STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065147	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on observation, record review and interviews the facility failed to provide the necessary services to maintain personal hygiene for one (#11) of three residents reviewed for services to maintain highest practicable quality of life out of 25 sample residents. Specifically, the facility failed to provide timely incontinence care for Resident #11. Findings include: I. Facility policy and procedure The Supporting Activities of Daily Living (ADL) policy, revised March 2018, was received from the nursing home administrator (NHA) on 9/5/24 at 5:08 p.m. It revealed in pertinent part, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting). II. Resident #11 A. Resident status Resident #11, age less than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes with diabetic neuropathy (nerve damage caused by diabetes), benign prostatic hyperplasia (BHP) (a noncancerous enlargement of the prostate gland) and phantom limb syndrome with pain (the perception of pain or discomfort in a limb that is no longer there). The 8/6/24 minimum data assessment (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required supervision to touching assistance with toileting hygiene and dressing. The resident was always incontinent of bowel and occasionally incontinent of bladder. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview and observations On 9/4/24 during a continuous observation, beginning at 12:31 p.m. and ending at 3:16 pm., the following was observed: Resident #11 was interviewed on 9/4/24 at 12:31 p.m. Resident #11 said he was sitting in his own feces during the interview. Resident #11 said an unidentified certified nursing aide (CNA) had entered the room approximately five minutes before the interview and left to go get the supplies she needed to change his brief but had not yet returned. Resident #11 said it was a normal occurrence to have a CNA enter the room to turn off the call light and leave without addressing the resident's needs and that it happened more frequently on the weekends. The room had a strong fecal odor. At 1:07 p.m. several unidentified nursing staff members started passing out lunch trays for Resident #11's hallway. -The unidentified CNA that Resident #11 said had entered his room and turned off the call light did not return to provide him assistance. At 1:13 p.m. an unidentified CNA walked into Resident #11's room to deliver his lunch tray. The CNA walked out of the room promptly after delivering the tray. At 1:43 p.m. an unidentified staff member walked into Resident #11's room to retrieve his lunch tray. The staff member left the room promptly after retrieving the tray. At 2:58 p.m. Resident #11's call light was activated. At 3:00 p.m. CNA #2 entered Resident #11's room and shut the door to provide care for the resident. At 3:14 p.m. Resident #11 left his room. Resident #11 said his brief had just been changed. -Resident #11 waited two hours and 45 minutes for a staff member to assist him with his incontinence episode. Resident #11 was interviewed a second time on 9/5/24 at 10:57 a.m. Resident #11 said he had to wait a long time to have his brief changed on a daily basis and that he once had to wait for five hours. Resident #11 said he felt frustrated by this issue. D. Record review The bladder incontinence care plan, initiated 5/10/24, revealed Resident #11 was at risk for incontinence due to reduced mobility and BHP. Pertinent interventions included ensuring Resident #11 had an unobstructed path to the bathroom, monitoring intake and output per facility policy and monitoring the resident for signs and symptoms of a urinary tract infection. -The care plan did not reveal any focus areas nor interventions related to his bowel incontinence or ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/22/24 annual exam notes revealed Resident #11 required moderate assistance for some ADLs. The provider also indicated Resident #11 was incontinent of both bowel and bladder. E. Staff interviews CNA #2 was interviewed on 9/4/24 at 3:19 p.m. CNA #2 said she primarily did brief changes for Resident #11 and that he was independent for everything else. CNA #2 said Resident #11 was able to turn himself but she needed to perform the whole brief change and clean him, since he could not perform these activities himself. CNA #2 said Resident #11 was mostly incontinent of bowel. She said he was able to use the urinal himself. CNA #2 said Resident #11 used his call light whenever he had episodes of incontinence. CNA #2 said she checked incontinent residents every two hours to see if they needed incontinence care. CNA #2 said there was quite a lot of fecal matter and some urine in the brief that she had just changed for Resident #11. Licensed practical nurse (LPN) #1 was interviewed on 9/5/24 at 8:49 a.m. LPN #1 said residents regardless of their continence status should be checked at least three to four times each eight hour shift. LPN #1 said the length of time residents could go without having incontinence care depended on the staff