STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065366	A. Building B. Wing	01/10/2024

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Pine Ridge Rehabilitation and Healthcare Center	119 Bastille Dr Pagosa Springs, CO 81147

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews the facility failed to ensure four (#11, #12, #21 and #46) out of 18 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to ensure blood pressure medication was ordered with administration parameters for Residents #11, #12, #21 and #46. Findings include: I. Professional reference According to Khashayar, F., [NAME], J. (2022). Beta Blockers. Stat Pearls. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK532906 retrieved on 1/19/24. Beta receptors are found all over the body and induce a broad range of physiologic effects. The blockade of these receptors with beta-blocker medications can lead to many adverse effects. Bradycardia (low heart rate) and hypotension (low blood pressure) are two adverse effects that may commonly occur. The patient's heart rate and blood pressure require monitoring while using beta-blockers. According to [NAME], R.G., [NAME], R.J. (2022). Calcium Channel Blockers. Stat Pearls. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK482473/ retrieved on 1/19/24. Calcium channel antagonists, also known as calcium channel blockers (CCBs), have been widely used for many indications. This cardiovascular drug class is one of the leading causes of drug-related fatalities. Patients require close monitoring. The improvement of their symptoms of angina or maintenance of their blood pressure is an indication of efficacy (effectiveness for the desired result). Hypotension (low blood pressure) may be profound and life-threatening. Many factors may affect the severity of overdose, including the calcium-channel antagonist dose, the formulation, ingestion with other cardioactive medications such as beta-blockers, the patient's age, and comorbidities. These medications may also be life-threatening with as little as one tablet in small pediatric patients. Kiziior, R. J., [NAME], K. J. (2023). Lisinopril. [NAME] Nursing Drug Handbook. Elsevier. P. 704. Obtain blood pressure, apical pulse immediately before each dose in addition to regular monitoring (be alert to fluctuations). According to [NAME], L.L, [NAME], P, [NAME] K (2023) Hydrochlorothiazide. National Library of Medicine. https://www.ncbi.nlm.nih.gov/books/NBK430766/ retrieved on 1/9/24. Hydrochlorothiazide is a (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication to treat hypertension and peripheral edema. Blood pressure should be closely monitored to ensure patients on hydrochlorothiazide treatment achieve and maintain their target blood pressure, minimizing the risk of adverse effects associated with high or low blood pressure. II. Resident #11 A review of the December 2023 computerized physician orders (CPO) revealed: -Metoprolol Tartrate Oral Tablet 25 milligrams (mg). Give 0.5 tablet by mouth twice daily, started 11/29/23. A review of the December 2023 medication administration record (MAR) revealed: -Metoprolol was administered on 12/4/23, 12/11/23 and 12/15/23 when the resident's blood pressure was low with normal blood pressure being 120/80. A review of the December 2023 blood pressure summary showed Resident #11 had a blood pressure of 85/44 on 12/4/23, a blood pressure of 85/54 on 12/11/23 and a blood pressure of 70/38 on 12/15/23. II. Resident #12 A review of the December 2023 CPO revealed: -Lisinopril Oral Tablet 20mg. Give one tablet by mouth one time a day related to essential primary hypertension, started 11/2/23. A review of the December 2023 MAR revealed: -Lisinopril was given on 11/24/23, 11/30/23 and12/26/23. A review of the November 2023 and December 2023 blood pressure summary showed Resident #12 had a blood pressure of 84/56 on 11/24/23, a blood pressure of 89/57 on 11/30/23 and a blood pressure of 78/53 on 12/26/23. III. Resident #21 A review of the December 2023 CPO revealed: -Hydrchlorithiazide (HCTZ) Oral Tablet 12.5 mg. Give one tablet by mouth three times daily related to essential primary hypertension. A review of the October 2023 medication administration record (MAR) revealed the HCTZ medication was administered consistently according to the order. A review of the October 2023 medication regimen review from the pharmacist revealed the resident had a diastolic blood pressure of less than 60, six times during the previous 30 days and the medication was administered. The pharmacist recommended either eliminating the medication or adding hold parameters in order to lessen the potential fall risk associated with hypotension (low blood pressure), drug to drug interactions and side effects. