STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065121	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion at Villa Pueblo, The	855 Hunter Dr Pueblo, CO 81001

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures.Specifically, the facility failed to ensure food was palatable and served at the appropriate temperature. Findings include:I. Facility policy and procedureThe Food and Nutrition Services policy, revised October 2017, was provided by the dietary supervisor (DS) on 9/25/25 at 12:20 p.m. It read in pertinent part, Each resident would be provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Reasonable efforts would be made to accommodate resident choices and preferences. Food and nutrition services staff would inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature."II. Resident group interviewA group of four residents (#20, #24, #63 and #80) who were assessed by the facility to be interviewable, requested to speak to a surveyor immediately after lunch on 9/23/25 at 1:05 p.m. The residents said dessert was hard. They said they could not break it up as it was too hard to eat.Resident #24 said she ate in the main dining room, but the food was usually cold when served. She said the dessert for lunch today was a lemon bar, but she could not break it up to eat it. She said if it were thrown at someone, it could knock a person out.Resident #80 said she had only been at the facility a little over a week and felt the food could be served warmer. She said the lemon bar at lunch was as hard as a rock.Resident #63 said the lemon bar dessert served at lunch was inedible because it was too hard to eat. She said her lunch was not served warm.Resident #20 said her lunch was not warm and the dessert was hard at lunch today. She said she could not eat hard food because it hurt her teeth. She said she could not eat the lemon bar.III. Resident interviewsResident #20 was interviewed on 9/24/25 at 9:10 a.m. Resident #20 said the food was always served cold. Resident #20 said she had difficulty chewing some of the food that was served Resident #63 was interviewed on 9/24/25 at 9:22 a.m. Resident #63 said the food was served cold.Resident #24 was interviewed on 9/24/25 at 4:51 p.m. Resident #24 said the food was served cold.IV. ObservationsOn 9/23/25, the lunch menu included a dinner roll, dijonnaise roasted pork loin, O'Brien potatoes, broccoli and cauliflower and lemon bar for dessert. -Several residents complained that the lemon bars were hard (see the resident group interview above).On 9/24/25, the lunch menu included pretzel breadsticks, bratwurst, baby bakers and braised sauerkraut.-The pretzel breadsticks, bratwurst, baby bakers and braised sauerkraut were not covered with a lid.A test tray for a regular diet was evaluated by three surveyors immediately after the last resident had been served their lunch tray on 9/24/25 at 12:40 p.m.The test tray consisted of bratwurst, baby bakers, and braised sauerkraut.The baby bakers were dry and had a temperature of 115 degrees Fahrenheit (F). The potatoes were cold to the palate.The bratwurst had a temperature of 113 degrees F and were cold to the palate.The braised sauerkraut was cold to the palate.V. Staff interviewsThe dietary manager (DM) was interviewed on 9/23/25 at 1:15 p.m. The DM said the dessert on the lunch menu on 9/23/25 was a lemon bar. She said it should have had a soft texture and be moist. The DM said the lemon bar was hard and had noticed most of the residents did not consume it. She said most of the residents received an ice cream cup or pudding as a substitute.She said they would immediately offer education to the kitchen staff to ensure recipes (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were followed accordingly.The DM was interviewed again on 9/24/25 at 1:00 p.m. She said the duration of time the room trays stay on the carts could be shortened by training more staff to assist with meal pass to keep the food warm. The DM said having lids for the steam table in the satellite dining room, where meals were served, could help keep the food warm.The dietary supervisor (DS) was interviewed on 9/25/25 at 11:15 a.m. The DS said it was important to ensure the right food texture and taste were obtained and food was served at an appetizing temperature to avoid residents not eating their food. The DS said the dietary aides and the kitchen staff should have noticed that the lemon bars were hard. The DS said education would be provided immediately to the kitchen staff regarding food texture and temperature.