that were on shift, but that wait times had improved. LPN #1 said she recently had a resident tell her a CNA came into their room, turned off their call light and left to go get supplies to provide incontinence care but never came back. LPN #1 said she immediately went to the CNA in question and had her correct this issue. LPN #1 also said she had residents tell her that they had been left for a while without having incontinence care performed. LPN #1 said she followed up with these residents to see if they spoke with their nurses and ensured their nurses were aware of the issue. CNA #1 was interviewed on 9/5/24 at 1:50 p.m. CNA #1 said incontinent residents should be checked every two hours. CNA #1 said this timeframe varied resident-to-resident and that some residents were incontinent more often than others. CNA #1 said Resident #11 needed help with incontinence care and changing his brief whenever he had bowel movements. The director of nursing (DON) was interviewed on 9/5/24 at 2:00 p.m. The DON said staff performed checks for incontinent residents. She said the care plan indicated if the resident was incontinent. The DON said the nursing staff tried to assess things like incontinence care when the resident was initially admitted and that the nursing staff and residents have their routines. The DON said the facility generally did not write their care plans to have specific timeframes on incontinence checks like saying they needed to be checked every two hours. Registered nurse (RN) #1 was interviewed on 9/5/24 at 2:06 p.m. RN #1 said Resident #11 needed help with changing his incontinence briefs and providing incontinence care. RN #1 said Resident #11 asked for help whenever he needed it, but that he waited longer than he should have when asking for help. RN #1 said incontinent residents should be checked at least every two hours.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for three (#2, #12 and #7) out of 25 sample residents. Specifically, the facility failed to: -Ensure the physician's orders for skin and wound care were followed for Residents #2 and #12; and, -Ensure Resident #7 received medication as ordered by the physician. Findings include: I. Facility policy and procedure The Wound Care policy, revised October 2010, was provided by the nursing home administrator (NHA) on 9/5/25 at 5:08 p.m. The policy read in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following information should be recorded in the resident's medical record: The type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name and title of the individual performing the wound care, all assessment data (wound bed color, size, drainage) obtained when inspecting the wound, how the resident tolerated the procedure, any problems or complaints made by the resident related to the procedure, if the resident refused the treatment and the reason(s) why, and the signature and title of the person recording the data. Notify the supervisor if the resident refuses the wound care. Report other information in accordance with facility policy and professional standards of practice. II. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), the diagnoses included cerebral palsy (disorder affecting balance and posture), chronic respiratory failure, type 1 diabetes mellitus, muscle weakness, anxiety, necrotizing fasciitis (soft tissue infection) and osteomyelitis (bone infection) of the left tibia (shin bone). The 8/22/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required substantial assistance to move left to right/right to left, to move from sitting to lying and sitting to stand in bed, and substantial assistance for transfers and lower body dressing. He needed moderate assistance for toileting and bathing, supervision for upper body dressing and oral hygiene and set up only for eating. The MDS assessment documented the resident was at risk of developing pressure ulcers and had an unhealed pressure ulcer present upon admission to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review Resident #2's skin care plan, revised on 8/7/24, documented he was at risk for skin breakdown related to anxiety, heart disease, chronic obstructive pulmonary disease (COPD), depression, existing other skin problems, impaired mobility, incontinence of bowel, incontinence of bladder, kidney disease, neuropathy, obesity, perspiration, a pressure ulcer of the right heel, surgical wounds, a history of wound infection, and diabetes. He scored as an at risk resident on the Braden Scale (pressure ulcer risk assessment) used to assess the risk of developing pressure ulcers. Pertinent interventions included to administer medications and administer treatments as ordered (initiated on 6/4/24) and elevating and off loading the right heel while in bed (initiated on 8/7/24). The 8/7/24 wound note revealed the resident was seen on 8/7/24 for an unstageable pressure ulcer to his right heel which was present upon admission. The note documented prevention interventions were in place which included staff encouragement for Resident #2 to float his heel while he was in bed. His risk factors included