STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065175	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kiowa Hills Rehabilitation and Nursing, LLC	924 W Kiowa St Colorado Springs, CO 80905

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure residents were treated with respect and dignity by providing care in a dignified, respectful and individualized manner for one (#5) of three residents reviewed out of 33 sample residents. Specifically, the facility failed to: -Ensure Resident #5 was provided beverages of his choice when requested; and, -Ensure Resident #5 was provided clothing when he requested to get dressed and was not dressed in a hospital gown. Findings include: I. Facility policy and procedure The Resident Rights policy, dated 5/1/17, was provided by the nursing home administrator (NHA) on 1/16/25 at 2:38 p.m. It read in pertinent part, Employees should treat all residents with kindness, respect and dignity, and honor each resident's rights. These rights include the resident's rights for a dignified existence, to be treated with respect, kindness and dignity, self-determination and to be supported by the facility in exercising his or her rights. II. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder depressive type, obsessive-compulsive personality disorder, anxiety disorder, binge eating disorder, type 2 diabetes mellitus, hypertensive heart failure and chronic obstructive pulmonary disease (COPD). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065175	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 12/20/24 minimum data set (MDS) assessment revealed Resident #5 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #5 was independent or required supervision with dressing, toileting and transferring. He was independent with mobility using a wheelchair. B. Resident interview and observations Resident #5 was interviewed on 1/14/25 at 8:59 a.m. Resident #5 said he was going through some unfair treatment at the facility. Resident #5 was observed asking an unknown staff person for a cup of coffee and the staff told him the dining room was closed. -The staff person did not offer Resident #5 an alternate beverage. Resident #5 said he was going to find the social services director (SSD) so he could get a coke. Resident #5 asked the nurse working on the other hallway if she knew where the SSD was. The nurse told Resident #5 the SSD was in a meeting and he would have to wait. -The nurse did not offer to assist Resident #5 or find another staff person who could assist him. On 1/16/25 at 9:39 a.m. Resident #5 was sitting in his wheelchair in the doorway to his room wearing only an incontinent brief. Resident #5 asked housekeeper (HK) #1 for a cup of coffee. HK #1 told the resident she would have to ask his nurse first and then said Resident #5 was on a fluid restriction. -However, review of Resident #5's electronic medical record (EMR) did not reveal the resident was on a physician-ordered fluid restriction (see record review below). On 1/16/25 at 9:40 a.m. registered nurse (RN) #2 approached Resident #5 and asked if he wanted to get dressed. Resident #5 told RN #2 he did not have any clothes in his room. RN #2 offered the resident a hospital gown and assisted him to put it on. RN #2 was interviewed on 1/16/25 9:41 a.m. RN #2 said Resident #5 had clothes and kept them in his room but he constantly soiled them with urine and they were probably all in the laundry. She said she would check with the laundry staff and try to find some clothes for him. C. Record review The January 2025 CPO documented Resident #5 was on a regular diet with no fluid restrictions. The psychosocial needs care plan, initiated 2/27/24, documented Resident #5 would remain at the facility for ongoing psychosocial and care needs. Interventions included the following, per the resident's representative: Resident #5 would be given two Mountain Dew sodas per day until he was able to utilize the bathroom in his room and keep his room clean. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bladder incontinence care plan, initiated 2/27/24, documented Resident #5 voided in inappropriate places such as his bed, the trash can and the floor. Interventions included staff reminding him to use the toilet or urinal frequently, encouraging him to change soiled clothing and encouraging him to limit fluid intake two to three hours before bedtime as he would allow. -Review of Resident #5's EMR indicated Resident #5's family member was the resident's medical and financial power of attorney (POA), however, there was no documentation supporting this in the EMR or on file at the facility. The behavioral health clinical treatment plan of care, reviewed 11/19/24, documented Resident #5 indicated staff at the facility did not like him because he had urinary accidents throughout the day and night. D. Other resident interviews Resident #255, who had a BIMS score of 15 out of 15, was interviewed on 1/16/25 at 9:36 a.m. Resident #255 said he had heard the staff tell Resident #5 he could not have coffee when he asked for it because he kept peeing on the floor. E. Additional staff interviews The SSD was interviewed on 1/16/25 at 9:20 a.m. The SSD said Resident #5 had signed his own consents and was very intelligent. The SSD said Resident #5 could make daily decisions regarding his routine. The SSD said he did not have a copy of the POA paperwork for Resident #5. The SSD was interviewed again on 1/16/25 9:48 a.m. The SSD said Resident #5's care plan needed to be updated because he had his own stock of pop at the facility. The SSD said resident #5 was allowed to choose when to drink soda or coffee. The SSD said the care plan should have been updated at his last care conference meeting on 1/2/25. The SSD said when clothing was sent to the laundry, it was a two-day turnaround time for the clothes to be returned to the residents. The SSD said if Resident #5 was running out of clothing he would contact his representative to bring more in. The SSD said there was some donated clothing downstairs and he would look for some clothing for Resident #5 to wear until he got more clothes. The SSD said if the resident wanted to get dressed, he should not have to wear a hospital gown. The NHA was interviewed on 1/16/25 at 11:19 a.m. The NHA said if a resident wanted to get dressed they should have clothing to wear and they should not have to wear a hospital gown. The NHA said if a resident had a POA, they should still be able to make daily decisions and make simple choices. The NHA said a POA should not be restricting a resident's choices. The NHA said the care plan for Resident #5 should not include statements that the resident had to keep his room clean or use the bathroom appropriately in order to receive soda. He said the care plan would be updated.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50853

Based on record review and interviews, the facility failed to ensure residents had a right to participate in the development and implementation of their person-centered plan of care for three (#5, #14 and #38) of five residents out of 33 sample residents.