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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 interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.Specifically, the facility failed to: -Ensure ready-to-eat foods were handled in a sanitary manner; and,-Ensure kitchen equipment was clean. Findings include:I. Failure to ensure ready-to-eat foods were handled in a sanitary manner.A. Professional reference The Colorado Retail Food Regulations, (3/16/24) and retrieved on 9/30/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)B. ObservationsDuring a continuous observation of the lunch meal service in the kitchen on 9/24/25, beginning at 10:40 a.m.and ending at 12:05 p.m., the following was observed:Cook (CK) #1 was preparing special orders for the lunch meal. At 10:42 a.m., CK #1 opened a refrigerator and pulled out an open bag of frozen chicken fingers. CK #1 stuck his hands into the frozen bag and grabbed several chicken fingers, and dropped them in the boiling oil next to the stove.At 10:48 a.m. without performing hand hygiene, CK #1 grabbed four slices of bread, applied butter, and placed them on a skillet without gloves.At 10:52 a.m. without performing hand hygiene, CK #1 picked two burger buns without gloves and placed them on the skillet At 11:06 a.m. CK #1 used a spatula to move the slices of bread onto the surface of the food preparation table. CK #1 added cooked bacon to the buttered bread and placed his hands on top of the bread to cut it into two parts without gloves.At 11:10 a.m. CK #1 washed his hands and donned a glove on his left hand and picked up the meal tickets, flipped through the tickets with a gloved hand, and separated the tickets into parts so he could read them.CK #1 did not remove the glove or perform hand hygiene after handling the meal tickets.At 11:14 a.m. CK #1 continued to place four premade hamburger patties onto a skillet with the same gloved hand he had used to handle the meal tickets. C. Staff interviewsCK #1 was interviewed on 9/24/26 at 1:50 p.m. CK #1 said it was important to practice safe food-handling procedures to avoid contamination and transmission of foodborne illness. CK #1 said he would remember to apply gloves during food preparation times.The dietary supervisor (DS) was interviewed on 9/24/25 at 2:14 p.m. The DS said kitchen staff and dietary aides were all trained on the proper handling of ready-to-eat food. He said CK #1 should have worn gloves and ensured that ready-to-eat food was not contaminated. He said he would immediately provide on-the-spot education for CK #1 to ensure he follows the facility's food preparation guidelines.The nursing home administrator (NHA) was interviewed on 9/25/25 at 2:15 p.m. She said she would immediately offer education for all the kitchen staff on food safety and ensure that ready-to-eat foods were handled in a sanitary mannerII. Failure to ensure kitchen equipment was cleanA. Professional referenceThe Colorado Department of Public Health and Environment (2024). The Colorado Retail Food Establishment Rules and Regulations was retrieved on 9/30/25 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view. Read in pertinent part,Equipment food contact surfaces and utensils shall be clean to sight and touch. (Chapter 4-20)B. Facility policy and procedureThe Kitchen Sanitation and Cleaning policy, revised November 2022, was provided by the DS on 9/24/25 at 12:30 p.m. It read in pertinent part, The food service area is maintained in a clean and sanitary manner.All utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and are free from breaks.All equipment, food contact surfaces, and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	utensils are cleaned and sanitized using heat or chemical sanitizing solution.C. ObservationsAn environmental tour of the kitchen was conducted on 9/24/25 at 9:30 a.m. The following was observed:The kitchen had a setup that divided the space into two cooking areas: the front and back. Each of these spaces possessed its own stove. These two stoves were positioned facing the opposite sides of the room, with one stove facing the north side of the kitchen and the other facing the south side. This arrangement allowed for dual, opposing workspaces within the kitchen area.There were black and red spots around the kitchen stove facing the south side of the kitchen The wall dividing both stoves had food particles and splashes of red watery substance, which appeared to be splashes of tomato juice on the wall. The outside of the stove, positioned to the north of the kitchen, and between a steamer, was greasy.There was dried oil mixed with lint around the surfaces and surrounding edges of the steamer and the stove positioned on the north side of the kitchen. There were splashes of white substances around the food preparation table. D. Staff interviewsThe DS was interviewed again on 9/25/25 at 12:20 p.m. He said he would conduct routine oversight of the kitchen and ensure all kitchen appliances were properly cleaned and maintained. He said some dirty areas were not being used during the food preparation. He said that all areas of the kitchen needed to be clean. The DS said deep cleaning was performed once a month, and a weekly cleaning checklist was completed each week. The DS said the staff had tried cleaning the splashes on the wall around the kitchen stove several times, but were unsuccessful in getting them off the wall.The NHA was interviewed on 9/25/25 at 2:15 p.m. The NHA stated that she would immediately re-evaluate the cleanliness of the kitchen equipment with the DS and ensure that proper