was 46 degrees F; -On 8/7/23, the temperature was 46 degrees F; -On 8/8/23, the temperature was 44 degrees F; -On 8/9/23, the temperature was 46 degrees F; -On 8/10/23, the temperature was 46 degrees F; -On 8/11/23, the temperature was 46 degrees F; -On 8/12/23, the temperature was 44 degrees F; -On 8/13/23, the temperature was 46 degrees F; -On 8/14/23, the temperature was 46 degrees F; -On 8/15/23, the temperature was 46 degrees F; -On 8/16/23, the temperature was 46 degrees F; -On 8/17/23, the temperature was 44 degrees F; -On 8/18/23, the temperature was 44 degrees F; -On 8/19/23, the temperature was 46 degrees F; -On 8/20/23, the temperature was 46 degrees F; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/21/23, the temperature was 46 degrees F; -On 8/22/23, the temperature was 46 degrees F; -On 8/23/23, the temperature was 46 degrees F; -On 8/24/23, the temperature was 46 degrees F -The refrigerator temperature log contained a column for corrective action of temperature greater than 41 degrees F, however, the column had no corrective action entries documented. The refrigerator contained two partial containers of milk, one opened ranch salad dressing, one vanilla nutrition shake, a labeled resident's mango, and a cooked hamburger in a plastic bag. The freezer was stocked with packaged frozen food. There was no thermometer was not present in the freezer, and there was no log for the freezer temperatures being monitored. A review of the snack refrigerator temperature log for the months of July 2023 revealed that daily documentation of temperatures were completed with documented temperatures ranging from 44 to 46 degrees F. The column for corrective action documentation had no entries. Freezer temperatures logs were requested on 8/24/2, The requested freezer temperature logs were not provided by the end of the survey to show that staff were monitoring the freezer temperatures. IV. Interviews Registered Nurse (RN) #1 was interviewed on 8/24/23 at 5:15 p.m. The RN stated that she did not know what the correct refrigerator temperature should be, and stated the night nurse checked the refrigerator temperature. The RN confirmed that the items in the refrigerator were for the residents. The nursing home administrator (NHA) was interviewed on 8/24/23 at 5:45 p.m. The NHA acknowledged the high refrigerator temperatures documented on the refrigerator temperature record logs for July 2023 and August 2023, and said that he would provide education regarding acceptable temperature ranges to the staff who were completing the logs.