limited mobility, poor impulse control, poor safety awareness, a history of necrotizing fasciitis, a history of cellulitis to his right lower extremity, type two diabetes mellitus, history of below knee amputation, chronic kidney disease, and a preference to spend prolonged periods of time in a wheelchair despite education and encouragement to lay down between meals. The August 2024 CPO revealed Resident #2 had the following physician's orders: -Cleanse and apply barrier cream to the peri-area every day and night shift for skin integrity, ordered on 6/4/24; hold administration from date 8/15/24 to 8/17/24. -Elevate and off load right heel and left below knee amputation while in bed every day and night shift for pressure injury to the right heel and left surgical wound, ordered on 8/7/24; hold administration from date 8/15/24 to 8/17/24. -A review of Resident #2's August 2024 medication administration record (MAR) and progress notes revealed the treatments (above) were documented as not administered per the physician orders on the 8/23/24 day shift and on the 8/27/24 and 8/31/24 overnight shifts. III. Resident #12 A. Resident status Resident #12, age greater than65, was admitted on [DATE]. According to the September 2024 CPO, the diagnoses included heart disease, high blood pressure, anxiety, type 2 diabetes mellitus and polyneuropathy (damage to multiple nerves throughout the body). The 6/27/24 MDS assessment revealed the resident was cognitively intact with aBIMS score of 15 out of 15. She required substantial/maximum assistance with oral, personal and toileting hygiene, bathing, dressing, transfers, and moving from sitting to standing position. She needed moderate assistance with lying to sitting/sitting to lying in bed, and set up help with eating. B. Resident #12's representative interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12's representative was interviewed on 9/4/24 at 1:07 p.m. She said Resident #12's post surgical skin treatments were not being provided as ordered and the facility nurses responded they were not aware of Resident 12's physician's orders for post surgical site care. C. Record review Resident #12's skin care plan, revised on 5/31/24, documented she was at risk for skin breakdown due to impaired mobility, diabetes mellitus, cardiac disease, polyneuropathy, weakness, assistance with activities of daily living (ADL), a history of skin issues, incontinence, perspiration, shearing and friction risk, and impaired cognition. She scored as an at risk resident on the Braden Scale assessment (assessment used to assess the risk of developing pressure ulcers). Pertinent interventions, initiated on 9/5/23, included checking Resident #12's skin daily while providing care and to notify the physician of any abnormal findings. Resident #12's pressure ulcer care plan, revised on 3/27/24, documented she had potential for pressure ulcer development due to immobility, incontinence, impaired cognition, anxiety and aphasia (difficulty expressing and understanding language). Pertinent interventions, revised on 3/27/24, included following the facility policies and protocols for the prevention and treatment of skin breakdown. The August 2024 CPO revealed Resident #12 had the following physician's orders: -Treatment for surgical site to upper mid back: cleanse with warm water and soap, pat dry and pack wound with aquaphor and cover with a dry dressing twice daily two times a day for wound management, ordered on 8/19/24 and discontinued on 8/21/24. -Wound care for the surgical site to the upper mid back, cleanse with wound cleanser, pat dry, apply silver sulfadiazine cream, ag alginate to wound bed, cover with adhesive foam dressing. one time a day for wound management, ordered on 8/22/24 and discontinued on 8/26/24. -A review of Resident #2's August 2024 MAR, TAR and progress notes revealed the following treatments were documented as not administered and left blank per the physician orders on 8/20/24. IV. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 9/5/24 at 8:49 a.m. LPN #1 said most physician's orders for skin or wounds were scheduled once each shift or twice a day. LPN #1 said nursing staff never knew which orders were completed because the orders were not always marked as completed on the treatment administration record (TAR) and dressings were not always dated or initialed to indicate the dressing was changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #3 was interviewed on 9/5/24 at 3:26 p.m. RN #3 reviewed the MAR and confirmed there was no documentation on 8/23/24 indicated the wound care was completed. RN #3 said she was trying to figure out if Resident #2 was out for an appointment that day. RN #3 said it was possible that a nurse was not sure how to sign off in the MAR to indicate Resident #3 was out for an appointment. RN #3 said Resident #2 must have been out for an appointment the morning of 8/23/24 as his barrier cream and heel offloading tasks in the MAR were also left blank. RN #3 said she was not sure why they were left blank if Resident #2 was out for an appointment. RN #3 confirmed there were blank