Specifically, the facility failed to invite and conduct regular care conferences to review the resident's plan of care with Resident #5, Resident #14 and Resident #38.

Findings include:

I. Facility policy and procedure

The Resident Participation, Assessment/Care Plans policy, dated December 2016, was provided by the nursing home administrator (NHA) on 1/15/25 at 12:22 p.m. It read in pertinent part,

The resident and his or her representative is encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan.

The social services director (SSD)or designee is responsible for coordinating care plan meetings or care conferences, with the resident or resident representative, including inviting the resident/representative and for maintaining records of such meetings. Care conference documentation should include: the date and time of the conference, the resident or representative invited to participate and the date he or she was invited, the members of the interdisciplinary team (IDT) who participated, input from the resident or representative if they are not able to attend and refusal of participation, if applicable.

II. Resident #5

A. Resident status

Resident #5, age less than 65, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder depressive type, obsessive-compulsive personality disorder, anxiety disorder, binge eating disorder, type 2 diabetes mellitus, hypertensive heart failure and chronic obstructive pulmonary disease (COPD).

The 12/20/24 minimum data set (MDS) assessment revealed Resident #5 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #5 was independent or required supervision with dressing, toileting and transferring. He was independent with mobility using a wheelchair.

B. Record review

The 7/22/24 quarterly care conference summary record attendance documented Resident #5 and his representative declined to attend the care conference.

(continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The next quarterly care conference summary record was dated 1/2/25 (five months since the previous care conference) and documented the resident representative attended. -There was no documentation in the electronic medical record (EMR) indicating a care conference was held between 7/22/24 and 1/2/25. III. Resident #14 A. Resident status Resident #14, age 76, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included cerebral infarction (stroke) with hemiplegia (paralysis) and hemiparesis (weakness) affecting the left non-dominant side, hypertension (high blood pressure) and type 2 diabetes mellitus. The 10/30/24 MDS assessment revealed Resident #14 had no cognitive impairment with a BIMS score of 15 out of 15. Resident #14 required supervision or touching assistance with personal hygiene, bed mobility and transfers. Resident #25 walked short distances with staff supervision and used a wheelchair for long distance mobility. B. Resident/representative interview Resident #5 and his representative were interviewed together on 1/13/25 at 10:04 a.m. The representative said she had not been invited to or attended a care conference meeting since the initial meeting this past summer (see below). C. Record review The 8/5/24 quarterly care conference summary record attendance page documented the resident and representative were in attendance. -There were no other care conference summary records found in the resident's EMR until 1/15/25 (during the survey). -There was no documentation found in the EMR of care conference meetings held between 8/5/24 and 1/15/25 (a period of five months). IV. Resident #38 A. Resident status Resident #38, age 80, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 CPO, diagnoses included fracture of the neck of the right femur, dementia, repeated falls and metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood). The 12/28/24 MDS assessment revealed Resident #38 had moderate cognitive impairment with a BIMS score of eight out of 15. Resident #38 required supervision or touching assistance with personal hygiene and partial assistance with transfers. She was independent with mobility in a wheelchair. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident representative interview Resident #38's representative was interviewed on 1/13/25 at 10:24 a.m. The representative said he had been invited to care conference meetings in the past but it had been several months since the facility had contacted him for another one. C. Record review The 7/24/24 care conference summary record attendance page documented the resident and representative attended. - There were no care conference summary records found in the resident's EMR since 7/24/24. - There was no documentation found in the EMR of care conference meetings held since 7/24/24 (a period of over five months). V. Staff interviews The social services director (SSD) was interviewed on 1/15/25 at 4:12 p.m. The SSD said each resident had a baseline care plan developed on admission and then it was reviewed quarterly during a care conference meeting with the IDT and the resident and/or the resident's family, if they chose to attend. The SSD said Resident #14 was supposed to have a care conference in November 2024. The SSD said when he was hired in November 2024 he was using the wrong care conference schedule and some residents, including Resident #5 and Resident #14, got missed. The SSD said now he was using the MDS assessment schedule for care conferences. The SSD said he invited families to attend care conference meetings by phone or in person if they were in the building. The SSD said he let the residents know about the meetings in advance. The SSD said he documented the care conference meeting in a progress note. He said, in addition, a care conference summary form was created where he documented if the resident was invited to the care conference. The SSD said a care conference meeting was held today (1/15/25) with Resident #14 and his representative. The regional clinical resource (RCR) responded by email on 1/16/25 at 10:49 a.m. that the facility was only able to locate a care conference meeting and notes from 7/24/24 for Resident #38. The RCR said the facility met with the family (during the survey) and were scheduling a care conference for later this month (January 2025). The NHA was interviewed on 1/16/25 at 11:19 a.m. The NHA said care conferences should be held quarterly corresponding with the MDS assessment schedule. The NHA said it was important to have the resident and the resident's family attend care conferences and be involved in the residents' plan of care.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219 Based on record review and interviews, the facility failed to honor resident choices for one (#46) of two residents out of 33 sample residents. Specifically, the facility failed to honor Resident #46's preference for assistance with bathing from female shower aides. Findings include: I. Facility policy and procedure The Accommodation of Needs and Preferences policy and procedure, dated 12/19/16, was provided by the nursing home administrator (NHA) on 1/16/25 at 2:38 p.m. It read in pertinent part, The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. II. Resident #46 A. Resident status Resident #46, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (a type of stroke that occurs when brain tissue dies due to a lack of blood flow), hemiplegia and hemiparesis (a neurological condition that causes paralysis or weakness on one side of the body). The 12/12/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident was dependent on staff for bathing. B. Resident interview Resident #46 was interviewed on 1/15/25 at 1:41 p.m. Resident #46 said she did not receive showers often enough. She said she preferred to shower every other day. Resident #46 said she preferred female shower aides and would not allow male shower aides to provide her assistance. She said she would refuse when the male shower aides tried to give her a shower, which led to either the facility getting a female shower aide or she would not receive a shower that day. Resident #46 said she told several staff members about her preference of having a female shower aide, but had not received any resolution to the issue. Resident #46 said she missed one or two showers as a result of the issue. C. Record review (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The activities of daily living (ADL) care plan, revised 9/17/24, revealed Resident #46 had an ADL performance deficit due to left-sided weakness/hemiplegia. Pertinent interventions revealed Resident #46 required assistance with bathing and preferred showers on Mondays, Wednesdays, and Fridays on evening or day shifts. -The care plan did not include any information regarding Resident #46's shower aide preferences. The trauma informed care care plan, initiated 8/30/24, revealed Resident #46 had a history of sexual assault and trauma that resulted in difficulty connecting with and trusting others. The care plan specified Resident #46 did not have a preference for male or female caregivers due to her trauma experience. -However, the resident's preference sheet, dated 8/30/24, documented Resident #46 preferred to receive care from female employees. Resident #46's representative filed a grievance with the facility on 12/5/24 which revealed Resident #46 would only like to be bathed by female staff members. The facility resolution, enacted 12/5/24, revealed the social services director (SSD) notified the nursing staff and made it known that only female staff would bathe Resident #46 from that point forward. Resident #46 signed the grievance form and indicated she was satisfied with the resolution. -However, Resident #46's care plan was not updated to reflect this preference, nor was this preference documented in the resident's electronic medical record (EMR) or on the Kardex (a tool utilized by staff to provide consistent resident care. Bathing records from 12/16/24 to 1/13/25 revealed a male aide assisted Resident #46 with her shower on 1/4/25 at 9:59 p.m. A resident preference sheet, undated, was uploaded to Resident #46's EMR effective 8/30/24. The preference sheet revealed Resident #46 preferred to receive showers on Tuesday and Friday evenings. Resident #46 indicated she preferred to receive care from female employees. A bathing preference sheet, dated 10/24/24, revealed Resident #46 preferred to have a shower on Monday, Wednesday, and Friday but did not have a preference for time of day. The preference sheet did not include any areas in which the resident could indicate a shower aide preference. The shower book, which was kept at the nurse's station, was reviewed on 1/15/24 at 2:06 p.m. The shower book revealed each resident's preference for time and day of week for their showers, but did not indicate any preferences regarding shower aides. D. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 1/15/25 at 2:06 p.m. CNA #6 said each resident's shower preferences were updated periodically and those updates were recorded in the shower book kept at the nurse's station. CNA #6 said he had not provided showers to Resident #46 so he was not aware of her preferences. CNA #6 said shower aide preferences were not documented in the shower book. He said the nursing staff knew that information from working with the residents. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7 was interviewed on 1/15/25 at 2:17 p.m. CNA #7 said Resident #46 received showers on Monday, Wednesday, and Friday evenings and preferred a female aide to assist her. CNA #7 said resident preferences were assessed when the resident first admitted and given to the nurse who then updated the resident's EMR. CNA #7 said the facility CNAs were told about resident preferences when they were initially trained but preferences were not recorded. Registered nurse (RN) #2 was interviewed on 1/15/25 at 3:10 p.m. RN #2 said resident preferences for showers were identified on admission then recorded in their Kardex and the shower book. RN #2 said preferences were also passed along between nursing staff at shift changes during the handoff report. The SSD was interviewed on 1/15/25 at 3:25 p.m. The SSD said he updated Resident #46's care plan to indicate Resident #46 preferred female bath aides. He said Resident #46 did not want to be touched by men due to her history of trauma. -However, a review of Resident #46's care plan revealed Resident #46 did not have a preference for male or female staff for bathing. Licensed practical nurse (LPN) #3 was interviewed on 1/15/25 at 5:33 p.m. LPN #3 reviewed Resident #46's Kardex but did not find any notes indicating her preference of shower aide. LPN #3 reviewed Resident #46's care plan and said it documented Resident #46 did not have a preference of male or female staff. The director of nursing (DON) was interviewed on 1/16/25 at 11:34 a.m. The DON said residents' bathing preferences were assessed upon admission and added to their baseline care plans. The DON said the facility staff identified if the resident preferred a bath or shower, time of day and the days of the week. The DON said the shower preference sheet did not ask about male or female aide preference. She said male or female preferences were determined by the staff and then should be documented on the bathing task in the EMR system. The DON said she was not aware of any specific shower aide preferences for Resident #46. The DON reviewed Resident #46's bathing task, care plan and Kardex and said she was unable to find any information regarding Resident #46's shower aide preferences.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50219 Based on observations and interviews, the facility failed to provide a functional, sanitary and comfortable environment for residents on four of five neighborhoods. Specifically, the facility failed to maintain a comfortable air temperature range on four out of five neighborhoods. Findings include: I. Facility policy and procedure The Quality of Life-Homelike Environment policy, dated 12/19/16, was provided by the nursing home administrator (NHA) on 1/16/25 at 2:38 p.m. It read in pertinent part, The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include comfortable and safe temperatures of 71 to 81 degrees fahrenheit (F). II. Group interview Residents who frequently attended monthly resident council meetings and the resident council president were interviewed on 1/14/25 at 10:38 a.m. The four residents (#1, #50, #205 and #23) who attended the meeting said the facility was not warm enough. Resident #205 said he talked to the maintenance supervisor (MS) regarding the cold temperatures in the facility but the MS was too busy to address the concern. Resident #205 said the heaters worked periodically at the facility. Resident #23 said the dining room was cold. She said she thought it was difficult to keep the dining room warm enough since it had a lot of windows. III. Resident and representative interviews Resident #37 was interviewed on 1/12/25 at 4:01 p.m. Resident #37 said her room was cold. She said the furnace in her room was barely warm. She said she was told the facility was having a repair person come in the following day to fix it and that the staff gave her extra blankets in the meantime. Resident #38's representative was interviewed on 1/13/25 at 10:24 a.m. Resident #38's representative said Resident #38 told him the heat register in her room had not been working for about thirty days. Resident #38's representative said Resident #38 complained to him about being cold at night. Resident #37 was interviewed a second time on 1/14/25 at 12:55 p.m. Resident #37 said it was still cold in her room. Resident #37 said the facility had told her they would have someone out to look at the furnace but no one had come. Resident #37 said she told the MS and one of her nurses that it was cold in her room. Resident #37 said it was colder at night and early in the morning in her room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #48 was interviewed on 1/14/25 at 1:29 p.m. Resident #48 said it was cold in her room. Resident #25 was interviewed on 1/14/25 at 2:40 p.m. Resident #25 said her heater was broken. Resident #25 touched the radiator in her room and said it did not feel warm. Resident #25 said the radiator had not been working all winter as far as she knew. Resident #37 was interviewed a third time on 1/14/25 at 2:44 p.m. Resident #37 said it was still cold in her room. Resident #37 was visibly shivering. IV. Observations On 1/14/25 at 2:28 p.m. ambient temperatures were taken throughout the facility. The following temperatures were observed: -At 2:28 p.m. the 300 hallway was 62.9 degrees F; -At 2:30 p.m. the 100 hallway was 70.1 degrees F; -At 3:32 p.m. the dining room was 68.9 degrees F; -At 2:34 p.m. the 600 hallway was 68.9 degrees F; and, -At 2:35 p.m. the 500 hallway was 67.4 degrees F. From 3:48 p.m. to 4:00 p.m. additional ambient temperatures were assessed by the administrator in training (AIT) and the MS which revealed the following: -The nurse's station measured 69.1 degrees F; -The 600 hallway measured 70.2 degrees F; -The 400 hallway measured 66.7 degrees F at one end of the hallway and 68.7 degrees F partway down the hallway; -The 100 hallway measured 71.4 degrees F; -The 300 hallway measured 63.5 degrees F at one end of the hallway and 65.1 degrees F part way down the hallway; and, -The dining room measured 67.1 degrees F. V. Staff interviews The MS was interviewed on 1/14/25 at 3:34 p.m. The MS said there was a mechanical service company working on the heaters at the time of the interview. The MS said he had confiscated several space heaters from employees and made them take them home. He said the company that previously owned the facility would not give him the funds to fix the heaters in the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Kiowa