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #46 A review of the November 2023 CPO revealed: -Amlodipine Besylate Oral Tablet five mg. Give one tablet by mouth one time a day related to essential primary hypertension, date started 11/2/23 and was discontinued on 11/13/23. A review of the November 2023 MAR revealed amlodipine was given on 11/5/23. -A review of the November 2023 blood pressure summary showed Resident #46 had a blood pressure of 87/56 on 11/5/23. V. Interviews Registered nurse (RN) #1 was interviewed on 1/8/24 at 10:57 a.m. She said there were no standing orders for acceptable blood pressure ranges for residents on blood pressure medications. She said she used her own judgment when determining if the medication should be administered. She said the certified nurse aides with medication authority (CNA/MA) only took the resident's blood pressure when necessary as ordered by the physician. She said in most cases, the blood pressure was only ordered to be checked once daily. CNA/MA #1 was interviewed on 1/8/24 at 11:01 a.m. He said he checked residents' blood pressure if he was requested to and reported the results to the nurse on duty. The director of nursing (DON) was interviewed on 1/9/24 at 1:32 p.m. She said she was aware there were not currently any orders that directed staff on when it was appropriate to hold blood pressure medications. She said the CNA/MAs and nursing staff were to use good judgment and withhold medications when appropriate.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#44 and #16) of seven residents reviewed for unnecessary medications out of 18 sample residents were free from unnecessary medications. Specifically, the facility failed to: -Ensure Resident # 44 was assessed by the interdisciplinary team (IDT) prior to implementation of a psychotropic medication treatment and appropriate non-pharmacological interventions were initiated; -Ensure Resident #16's psychoactive medication, an antidepressant, was not increased without evidence and documentation of change of behaviors or attempts of non-pharmacological interventions, and, -Resident # 16's hours of sleep were documented for hypnotic medication use. Findings include: I. Facility policy The Psychotropic Medication Use policy, revised July 2022, was provided by the nursing home administrator (NHA) on 1/10/24 at 8:02 a.m. and read in parts: Residents who have not used psychotropic medications are not prescribed or given these medications unless the medication is determined to be necessary to treat a specific condition that is diagnosed and documented in the medical record. Consideration of the use of any psychotropic medications is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes. Non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications, permit the lowest possible dose, and allow for discontinuation of medications when possible. When determining whether to initiate, modify, or discontinue medication therapy, the IDT (interdisciplinary team) conducts an evaluation of the resident. II. Resident # 44 A. Resident status Resident #44, age [AGE], was admitted on [DATE]. According to the January 2023 computerized physician order (CPO) diagnoses included dementia, history of urinary tract infections and type 2 diabetes mellitus. The 1/2/24 minimum data set (MDS) assessment revealed resident's cognition was severely impaired with a brief interview for mental status (BIMS) score of two out of 15. Section E revealed presence of (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hallucinations and delusions, physical and verbal behavioral symptoms directed towards others occurred in one to three days. Rejection of care and wandering occurred in one to three days. B. Resident observations Resident #44 was observed on 1/8/24 throughout the day. She was wearing a dark coat and was carrying a purse. She was walking up and down the hallways throughout the facility and occasionally rested in the television room next to the nurses' station. She was invited to participate in the afternoon activities, however she did not stay. On 1/10/24 at approximately 9:30 a.m. the resident was observed walking on the 300 hall. She was dressed in a dark coat and was carrying a purse. She appeared upset and agitated. She said she did not know where she was and would like to go home. C. Record review Physician orders: -Seroquel oral tablet 25 mg (Quetiapine Fumarate) (antipsychotic medication), give one tablet by mouth three times a day related to unspecified dementia, mild, without behavioral disturbance. Start date 1/4/24 -Melatonin oral tablet 10 mg (Melatonin) (supplement used for insomnia), give one tablet by mouth at bedtime for insomnia. Start date12/28/23 Care plan: The comprehensive care plan review revealed the following: -(Resident) takes psychotropic medications r/t (related to) dementia with behaviors. Interventions included: Administer medications as indicated by physician orders. Consult with pharmacist/physician for gradual dose reduction if appropriate. Monitor for and report to physician adverse effects of antipsychotic medication use (drowsiness, dizziness, restlessness, weight