training and education were provided to the kitchen staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on two of four units.Specifically, the facility failed to:-Ensure nursing staff properly performed hand hygiene during medication administration;-Ensure staff donned (put on)) when providing care for a resident who was on enhanced barrier precautions (EBP); and,-Ensure staff sanitized the Hoyer lift between residents. Findings include: I. Failure to ensure nursing staff performed hand hygiene during medication administration A. Facility policy and procedure The Hand Hygiene policy, undated, was provided by the nursing home administrator (NHA) on 9/25/25 at 2:02 p.m. It read in pertinent part, All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to: after handling contaminated objects; before applying and after removing personal protective equipment (PPE), including gloves; before preparing or handling medications; and before performing resident care procedures. B. Observations During a continuous observation on 9/24/25, beginning at 10:29 a.m. and ending at approximately 10:42 a.m. licensed practical nurse (LPN) #2 was observed administering medications to Resident #14 on the Columbine unit. The following was observed: At 9:22 a.m. LPN #2 performed hand hygiene after approaching the medication cart. LPN #2 obtained Resident #14's medications LPN #2 dispensed Resident #14's ordered medications into the cup. LPN #2 poured water into the cup from a pitcher sitting on top of the medication cart. LPN #2 secured her computer and locked the medication cart. LPN #2 grabbed a pair of gloves from a box on top of the medication cart, the medication cup, a box of Prednisolone one percent (1%) eye drops (medicated antisteroidal eye drops) and the cup of water and walked into Resident #14's room. -LPN #2 did not perform hand hygiene upon entering Resident #14's room. At approximately 10:35 a.m. LPN #2 entered Resident #14's room and placed the medication cup and the cup of water on the resident's bedside table in front of her. While waiting for Resident #14 to take her medications, LPN #2 donned the pair of gloves she brought in, in preparation for administering the resident's eye drops. At 10:39 a.m. LPN #2 used her left gloved hand to grab the resident's privacy curtain and pull it closed. LPN #2 then walked to Resident #14's door and used her right gloved hand to push the door closed. LPN #2 walked back to Resident #14's side. LPN #2 removed the bottle of eye drops from the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	box, removed the cap from the bottle, and instilled one drop into each of Resident #14's eyes. LPN #2 placed the bottle back into its box. LPN #2 removed gloves and threw them away. LPN #2 walked out of the resident's room and returned to the medication cart. -LPN #2 failed to perform hand hygiene appropriately. During a continuous observation on 9/24/25, beginning at 11:52 a.m. and ending at approximately 12:00 p.m., LPN #1 was observed administering medications to Resident #42 on the Pavilion unit. The following was observed: At 11:52 a.m. LPN #1 obtained a bag that contained a Humalog kwikpen (a prefilled, multidose syringe of rapid-acting insulin) 100 unit per milliliter (mL) three mL syringe. LPN #1 obtained and opened an alcohol pad. LPN #1 placed the pad's wrapper on top of the medication cart, and placed the pad on top of the wrapper. LPN #1 donned a pair of gloves. LPN #1 removed the protective cap from the insulin syringe and wiped the top against the alcohol pad approximately four to six times. LPN #1 obtained a disposable needle from the medication cart and secured it to the top of the syringe. LPN #1 dialed the insulin syringe to dispense eight units of insulin. LPN #1 primed the needle with two units of insulin, leaving six units to administer per physician's order. LPN #1 removed and discarded gloves, grabbed an alcohol swab from a drawer in the medication cart and the Humalog insulin syringe, secured her computer, locked the medication cart, and walked into Resident #42's room. -LPN #1 failed to perform hand hygiene after preparing Resident #42's medication and before walking into the resident's room. At approximately 11:56 a.m. LPN #1 entered Resident #42's room. LPN #1 grabbed a pair of gloves and walked to the resident's right side. LPN #1 placed the Humalog syringe and alcohol pad on top of the resident's bedside table and donned the pair of gloves. LPN #1 opened the alcohol pad. Using her left hand, LPN #1 lightly pinched the back of Resident #42's right upper arm and used right hand to wipe an area of skin with the alcohol pad. LPN #1 discarded the alcohol pad, grabbed the insulin syringe with her right hand, and injected the resident's insulin into his right upper arm. LPN #1 removed the needle from the syringe and discarded it into a sharps contained secured to a wall in Resident #42's room. LPN #1 removed gloves and walked out of the resident's room. -LPN #1 failed to perform hand hygiene prior to putting on gloves. C. Staff interviews LPN #2 was interviewed