Hills Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 924 W Kiowa St, Colorado Springs, CO 80905	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MS said residents complained to him about being cold, so he did everything he could to help, including bleeding the radiators and setting the thermostats as high as they could go. The MS said the thermostats throughout the whole facility were set to 90 degrees F. The MS said he monitored the facility's temperatures daily and measured the temperatures throughout the facility every morning and again after lunch. The MS said the temperatures in the facility typically ranged between 68 and 72 degrees F. The MS said they were supposed to maintain temperatures between 71 and 81 degrees F in resident areas, and that below 70 degrees F was too cold and above 82 degrees F was too hot. The AIT and the MS were interviewed together on 1/14/25 at 3:48 p.m. The AIT said the facility temperatures should be between 71 and 81 degrees F. The AIT said the doors where residents went out to smoke were open all the time and let cold air into the building. The MS said the 300 hallway was like a wind tunnel because the handicap accessible door kept the door open for the smoking patio. The MS said the facility had been having issues with its heating system since before September 2024. The MS said he had been working on getting quotes and getting the heaters serviced since then. VI. Additional information Heater service invoices were provided by the NHA on 1/15/25 at 8:46 a.m. The invoices revealed the following: On 10/23/24 cleaning and flushing of supply lines was performed on the facility's boiler. The boiler was tested and its operation was verified. On 11/13/24 the maintenance company responded to the facility to address a reported issue of no heating. The maintenance company discovered several sensors for the heating system were not set correctly and adjusted them accordingly. The maintenance company tested the functionality of the heating system afterward and the issue had been resolved. On 11/22/24 the maintenance company responded to the facility to address a reported issue of no heating. The company found the 400 hallway thermostat was working intermittently and recommended a replacement. The company also determined there was a blockage in the heating pipes in the 300 hallway which needed to be repaired. On 12/3/24 a quote was provided by the maintenance company to supply and install baseboard covers for several rooms in the 500 hallway, two rooms in the 400 hallway, one room in the 100 hallway, and three rooms in the 600 hallway. The quote also involved servicing the facility's hydronic (radiant heat) system. -However, no quotes were provided for the thermostat replacement in the 400 hallway nor the repair work in the 300 hallway that was recommended on 11/22/24. On 1/15/25 at 8:56 a.m. the NHA said via email that the services provided on 1/14/25 involved replacing the baseboard heater covers in the 300 hallway but that the facility had not yet received an invoice for those repairs.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on interviews and record review, the facility failed to ensure residents and their representatives were provided prompt efforts by the facility to resolve grievances for one (#14) of four residents out of 33 sample residents. Specifically, the facility failed to document and follow-up on grievances reported by Resident #14 regarding a missing blanket and socks. Findings include: I. Facility policy and procedure The Filing Grievance/Complaints policy, dated December 2021, was provided by the nursing home administrator (NHA) on 1/15/25 at 5:37 p.m. It read in pertinent part, Any resident, his or her representative (sponsor), family member, or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other residents, staff members and theft of/missing property without fear of threat or reprisal in any form. Grievances and/or complaints may be submitted orally or in writing. Residents or the resident representative also has the right to file a grievance anonymously. Upon receipt of a grievance and/or complaint, the resident advocate or designee will investigate the allegations and submit a written report of such findings to the administrator within five (5) working days of receiving the grievance and/or complaint. The resident, or person filing the grievance and/or complaint on behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. The administrator, or his or her designee, will make such reports orally within five working days of the filing of the grievance or complaint with the facility. A written summary of the investigation will also be provided to the resident if requested, and a copy will be filed in the grievance log. II. Resident status Resident #14, age 76, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral infarction (stroke) with hemiplegia (paralysis) and hemiparesis (weakness) affecting the left non-dominant side, hypertension (high blood pressure) and type 2 diabetes mellitus. The 10/30/24 minimum data set (MDS) assessment revealed Resident #14 had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #14 required supervision or touching assistance with personal hygiene, bed mobility and transfers. Resident #14 walked short distances with staff supervision and used a wheelchair for long distance mobility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Resident/representative interview Resident #14 and his representative were interviewed together on 1/13/25 at 10:04 a.m. The representative said Resident #14 was missing a blanket and four pairs of socks. The representative said the blanket had gone missing before, was found, and was now missing again. She said the items had been missing for a while. Resident #14 and his representative were interviewed together again on 1/15/25 at 10:30 a.m. Resident #14 verified the blanket was missing again. The representative said the last time the blanket went missing it took the facility five weeks to find it. The representative said the facility found two pairs of socks this week (during the survey), but the resident was still missing two more pairs of socks. The representative said she reported the missing items to a certified nurse aide (CNA), a nurse and the social services director (SSD). She said the SSD reported he was going to fill out a grievance form for the missing items. -However the facility was unable to find a grievance/concern form that had been completed for the current missing items (see record review below). IV. Record review A grievance concern form, dated 11/12/24, was completed by the SSD and documented Resident #14 was missing a blanket. It was noted on the form that the blanket was found and returned to Resident #14 on 11/13/24. -The facility was unable to provide a grievance concern form for the resident's blanket and four pairs of socks that had been reported missing to several staff members, according to the resident's representative (see interview above). V. Staff interviews The SSD was interviewed on 1/15/25 4:09 p.m. The SSD said the facility had a care conference with Resident #14 today (1/15/25) and reported to the resident the blanket was found and was being washed. The SSD said he was just informed today about the missing socks. The SSD said if the facility did not find the socks the facility would offer to replace them. The SSD said he thought the NHA would be completing a concern form regarding the missing socks. -However, according to the resident's representative, several staff members had been informed of the resident's missing items and the facility had not completed a grievance complaint form (see interview above). The NHA was interviewed on 1/16/25 11:19 a.m. The NHA said any staff member could report missing items to the NHA. He said there was a form staff could fill out for the resident and turn in to the NHA. He said the facility would be re-educating staff on the process for reporting residents' missing items.