gain, dry mouth, constipation, nausea/vomiting, blurred vision, low blood pressure, uncontrolled movements/tics/tremors, seizures, increased risk for falls). Review with resident/family/responsible person the risks vs. benefits of psychotropic medication use. Care plan was initiated on 1/7/24 -(Resident) has impaired cognitive function r/t (related to) diagnosis of dementia (dated 9/12/23). Interventions included: Encourage resident to participate in daily decision making with daily activities. Keep resident's routine as consistent as possible to avoid anxiety and frustration. Notify nurse, physician of any significant change in (Resident's) baseline cognitive status. Reassure (Resident) of safety. Redirect as needed. -The resident's care plan did not include non-pharmacological interventions for the psychotropic medication Seroquel. -The resident's care plan did not include the use of Melatonin for insomnia. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interdisciplinary notes: On 11/11/23 a nurse documented: Resident was found standing outside the door of her room crying stating 'no one likes me, no one wants me' . RN (registered nurse) provided therapeutic listening and reassurance, given cup of tea and encouraged to socialize. Then she wandered around the unit, and required encouragement to return to her room to change into pajamas. Resident's roommate voiced complaints that resident was talking loudly to self in her room. When RN arrived, resident was sleeping sitting upright in bed. RN closed room window as (resident) seems bothered by the cold. Will pass on to dayshift that new room assignment may not be best fit. On 11/15/23 a nurse documented: This resident has been up wondering the hallways t/o the noc (throughout the night). Resident will sleep for two hours and then get back up. When approached by this RN, resident states 'I just can't sleep'. On 11/17/23 a nurse documented: Resident appears to be having more issues during the night. At the beginning of the shift resident was wondering the halls but not really communicating what she was looking for, commenting she was waiting on the baby, or looking for a coat she had misplaced. Resident was then standing in the hall in front of her room being very weepy making comments that she only wanted to be nice to people. Reassured resident that all was well and encouraged her to go to bed. Later in the evening she was assisted to bed by staff and has been asleep since that time. On 12/26/23 a nurse documented: Resident redirected to stay in room several times per hour due to isolation precautions. Encouraged to wear mask when out of the room. Resident forgetful and becomes anxious, confused, and agitated. Redirected and reiterated that resident is safe and shown location of room through day. Call light within reach and resident encouraged to use as needed. On 1/1/24 a nurse documented: Resident continues to be very upset, agitated towards staff. Also continues to go into other rooms frequently upsetting other residents. Very difficult to redirect. Will not stay in her room, getting very little sleep. On 1/3/24 a nurse documented: Resident attempted to hit CNA (certified nurse aide) while being redirected out of another resident's room. Resident walking up and down the hallway shouting 'cheaters' Resident not easily redirectable at this time. Encouraged adequate space while ensuring safety. On 1/4/24 a nurse documented: Resident was arguing with another resident this evening and the altercation almost became physical. Nursing staff intervened prior to this occurring. Resident not easily redirectable. Resident was noted to be very agitated, yelling, wandering, and aggressive with other residents and staff at the beginning of this shift. Resident was walking up and down the hallway in the eve on January 3rd, 2024, and was calling staff 'liars'. Nursing staff encouraged space while ensuring safety of all residents and staff. Resident was assisted to change into pajamas and into bed at 2130 (9:30 p.m.). Resident still lying in bed resting. Call light and personal items are within reach. On 1/6/24 a nurse documented: Resident noted with verbal outbursts and verbal aggression toward staff. Pacing and upset about 'missing the bus to Texas', positive reinforcement and redirection provided but resident responds angrily and walks away. Resident allowed space and frequent visual checks continue. Staff will continue to provide a safe and hazard free environment. D. Staff interviews (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical director (MD) was interviewed on 1/8/24 at 10:35 a.m. He said the antipsychotic medication Seroquel was prescribed for dementia with behaviors. He said the nursing staff told him the resident was verbally and physically aggressive towards staff and occasionally with other residents. He said he did not consider a lower dose for the resident. He said the medication had six