on 9/24/25 at 11:06 a.m. LPN #2 said hand hygiene should be performed before and after resident care, before and after administering medications. LPN #2 said hand sanitizer could be used for hand hygiene, however hands needed to be washed with soap and water if they were visibly dirty. LPN #2 said proper hand hygiene was important for infection control and preventing the transmission of germs back and forth. LPN #1 was interviewed on 9/24/25 at approximately 12:00 p.m. LPN #1 said hand hygiene should be performed before and after resident care to prevent the transmission of organisms. The director of nursing (DON) and the assistant director of nursing (ADON) were interviewed on 9/25/25 at 12:11 p.m. The DON said hand hygiene should be performed before and after resident care, and more frequently as needed if a procedure was being performed. The DON said hand hygiene was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	important to help decrease the risk of infections and transmission of organisms. The DON said LPN #1 should have performed hand hygiene before administering Resident #42's insulin to him. The DON said LPN #2 should have removed her gloves, performed hand hygiene, and donned a new pair of gloves before administering Resident #14's eye drops. II. EBP failures A. Professional reference According to The Centers for Disease Control and Prevention's (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDROs) (4/2/24), retrieved on 9/29/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, EBP are an infection control intervention, designed to reduce transmission of resistant organisms, that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. B. Facility policy and procedure The Enhanced Barrier Precautions policy, dated August 2022, was provided by the nursing home administrator (NHA) on 9/25/25 at 12:58 p.m. It read in pertinent part, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multidrug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Personal protective equipment (PPE) is changed before caring for another resident. Face protection may be used if there is also a risk of splash or spray. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care (any skin opening requiring a dressing). EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signage was posted at the resident's door of what type of isolation they were on as well as what PPE was required when providing direct care. She said both RN #1 and LPN #1 should have been wearing a gown when providing care to Resident #68. IIII. Shared equipment A. Facility policy and procedure The Cleaning and Disinfecting of Resident care Equipment policy, dated May 2025, was provided by the NHA on 9/25/25 at 12:58 p.m. It read in pertinent part, Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. Non-critical items come in contact with intact skin, but not mucous membranes. These items require cleaning followed by low/intermediate-level disinfection (use of EPA (Environmental Protection Agency) -registered disinfectants) following manufacturers' instructions. Staff shall follow established infection control principles for cleaning and disinfecting reusable, non-critical equipment. Verify whether the equipment is single-use or reusable. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Multiple-resident use equipment shall be cleaned and disinfected after each use. Use only EPA-registered disinfectants with kill claims for the common organisms found in the facility. If the equipment is exposed to residents on transmission-based precautions, verify the disinfectants are registered for use with the relevant organism.Verify the disinfectant is compatible with the equipment and follow manufacturer recommendations for cleaning equipment. B. Observations On 9/23/25 at 10:24 a.m. an unidentified certified nurse aide (CNA) was removing the Hoyer lift (mechanical lift used to transfer residents) from storage She pushed the lift to room [ROOM NUMBER] and entered the room. She transferred the resident into bed and exited the room. She placed the lift back into its parking spot. -The CNA failed to clean the lift after using it to transfer the resident in room [ROOM NUMBER]. On 9/24/25 at 10:55 a.m. CNA #1 removed the Hoyer lift from storage She pushed the lift to room [ROOM NUMBER] and entered the room. She transferred the resident and exited the room. She placed the lift back into its parking spot. -CNA #1 failed to clean the lift after using it to transfer the resident in room [ROOM NUMBER]. C. Staff interviews CNA #2 was interviewed on 9/24/25 at 1:36 p.m. CNA #2 said the Hoyer lift was shared with five residents who required the lift for transfers. She said the lift should be cleaned with bleach wipes after every use. She said each resident had their own transfer sling but shared the lift. CNA #1 was interviewed on 9/24/25 at 1:39 p.m. CNA #1 said the Hoyer lift was to be cleaned after every use. She said she did not clean the lift after transferring the resident in room [ROOM NUMBER] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because there were no cleaning wipes on the lift where they were usually stored. The ADON was interviewed on 9/24/25 at 1:55 p.m. The ADON said the Hoyer lift should be cleaned after use. She said the residents all had individual slings and shared the lift. She said she would immediately provide education to the staff on properly cleaning the lift between resident use. The DON was interviewed on 9/25/25 at 12:00 p.m. The DON said the Hoyer lift should be cleaned after every use and deep cleaned by night shift. D. Facility follow up On 9/25/25 the ADON provided documentation indicating CNA #1 was educated on the correct procedure for cleaning the Hoyer lift as well as EBP by the ADON.