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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** 50219 Based on observations and interviews, the facility failed to ensure residents were provided services that meet professional standards for five (#1, #205, #255, #46 and #4) of nine residents out of 33 sample residents. Specifically, the facility failed to: -Ensure Resident #1 and Resident #205 received medications in a timely manner according to the physician's orders; and, -Ensure lancets were used instead of a syringe with a needle to check blood sugar levels for Resident #205, Resident #255, Resident #46 and Resident #4. Findings include: I. Failed to ensure Resident #1 and Resident #205 received medications in a timely manner according to the physician's orders A. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. B. Resident #1 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident status Resident #1, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included cerebral palsy (a disorder that affect a person's movement, balance, and posture), quadriplegia (paralysis of all four limbs), neuropathy (nerve pain) and contractures to the right elbow, left hand, left elbow, left shoulder, and left wrist. According to the 12/26/24 minimum data (MDS) assessment, the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 12 out of 15. The assessment indicated the resident was on a scheduled pain medication regimen. 2. Record review The chronic pain care plan, revised 6/21/24, revealed Resident #1 had chronic pain due to neuropathy. Pertinent interventions included evaluating the effectiveness of pain interventions and reviewing for compliance, alleviation of symptoms and dosing schedules for pain medications. The January 2025 CPO revealed Resident #1 was prescribed the following medications: -Gabapentin 100 milligram (mg) capsule. Give one capsule by mouth three times a day for neuropathy, ordered 10/13/24; and, -Baclofen 5 mg oral tablet. Give one tablet by mouth three times a day for muscle spasms, ordered 10/13/24. Review of Resident #1's progress notes revealed the following: -Gabapentin was not given on 11/20/24, 11/21/24, 11/22/24, 11/23/24, 11/25/24, 11/26/24 and 11/29/24 due to the medication being on order; and, -Baclofen was not given on 11/22/24, 11/23/24, 11/25/24 and 11/26/24 due to the medication being on order. A progress note, dated 11/24/24 at 4:43 p.m., revealed the last gabapentin capsules had been taken out of the emergency medication supply for Resident #1's dose that morning (11/24/24) so the medication was not available. -The progress notes from 11/20/24 through 11/29/24 did not reveal any note of Resident #1's provider being contacted for the missed medication doses. The November 2024 medication administration record (MAR) revealed Resident #1 was scheduled to receive the gabapentin and baclofen at 8:00 a.m., 4:00 p.m. and 8:00 p.m. each day. The November 2024 MAR revealed Resident #1 did not receive the following doses of gabapentin as prescribed: -At 8:00 p.m. on 11/20/24; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:00 p.m. on 11/21/24; -At 8:00 a.m., 4:00 p.m., and 8:00 p.m. on 11/22/24; -At 8:00 a.m. and 4:00 p.m. on 11/23/24; -At 4:00 p.m. on 11/24/24; -At 8:00 a.m. and 4:00 p.m. on 11/25/24; -At 8:00 a.m. and 4:00 p.m. on 11/26/24; and, -At 4:00 p.m. on 11/29/24. The November 2024 MAR revealed Resident #1 did not receive the following doses of baclofen as prescribed: -At 8:00 a.m. and 4:00 p.m. on 11/22/24; -At 8:00 a.m. and 4:00 p.m. on 11/23/24; -At 8:00 a.m. and 4:00 p.m. on 11/25/24; and, -At 8:00 a.m. on 11/26/24. 3. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 1/15/25 at 2:58 p.m. LPN #2 said the facility should not run out of medications. LPN #2 said every shift she worked she checked the medication cart to ensure medications were stocked. LPN #2 said if a medication did run out, she would alert the pharmacy so they could send the medication with their next delivery. LPN #2 said she would also alert the provider that the resident was out of the medication and get orders for what to do in the meantime. Registered nurse (RN) #2 was interviewed on 1/15/25 at 3:10 p.m. RN #2 said most medication sheets had a reorder point indicated on the sheet seven days prior to running out of the medication. RN #2 said once that reorder point was reached, the nurse could go into the MAR and reorder the medication. RN #2 said the facility just started using a brand new pharmacy that automatically ordered medications when they were close to running out. RN #2 said if she did run out of a medication, she would call the pharmacy to ensure it was reordered and see when it would arrive. RN #2 said she would then contact the resident's provider and let them know the resident was out of the medication in question and see what the provider wanted them to do in the meantime. RN #2 said this information would be charted in the resident's progress notes. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #2 said there were issues with the pharmacy they had been using, as there was a cutoff time in which they needed to have the medication ordered and they had transitioned to a new pharmacy. RN #2 said there were also newer staff members and potentially some issues with their training for medication ordering. The director of nursing (DON) was interviewed on 1/16/25 at 10:25 a.m. The DON said the facility just transitioned to using a new pharmacy. The DON said they had previously had issues with medications taking a long time to be delivered, so the pharmacy would send the prescriptions to a local pharmacy to be filled instead of shipping them directly. The DON said if the facility ran out of a medication, the nurse should check the emergency medication supply The DON said if the medication was not in the emergency medication supply, the nurse would call the pharmacy to let them know the resident was out. The DON said if a resident missed a dose of medication, the nurse should contact their provider. The DON evaluated Resident #1's November 2024 MAR and verified each of the missed doses of gabapentin and baclofen (see record review above). The DON said Resident #1 received gabapentin for nerve pain and baclofen as a muscle relaxant for her muscle spasms, as she had contractures (a permanent tightening of muscles, tendons, ligaments, or skin that limits movement). After looking at Resident #1's progress notes, the DON said she did not see any documentation to indicate that the provider was notified about the missed doses of medication. The DON said Resident #1 missed quite a few doses of medication. The DON said she was not sure how Resident #1's medications were administered or marked as administered between 11/20/24 and 11/29/24 if the medications were not available. The DON said it was not okay to start and stop gabapentin because if it was not given consistently, it did not achieve the same effect. The DON said the same was true for the baclofen. The DON said if baclofen was not given as scheduled, it did not prevent muscle spasms. The DON said the baclofen was very helpful for Resident #1. The DON said she would have expected the nursing staff to contact the Resident #1's provider when the resident missed the doses of the medications. C. Resident #205 1. Resident status Resident #205, age less than 65, was admitted on [DATE]. According to the January 2025 CPO, diagnoses included chronic respiratory failure, anxiety disorder and depressive episodes. The 11/25/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. The resident was mostly dependent and required supervision and assistance with most activities of daily living. 