hours half-life and the nursing staff observed significant positive changes in resident's behaviors. The director of nursing (DON), the social service director (SSD) and the activities director (AD) were interviewed on 1/9/24 at 5:00 p.m. The DON said it was the facility policy the interdisciplinary team (IDT) should review and assess a resident's behaviors prior to asking physician for a drug, especially an antipsychotic medication. She said the nurses were frequently reminded not call the physician and ask for a psychotropic medication. The SSD said there were no non-pharmacological interventions implemented for resident increased behaviors and there was no care plan for it. She said the resident was moved to different rooms three times in the past two months and that could have triggered increased of confusion and behaviors. The AD said Resident #44 was always invited to the group activities however she would not stay long. RN #1 was interviewed on 1/9/24 at 5:30 p.m. She said Resident #44's behaviors increased during her isolation due to COVID-19 diagnosis. She would not stay in her isolation room and would not wear a facemask. She began being aggressive towards staff. RN#1 said after the COVID-19 isolation was over, the resident returned to her previous room and became more confused. She said the resident was wandering to other residents' rooms and was not easily redirectable. She said she notified the MD of Resident #44's behaviors and he prescribed the antipsychotic medication. III. Resident #16 A. Resident status Resident # 16, age [AGE], was admitted on [DATE]. According to the January 2024 computerized physician order (CPO) diagnoses included pneumonia, chronic obstructive pulmonary disease (COPD), insomnia, major depressive disorder and anxiety. The 12/5/23 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 12 out of 15. She had no identified behaviors or rejections of care. The mood interview PHQ-9 (the nine questions of patient health questionnaire objectifies degree of depression severity) score was two out of 27 which indicated no depression. She was administered high risk medications included an antidepressant, hypnotic and anticoagulant. B. Resident interview Resident #16 was interviewed on 1/10/24 at 9:55 a.m. She said she was not aware her antidepressant was increased a week ago. She said she usually went to bed and fell asleep around 10:30 p.m. woke up one time to go to the bathroom and slept the rest of the night. C. Record review Physician orders: -Citalopram Hydrobromide, oral tablet 10 mg (Citalopram Hydrobromide) (antidepressant known as selective serotonin reuptake inhibitors). Give one tablet by mouth one time a day related to major (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depressive disorder. Start date 12/5/23. End date 1/2/24. -Citalopram Hydrobromide, oral tablet 20 mg (Citalopram Hydrobromide). Give one tablet by mouth one time a day related to major depressive disorder and anxiety disorder. Start date 1/3/24. -Temazepam oral capsule 15 mg (Temazepam) (Benzodiazepine used to treat severe insomnia). Give 15 mg by mouth at bedtime for insomnia. Start date11/22/23. Care plan The comprehensive care plan review revealed the following: -There was no care plan for the antidepressant medication in resident's record. -There was no care plan for the hypnotic medication in resident's record -There was no care plan for non-pharmacological interventions for the above medications. Review of the resident's electronic record revealed there were no behavior notes identifying any behaviors. The January 2024 CPO identified the medication Citalopram Hydrobromide for depression and anxiety was increased on 1/3/24 from 10 mg to 20 mg every day (qd). -The facility failed to have evidence of increased behaviors and attempts at non-pharmacological interventions prior to the increase of Citalopram Hydrobromide from 10 mg to 20 mg. Interdisciplinary notes On 12/5/23 a nurse documented: Citalopram 10mg started for increased anxiety. No unusual behaviors noted with no adverse reactions. On 1/2/24 a nurse documented: MD in house to see resident. Resident verbalizing increase in anxiety. New orders obtained to change Citalopram to 20mg PO QD. Orders noted and carried out. Resident made aware. D. Staff interviews The DON and MDS coordinator (MDSC) were interviewed on 1/10/24 at 8:35 a.m. The MDSC said the resident's care plan was not finished timely. She said the resident's care plan did not address the insomnia and antidepressant medications. She said there were no non-pharmacological approaches for the above medications in the resident's care plan. The DON was interviewed on 1/10/24 at 9:40 a.m. She said the resident was admitted on Tomazepam from the hospital. She said there were no hours of sleep documented. She said she was not aware the resident's antidepressant was increased and IDT did not review change in behaviors or increase in depression.