spots in the MAR for the barrier cream and heel unloading tasks on 8/27/24 and 8/31/24. RN #3 said she was not sure why they were blank. -However, there was no documentation that Resident #2 was out of the facility on 8/27/24 and 8/31/24. RN #3 said wound care was not marked as complete in the MAR for Resident #12 for one day. RN #3 said whenever residents missed wound treatments due to being out of the facility, the process was to let the nurse on the next shift know the resident still needed to have their wound treatment whenever the resident returned from their appointment. RN #3 said a blank spot in the MAR could be the result of a progress note not being saved by the software. RN #3 said the facility was having issues with their software in August 2024, that had since been resolved. The regional director of clinical services (RDCS) was interviewed on 9/5/24 at 2:00 p.m. The RDCS said the nurses should have documented in the medication administration record (MAR) if the resident refused a treatment or what the circumstance was. She said it was a missed opportunity to have the correct documentation. 50219 V. Resident #7 A. Resident status Resident #7, age less than 65, was admitted to the facility on [DATE]. According to the September 2024 CPO, diagnoses included non-pressure chronic ulcers to the left and right lower legs with fat layers exposed, cellulitis (a bacterial infection that affects the skin's deeper layers and underlying tissue) of the right lower limb, third degree burns to multiple sites over the left and right lower limbs and long-term use of opiate analgesics (pain medications). The 8/9/24 MDS assessment revealed the resident was cognitively intact with a brief interview for mental status BIMS score of 15 out of 15. The assessment revealed the resident had chronic pain. B. Resident interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 was interviewed on 9/5/24 at 10:03 a.m. Resident #7 said he had ongoing issues with his methadone (pain medication) being administered. Resident #7 said the pharmacy did not keep the medication in stock and there had been several instances where he ran out of the medication on a Friday and could not get it again until the following Monday. Resident #7 said he had to take Oxycodone (pain medication) more frequently when his methadone was out of stock, which led to him feeling doped up. Resident #7 said the other medications they use for his pain did not control his pain as effectively, and whenever the methadone was back in stock it took a while for his pain levels to become regulated again. C. Record review The analgesic/opioid care plan, revised on 10/23/23, revealed Resident #7 may have side effects related to his use of methadone. Pertinent interventions included administering the methadone as ordered and not having any abrupt discontinuation as it could cause withdrawal symptoms. The chronic pain care plan, initiated on 4/8/21 and revised on 11/28/23, revealed Resident #7 was at risk for alterations in comfort related to chronic wounds on both of his lower extremities and chronic pain. Pertinent interventions included administering medications as ordered. A review of Resident #7's September 2024 CPO revealed a physician's order for Methadone HCl 10 milligram (mg) oral tablets. Instructions were to give one tablet by mouth every eight hours for severe pain related to type two diabetes, ordered on 4/27/24. A review of Resident #7's MAR from June 2024 (6/1/24 to 6/30/24) revealed the following: -The 8:00 a.m. dose on 6/4/24 was marked with a nine, which indicated other/see nurses notes; -The 4:00 p.m. dose on 6/4/24 was marked with a nine, which indicated other/see nurses notes; and, -The 12:00 a.m. dose on 6/7/24 was marked with a nine, which indicated other/see nurses notes. A review of Resident #7's MAR from July 2024 (7/1/24 to 7/31/24) revealed the following: -The 8:00 a.m. dose on 7/8/24 was marked with a nine, which indicated other/see nurses notes; and, -The 4:00 p.m. dose on 7/8/24 was marked with a nine, which indicated other/see nurses notes. -Review of the progress notes from 6/1/24 to 8/30/24 did not reveal any nursing notes related to the missed doses on 6/4/24, 6/7/24 and 7/8/24. VI. Staff interviews LPN #2 was interviewed on 9/5/24 at 7:47 a.m. LPN #2 said a nine marked on the MAR usually indicated a medication was on order. LPN #2 said there would be something recorded in the notes on the MAR if a nine was marked. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #2 was interviewed on 9/5/24 at 8:00 a.m. RN #2 said a nine marked on the MAR meant other. RN #2 said if this was marked, the nurse would put a note as to why the medication was not administered. RN #2 said this note would also appear in the progress notes. LPN #1 was interviewed on 9/5/24 at 8:49 a.m. LPN #1 said she had noticed medications had ran out of stock frequently. LPN #1 said there was not an established system of who was ordering what and when it was being ordered. LPN #1 said if a medication ran out, she needed to mark on the MAR that it was unavailable, call the pharmacy to try to get the medication in stock, and alert the DON. LPN #1 said she would alert the resident's provider if it was a medication that was dire or if the medication was not going to be in stock for an extended period of time. The DON was interviewed on 9/5/24 at 2:00 p.m. The DON said she had not heard about any delays from the pharmacy. The DON said if a medication ran out, the nursing staff should call the pharmacy to see when the medication was coming and to check the emergency medication back-up supply. The DON said her phone number was posted everywhere. The DON said with any missed doses the nursing staff needed to contact a provider. RN #1 was interviewed on 9/5/24 at 2:06 p.m. RN #1 said the process for reordering medications began with the nurse running the medication cart noticing a medication was starting to run low. RN #1 said the facility nurses were able to use their software to order the medication directly but the nurses could call the pharmacy if the medication was nearly out of stock. RN #1 said a nine in the MAR meant the medication was not administered and the nurse would have to put a note into the record indicating why the medication was not given. RN #1 said the note would be in the progress notes along with the MAR. RN #1 said she could not find any notes indicating why a nine was marked in the MAR for Resident #7's methadone. RN #1 said Resident #7's Methadone had last been refilled on 8/6/24 but none of the missed doses were around that refill date. RN #1 said Resident #7 was on the methadone for his neuropathy and his pain was very difficult to manage due to his chronic wounds.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47536 Based on record review, observations and interviews, the facility failed to establish a system of records and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and failed to determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. Specifically, the facility failed to: -Maintain a system of controlled substance records for discontinued controlled substances. Findings include: I. Facility policy and procedure The Controlled Substance policy, revised November 2022, was provided by the nursing home administrator (NHA) on 9/5/24 at 10:56 a.m. The policy read in pertinent part, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Dispensing and reconciling controlled substances: -Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. -The system of reconciling the disposition of controlled substances includes the destruction and waste. -Waste and/or disposal of controlled medication are done in the presence of the nurse and a witness who also signs the disposition sheet. -Disposal methods are used to prevent diversion and/or accidental exposure to controlled or hazardous substances. -The consultant pharmacist or designee routinely monitors controlled substance storage records. II. Observations On 9/5/24 at 8:35 a.m., the inventory of discharged /discontinued controlled substances waiting for destruction was observed with the director of nursing (DON) and the NHA. The controlled medications were stored in a four drawer file cabinet that was secured with a padlock. The file cabinet was locked inside the DON's office. The DON unlocked and opened each file cabinet drawer. The drawers contained controlled medications and each drawer was completely full. The medications were dated March 2024 to September 2024. (continued on next page)

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Mountain View Post Acute	835 Tenderfoot Hill Rd Colorado Springs, CO 80906

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Record review On 9/5/24 at 8:45 a.m., a request was made for the documentation that indicated a system was in place to ensure controlled drugs were periodically reconciled. The DON said there was not a system in place to document the process that medications were tracked after they were discontinued and taken into her custody for destruction (see interview below). V. Staff interviews The DON and the NHA were interviewed together on 9/5/24 at 8:45 a.m. The DON said when the medication nurses alerted her to remove controlled substance medications from the medication cart, she reviewed the controlled medication count and signed the control sheet with the nurse. She said after she took the medication into her custody, she stored the controlled medications in the locked file cabinet inside her office. The DON said the NHA and herself had keyed access to her office and she had the keys to the padlocks. The DON said the process to destroy medications included two nurses to witness every destruction and the destroyed items would be entered on a tracking log. She said she placed the discontinued medication in her office until she had the opportunity to complete destruction of the controlled substances. The DON said when she took custody of the controlled substance medication she did not have a system in place to reconcile the discontinued medications. The DON said she had not destroyed any items since took her position in February of 2024. The NHA and DON said the file cabinet drawers included medications from March 2024 to September 2024. The NHA said he was unaware of the large inventory of medications awaiting destruction. He said he would review the facility's resources and consider using a third party to assist in destroying the controlled medications. The NHA said that he contacted the facility pharmacy and said the pharmacist had not completed reconciliation monitoring of controlled substance destruction.