2. Record review The oxygen therapy care plan, revised 10/9/24, revealed Resident #205 received oxygen therapy due to his chronic pulmonary disease and was at risk for shortness of breath. Pertinent interventions included giving medications as ordered by the physician. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The anti-anxiety care plan, revised 2/27/24, revealed Resident #205 received an anti-anxiety medication to treat his anxiety. Pertinent interventions include administering anti-anxiety medications as ordered by the physician. The January 2025 CPO revealed Resident #205 was prescribed the following medications: -Advair diskus aerosol powder. Inhale one puff orally two times a day for maintenance related to chronic respiratory failure, ordered 10/17/24; and, -Buspirone HCl 5 mg oral tablets. Give one tablet by mouth three times a day for anxiety, ordered 10/8/24. Review of Resident #205's progress notes revealed the following: -Buspirone was not given on 11/24/24 and 11/25/24 due to the medication being on order; and, -Advair was not given on 12/25/24, 12/26/24 and 12/27/24 due to the medication being on order. A progress note, dated 12/26/24 at 11:25 a.m., revealed the Advair was not available. The nurse called the pharmacy and the order had not been seen on their end. The pharmacy entered the order and said the medication would be delivered to the facility the following day. A progress note, dated 12/26/24 at 8:54 p.m., revealed the Advair was not available and the day shift nurse had notified the pharmacy. -However, the progress notes from 11/24/24 through 11/25/24 and 12/25/24 through 12/27/24 did not reveal any note of Resident #205's provider being contacted for the missed medication doses. The November 2024 MAR revealed Resident #205 was scheduled to receive buspirone at 8:00 a.m., 4:00 p. m. and 8:00 p.m. each day. Review of the November 2024 MAR revealed Resident #205 did not receive the following doses of buspirone as prescribed: -At 8:00 a.m. and 4:00 p.m. on 11/24/24; and, -At 8:00 a.m. on 11/25/24. The December 2024 MAR revealed Resident #205 was scheduled to receive Advair at 8:00 a.m. and 8:00 p. m. each day. Review of the December 2024 MAR revealed Resident #205 did not receive the following doses of Advair as prescribed: -At 8:00 a.m. on 12/25/24; -At 8:00 a.m. and 8:00 p.m. on 12/26/24; and, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 8:00 a.m. and 8:00 p.m. on 12/27/24. 3. Staff interviews LPN #3 was interviewed on 1/15/25 at 5:33 p.m. LPN #3 verified that Resident #205's December 2024 MAR indicated he missed doses of his Advair on 12/25/24 through 12/27/24. LPN #3 said she could not find any progress notes indicating why those doses were missed. RN #2 was interviewed on 1/16/25 at 10:16 a.m. RN #2 verified Resident #205 missed doses of his Advair from 12/25/24 to 12/27/24 due to the medication being on order. RN #2 said she was not sure how or why the evening dose on 12/25/24 was marked as administered if Resident #205 was out of the medication. The DON was interviewed on 1/16/25 at 10:25 a.m. The DON verified the missed doses of medication in Resident #205's November 2024 and December 2024 MARs. The DON said she knew the nurses on duty notified the provider for Resident #205's missed medication doses, but she said she did not see that they had documented it. The DON said it did not make sense to her that Resident #205 missed a dose the morning of 12/25/24 but was administered or marked as administered a dose on the evening of 12/25/24. The DON verified Resident #205's buspirone dose was missed the morning of 11/24/24 but marked as given on the evening of 11/24/24. The DON said it was very confusing to her and she thought maybe the nurses were not paying attention to what they were documenting. The DON said the buspirone was to treat anxiety and the Advair was an inhaler for Resident #205's shortness of breath. The DON said Resident #205 frequently went to the hospital because he was short of breath and he had pneumonia and lots of respiratory issues. 48458 II. Failed to ensure lancets were used instead of a syringe with a needle to check blood sugar levels for Resident #205, Resident #255, Resident #46 and Resident #4 A. Professional reference According to the Centers for Disease Control and Prevention (CDC), Considerations for Blood Glucose Monitoring and Insulin Administration, (8/7/24), retrieved on 1/21/25, from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html, Fingerstick devices, also called lancing devices, prick the skin to obtain drops of blood for testing. Single-use, auto-disabling fingerstick devices are disposable and prevent reuse through an auto-disabling feature. These should be used in settings where you perform assisted blood glucose monitoring. B. Observations and interview (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/25 at 5:40 p.m. registered nurse (RN) #2 performed a fingerstick using a disposable lancet and obtained a blood sample from Resident #28 for blood glucose testing. RN #2 said the facility ran out of the lancets for a few days in December 2024 and the nursing staff used insulin syringes with needles attached to prick the finger for blood glucose testing of residents. RN #2 said a facility staff member obtained additional lancets from a pharmacy, but that supply ran out before the new supply of lancets arrived, so the nurses continued to use the insulin syringes with needles for testing. The medication storage room was observed on 1/12/25 at 5:40 p.m. Seven boxes of disposable lancets (100 per box) were on a shelf. RN #2 said the facility had staff who kept track of the supplies in the medication room, but the staff left the facility prior to the depletion of the lancet supply. RN #2 said the assistant director of nursing (ADON) had taken over the ordering of supplies, including lancets, at that time. C. Resident interviews Resident #255 was interviewed on 1/13/25 at 2:30 p.m. Resident #255 said the facility ran out of lancets a few weeks ago. He said the facility used syringes with needles attached to obtain blood for glucose testing. Resident #255 said the syringe needle hurt more than the lancets that the facility usually used. Resident #255 said the facility was using the needle method to test his blood for approximately three days. He said the facility did not have anyone in the supply room to order supplies. Resident #205 was interviewed on 1/15/25 at 1:44 p.m. Resident #205 said the facility ran out of lancets for a few days and used a syringe with a needle on the end to obtain his blood. Resident #46 was interviewed on 1/15/25 at 1:56 p.m. Resident #46 said the facility ran out of lancets a few weeks ago and for a few days the nurses used the needles they used to give insulin to prick her finger and check blood sugars. Resident #46 said this was done at least two to three times and it hurt her more than the lancet that was usually used to test her blood. Resident #4 was interviewed on 1/15/25 at 5:00 p.m. Resident #4 said the facility ran out of lancets for blood sugar checks. She said the nurses used a needle on the end of a syringe to obtain blood from her finger. Resident #4 said the needle hurt more than the lancets did. She said her blood was tested in this manner for two days (about six times per Resident #4). D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 1/13/25 at 2:50 p.m. LPN #1 said a few weeks ago the facility was low on their supply of lancets. LPN #1 said she had enough in her medication cart to use and she reported the low supply to management (she was unable to identify the specific manager notified). LPN #1 said she did not return to work for several days and did not know if the facility ran out of the lancet supply. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kiowa Hills Rehabilitation and Nursing, LLC	924 W Kiowa St Colorado Springs, CO 80905