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that residents were free of unnecessary psychotropic medications for one (#7) of six residents reviewed for unnecessary medications out of 44 sample residents.Specifically, the facility failed to:-Ensure an as needed (PRN) psychoactive medication were discontinued after 14 days for Resident #7;-Provide documentation and rationale to justify the continued use of a PRN psychotropic medication for Resident #7; and, -Ensure a care plan was in place with monitoring and effectiveness of Resident #7's psychotropic medication. Findings include:I. Facility policy and procedureThe Psychotropic Medication use policy, dated July 2022, was provided by the nursing home administrator (NHA) on 9/25/25 at 12:58 p.m. It read in pertinent part, A psychotropic medication is any mediation that affects brain activity associated with mental processes and behavior.Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications. Anti-psychotics, Anti-depressants, Anti-anxiety medications and Hypnotics.Consideration of the use of any psychotropic medication is based on comprehensive review of the resident. This includes evaluation of the resident's signs and symptoms in order to identify underlying causes.Psychotropic medications are not prescribed or given on a PRN (as needed) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are not antipsychotics and the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.II. Resident #7A. Resident status Resident #7, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, anxiety disorder and depression. The 8/5/25 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems and her cognitive skills for daily decision-making were severely impaired per staff assessment. She was dependent on staff for all activities of daily living (ADL). The MDS assessment documented she received an antidepressant.III. Record reviewThe September 2025 CPO documented the following physician's order:Lorazepam (anti-anxiety medication) oral tablet 0.5 mg (milligrams) by mouth every four hours as needed for agitation/anxiety, ordered on 9/9/25.-The physician's order did not have a stop date.-Review of Resident #7's comprehensive care plan did not reveal a care plan related to Resident #7's use of antianxiety medication. -Review of Resident #7's electronic medical record (EMR) did not reveal documentation regarding non-pharmacological interventions that were attempted. -Review of Resident #7's EMR revealed the physician failed to document a rationale for the continued use of the PRN Lorazepam after 14 days.-Review of Resident #7's EMR did not reveal monitoring of Resident #7's behaviors or the effectiveness of the PRN antianxiety medication. IV. Staff interviewsLicensed practical nurse (LPN) #2 was interviewed on 9/25/25 at 10:09 a.m. LPN #2 said a PRN psychotropic medication order was only good for 14 days. She said after 14 days the resident needed to be reassessed by a physician for the continued use of the medication. She said the staff should monitoring Resident #7 for side effects and effectiveness of the medication. She said a care plan should have been in place for the use of the medication. The assistant director of nursing (ADON) was interviewed on 9/25/25 at 10:26 a.m. The ADON said a PRN psychotropic medication order was only good for 14 days and after the 14 days the resident needed to be assessed by the physician for the continued use of the psychotropic medication. She said Resident #7 was on hospice and the hospice agency ordered the medication. She said the staff should have monitored Resident #7 for side effects and effectiveness of the medication. She said a care plan should have been initiated when the psychotropic medication (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was prescribed. The director of nursing (DON) was interviewed on 9/25/25 at 12:00 p.m. The DON said any psychotropic PRN medication should only be ordered for 14 days. She said the physician's order should have a stop date for the medication. She said after the 14 days the resident needed to be reassessed by the physician for continued use. She said the psychotropic medication should have a care plan addressing the need for the medication, monitoring any adverse reactions and the effectiveness of the medication.