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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. Based on observations and interviews the facility failed to ensure one of one medication refrigerators stored narcotic medications in accordance with accepted professional standards and that only licensed staff had access to resident-prescribed medications. Specifically, the facility failed to ensure controlled medications were in a locked storage container that was permanently secured to the refrigerator. Findings include: I. Facility policy and procedure The Storage of Medications policy and procedure, revised February 2023, was provided by the director of nursing (DON) on 1/9/24 at 1:00 p.m. It read in pertinent part, Controlled substances (listed as Schedule 11-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. II. Observations On 1/8/24 at 10:33 a.m. the medication refrigerator was observed with registered nurse (RN) #1. There were two controlled medication locked boxes in the refrigerator not permanently affixed to the refrigerator and they contained liquid Ativan (a benzodiazepine and a schedule IV controlled substance used to treat anxiety) and liquid morphine (pain medication). III. Staff interviews RN #1 was interviewed on 1/8/24 at 10:36 a.m. She said she was not aware that the controlled medication box in the refrigerator should be permanently affixed to the refrigerator. She said she now knew that anyone with access to the refrigerator could just take the boxes of controlled medications out of the refrigerator. The director of nursing (DON) was interviewed on 1/9/24 at 1:14 p.m. The DON said she was not aware of the requirement that the controlled medication boxes should be permanently affixed to the refrigerators.

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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. Based on observations and staff interviews, the facility failed to ensure the dietary department followed safe practices to prevent the potential contamination of food and spread of food-borne illness. Specifically, the facility failed to: -Ensure reheated food reached the appropriate temperature; and, -Ensure beard nets were worn in the kitchen. Findings include: I. Reheated food A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved from: https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. Reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees Fahrenheit and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. (Retrieved 1/10/24) B. Observations Cook #1 was asked on 1/7/24 at 11:52 a.m. to reheat soup that was brought by the family. The cook placed the soup in the microwave for less than two minutes. He did not rotate or stir the soup, did not take the temperature of the soup and did not allow the soup to stand covered for two minutes. Dietary aide (DA) #2 was asked on 1/9/24 at 11:12 a.m. to reheat a cinnamon roll that was in a paper bag. DA #2 placed the cinnamon roll in the original packaging in the microwave for less than two minutes. She did not take the temperature of the cinnamon roll. She did not rotate the cinnamon roll, did not take the temperature of the cinnamon roll and did not allow the cinnamon roll to stand covered for two minutes. C. Staff interviews The corporate dietary manager was interviewed on 1/9/24 at 3:20 p.m. She said cooks should be the only ones who reheat food. She preferred outside food to be sealed and in its original packaging. She said that any food that is reheated should be tested with a thermometer to ensure the food reached 165 degrees Fahrenheit. D. Facility follow-up The corporate dietary manager provided documentation on 1/10/24 at 9:47 a.m. training was provided (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to kitchen staff that food should be reheated to reach 165 degrees Fahrenheit. II. Hair restraints A. Professional reference The Colorado Department of Public Health and Environment (2019) The Colorado Retail Food Establishment Rules and Regulations, retrieved from: https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_6CCR10102_RFFC_EffJan2019.pdf. Employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints and clothing that covers body hair, that are designed and worn effectively keep their hair from contacting exposed food. (Retrieved 1/22/24) B. Observations Cook #1 and an unidentified dietary aide were observed on 1/9/24 at 11:01 a.m. Both staff were continuously observed during the lunch meal on 1/9/24 from 11:01 a.m. until 11:48 a.m. Both staff had a beard that was less than one inch. They both did not have a beard net worn to prevent their hair from contacting exposed food. C. Staff interviews The corporate dietary manager provided documentation on 1/10/24 at 9:47 a.m. She said any dietary staff that entered the kitchen should have worn hair coverings that covered body hair including beards. She said she would talk to the kitchen staff who have beards to wear hair coverings. D. Facility follow-up The corporate dietary manager provided documentation on 1/10/24 at 9:47 a.m. She provided documentation training was provided to all kitchen staff to wear hair coverings including beard nets.