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50219 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to ensure nursing staff followed proper infection control procedures for a resident on enhanced barrier precautions (EBP). Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 9/9/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status. II. Facility policy and procedure The Enhanced Barrier Precautions policy, revised March 2024, was received from the nursing home administrator (NHA) on 9/5/24 at 5:08 p.m. It read in pertinent part, EBPs are used as an infection prevention and control intervention to reduce the transmission of MDROs to residents. EBPs employ targeted gown and glove use in addition to standard precautions 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. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include changing briefs or assisting with toileting. III. Observations On 9/4/24 at 12:31 p.m. a sign indicating that Resident #25 was on EBP was posted next to his door below the room number. The sign read in pertinent part, everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 3:16 p.m. certified nursing aide (CNA) #2 left a resident' s room across the hall from Resident #25 with a bag of soiled linens. CNA #2 put the soiled linens away then went into Resident #25' s room and closed the door to perform incontinence care (see interview below). -CNA #2 did not perform hand hygiene before entering the resident' s room, nor was she observed donning (putting on) the PPE necessary to perform EBP. IV. Record review The September 2024 CPO revealed Resident #25 had a physician's order for EBP due to Resident #25' s chronic wound, ordered on 5/11/24 at 6:00 a.m. V. Staff interviews CNA #2 was interviewed on 9/4/24 at 3:19 p.m. CNA #2 said she went into Resident #25' s room and interacted with that resident specifically. CNA #2 said during this interaction she checked to see if Resident #25 needed incontinence care. CNA #2 said to accomplish this she donned gloves, lifted the bed sheet and opened Resident #25' s brief to see if it was soiled. CNA #2 said Resident #25 had not been incontinent, so she wiped his peri-area with a wipe and put his brief back on. CNA #2 said she was not sure if the EBP signs meant the room itself needed EBP or if it was for a resident. CNA #2 said she did not see the EBP sign next to Resident #25' s door before she entered the room and that she did not wear any of the EBP PPE while she was in his room. Licensed practical nurse (LPN) #2 was interviewed on 9/5/24 at 7:47 a.m. LPN #2 said Resident #25 was on EBP for an open wound. LPN #2 said the EBP signs next to the resident' s door were there to let the staff know which precautions when caring for the residents. LPN #2 said the staff needed to don a gown and gloves when performing activities such as wound care, but would not need a gown for no-contact interactions such as setting a meal tray down. Registered nurse (RN) #2 was interviewed on 9/5/24 at 8:00 a.m. RN #2 said that EBP was used for residents with catheters, ports and wounds. RN #2 said any time the staff had to touch the resident or come into contact with their bodily fluids, they would need to wear PPE including a gown and gloves. RN #2 said checking or changing a brief would require EBP PPE. CNA #3 was interviewed on 9/5/24 at 1:29 p.m. CNA #3 said EBP meant the resident had a colostomy bag or a catheter. CNA #3 said this meant staff needed to wear PPE including gloves and a gown when working with those residents. CNA #1 was interviewed on 9/5/24 at 1:50 p.m. CNA #1 said EBP meant the resident had an open wound or catheter, and that the staff needed to wear a gown, mask and gloves when working with those residents. CNA #1 said she had not worn PPE while working with a resident that needed EBP the day prior, as she was moving so fast that she did not even look at the sign before she went in. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The infection preventionist (IP) was interviewed on 9/5/24 at 4:42 p.m. The IP said she did rounds each morning and audits to see how well staff followed EBP when working with residents. The IP said she did training when the new EBP guidance was established and had started additional training that day (9/5/24). The IP said she had provided additional spot-trainings during her audits if she saw any staff failures to follow EBP. The IP said staff needed to wear a gown and gloves when making any sort of physical contact, including checking and changing a brief, for residents with wounds or indwelling devices. The IP said hand hygiene should be performed before entering an EBP room, if they become soiled during care, and after leaving the room.