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#82) residents of seven residents received treatment and care in accordance with professional standards of practice out of 44 sample residents.Specifically, the facility failed to ensure staff reported a fall for Resident #82. Findings include:I. Facility policy and procedureThe Fall Guidelines policy, revised October 2010, was provided by the nursing home administrator (NHA) on 9/25/25 at 12:58 p.m. It revealed in pertinent part, The purpose of the procedure is to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of a fall. Falls are a leading cause of morbidity (medical condition) and mortality (death) among the elderly in nursing homes. Residents must be assessed in a timely manner for potential causes of a fall. If a resident had a fall, or was found on the floor without a witness to the event, nursing staff will record vital signs and evaluate for possible injuries to the head, neck, spine and extremities. An incident report must be completed for resident falls in Risk Management. The incident report should be completed by the nurse and submitted to the director of nursing (DON).A post fall head to toe evaluation should be conducted by a licensed nurse. Upon completion of the evaluation the physician should be notified and new orders obtained. When a resident has a fall, notify the physician, the DON and the nursing supervisor. Report other information in accordance with the facility policy and professional standards practice.The Fall Risk Managing policy, revised July 2025, was provided by the nursing home administrator (NHA) on 9/29/25 at 4:19 p.m. It read in pertinent part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.A fall is defined as an unintentional coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force. An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall.II. Resident #82A. Resident statusResident #82, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included after care following joint replacement surgery, long term use of an anticoagulant (blood thinner), chronic pain and depressive episodes. Resident #82 was a new admission and had not yet completed the minimum data set (MDS) assessment. According to the nursing admission assessment Resident #82 was alert and orientated to person, place, situation and time. She required moderate assistance with one staff member and a front wheel walker for transfers. B. Resident representative interviewResident #82's representative was interviewed on 9/22/25 at 10:27 a.m. The representative said on 9/21/25 Resident #82 was being transferred by a certified nurse aide (CNA) and was dropped. She said Resident #82 hurt her left hand and right shoulder when she fell. She said the nurse did not assess the resident following the fall. -The NHA was notified of the fall after the interview with Resident #7's representative.C. Record reviewThe fall care plan, initiated 9/20/25, revealed Resident #82 was at risk for falls. The interventions included a clutter free environment, adequate lighting, ensuring items were within reach, ensuring the call light was within reach and encouraged to use, providing appropriate footwear when transferring/ambulating, providing assistive devices as needed and reviewing information on past falls to attempt to determine cause of the falls.A nursing progress note, dated 9/22/25 at 12:32 p.m., documented Resident #82's daughter reported that yesterday (9/21/25) between 3:00 pm and 5:00 p.m. a CNA was walking the resident back to bed from the bathroom when her legs became weak and she fell back into the recliner hitting her left hand and right shoulder. A purple bruise was observed over the resident's left hand. Her right shoulder was assessed with no redness or bruising. The physician was notified and gave an order for Xrays to the left hand and right shoulder. The Xray results revealed no fractures. A fall risk assessment, dated 9/20/25, identified Resident #82 as a high fall risk.D. Staff interviewsCNA #2 was interviewed on 9/25/25 at 10:04 a.m. CNA #2 said if a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had a fall the CNA should immediately report the fall to the nurse. She said the nurse then assessed the resident for any injuries before the resident was moved. She said if the fall was unwitnessed the staff would initiate neurological assessment for 72 hours. Licensed practical nurse (LPN) #2 was interviewed on 9/25/25 at 10:09 a.m. LPN #2 said if a resident had a fall the CNA should immediately report the fall to the nurse. She said after reporting the fall, a registered nurse (RN) would assess the resident for any injuries prior to the resident being moved. LPN #2 said the nurse then notified the physician, family and the director of nursing (DON). She said the resident would be monitored for 72 hours following the fall. The assistant director of nursing (ADON) was interviewed on 9/25/25 at 10:26 a.m. The ADON said if the CNA was transferring the resident and the resident had a fall, the CNA should immediately report the fall to the nurse. She said the nurse would assess the resident for injuries before the resident was moved. She said the interdisciplinary team (IDT) had a risk management meeting every morning and were not aware of Resident #82's fall. The DON was interviewed on 9/25/25 at 11:oo a.m. The DON said she was not aware of Resident #82's fall until it was reported to her at the start of the survey. She said the CNA should have immediately reported the fall to the nurse so an assessment could have been completed to identify any injuries. She said she immediately initiated an investigation of the fall, suspended the CNA, notified the physician, received orders for Xrays and provided education to the staff on following the facility fall policy.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to develop and implement an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for one (#7) of one resident out of 44 sample residents.Specifically, the facility failed to have a system in place to monitor Resident #7's prophylactic antibiotic use.Findings include:I. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC), The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix B, retrieved online on 9/29/25 from https://www.cdc.gov/antibiotic-use/media/pdfs/Consult-pharm-11by17poster-Urinary-Tract-P.pd.Antibiotics are frequently prescribed for prolonged duration for the prevention of infection or prophylaxis in nursing homes. While antibiotic prophylaxis may reduce recurrent UTIs (urinary tract infections) in specific populations, there is no clear evidence on prevention of recurrent UTIs among nursing home residents with asymptomatic bacteriuria. Furthermore, antibiotic use carries the risk of harm to residents, including adverse drug events and increased antibiotic resistance, which argue against the use of prolonged antibiotic therapy in nursing home residents.Identify residents on prolonged antibiotic therapy for the prevention of recurrent UTI. Discuss the indications, rationale, and planned duration of prolonged antibiotic therapy with healthcare professionals to ensure that the benefits outweigh the risk of adverse drug events.II. Facility policy and procedureThe Antibiotic Stewardship policy and procedure, revised May 2025, was provided by the nursing home administrator (NHA) on 9/25/25 at 12:58 p.m. It revealed in pertinent part, The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community. -The policy did not address prophylactic antibiotics.II. Resident #7A. Resident statusResident #7, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease and stage 4 chronic kidney disease. The 8/5/25 minimum data set (MDS) assessment revealed the resident had short and long-term memory problems and her cognitive skills for daily decision-making were severely impaired per staff assessment. She was dependent on staff for all activities of daily living (ADLs).According to the MDS assessment she received an antibiotic.B. Record reviewThe July 2025 CPO documented the following physician's order:Cephalexin (an antibiotic) 500 mg. Give one capsule by mouth four times a day for UTI for 10 days, ordered on 7/28/25. The September 2025 CPO documented the following physician's order:Nitrofurantoin Macrocrystal (an antibiotic) oral capsule 50 mg (milligrams). Give one capsule by mouth at bed time for UTIs per urology (kidney specialist) as a prophylaxis (an attempt to prevent UTIs), ordered on 4/4/24. -The physician's order for Nitrofurantoin Macrocrystal did not have a stop date.-Review of Resident #7's comprehensive care plan did not reveal a care plan related to Resident #7's antibiotic medication. -Review of Resident #7's electronic medical record (EMR) did not reveal documentation that the facility was monitoring Resident #7' for adverse reactions and ethe effectiveness of the prophylaxis antibiotic. III. Staff interviewsThe assistant director of nursing (ADON) was interviewed on 9/25/25 at 10:26 a.m. The ADON said the facility followed the Mcgeer criteria when prescribing an antibiotic. She said prophylactic antibiotics were tracked on a monthly log. She said she did not know when a resident on a prophylactic antibiotic should be reassessed for effectiveness by the physician. She said all antibiotics should have a care plan and should be monitored for side effects and effectiveness. The infection preventionist (IP) was interviewed on 9/25/25 at 12:00 p.m. The IP said a prophylactic antibiotic should be reassessed for continued effectiveness. She said Resident #7 had been on her prophylactic antibiotic since April 2024 and should have been reassessed for the continued effectiveness of the antibiotic especially since she still had UTIs. The IP said when the resident started on Cephalexin the prophylactic antibiotic should (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been discontinued. She said when Resident #7 was prescribed two antibiotics at the same time, which should have been a red flag to her. She said the use of prophylactic antibiotics was not mentioned in the facility antibiotic policy and the facility did not have a tracking and monitoring system in place for the use of prophylactic antibiotics.