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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	The ADON and the director of nursing (DON) were interviewed together on 1/13/25 at 3:07 p.m. The ADON said the facility ran out of lancets in December 2024. The ADON said a staff member went to a pharmacy to obtain additional lancets but returned to the facility with the wrong devices. The ADON said she assumed the responsibility for ordering supplies after the previous central supply personnel left the facility in November 2024. The ADON said she placed an order for lancets when she learned the supply had been exhausted. The ADON said she directed nurses to use a tuberculin/insulin syringe with the needle attached to obtain blood from residents for glucose testing. The ADON said this method was used for testing until a lancet supply was obtained from a sister facility, which was later the same day. The ADON said the borrowed lancets from the sister facility also ran out a day before the ordered supply of lancets arrived so the nursing staff used the insulin syringes with needles again for blood glucose testing. The DON said it was not appropriate to check residents' blood sugars with an insulin syringe and a needle. The DON said the facility did not have same day service to order lancets from their pharmacy when the supply of lancets was exhausted, however, the pharmacy was now able to provide same day supplies. The DON said she thought it would be more painful for residents if nurses used insulin syringes with needles for testing, as it was not possible to control the depth of the needle.The DON said she did not know why it took so long to obtain lancets from the sister facility. The ADON said the order for lancets was placed as an overnight order, however, it took three days for the supplies to arrive. The ADON said the facility now kept 10 boxes on hand and she checked supplies two to three times weekly. The DON and the regional clinical resource (RCR) were interviewed together on 1/15/25 at 6:15 p.m. The DON said the ADON should not have directed staff to use an insulin syringe with a needle attached to obtain blood for glucose testing from residents. The RCR said the ADON should not have directed staff to use insulin syringes with needles attached to obtain residents' blood for glucose testing under any circumstances. The medical director (MD) was interviewed on 1/16/25 at 9:02 a.m. The MD said it would cause more pain to residents to use a syringe with a needle for glucose testing than a lancet. He said lancets were usually a higher gauge device (needle was smaller) and the needle would be a smaller gauge (the needle was larger with a smaller gauge). The MD said he had never seen a syringe with a needle attached used before to obtain blood for glucose testing. The MD said he would never think about using anything other than the lancet to obtain blood for glucose testing, and other than causing more discomfort, he did not think there would be any long term consequences of using the needle.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure one (#16) of three residents reviewed for activities out of 33 sample residents received an ongoing program of activities designed to meet needs and interests and promote physical, medical and psychosocial well-being. Specifically, Resident #16 was not provided with meaningful activities or one-to-one staff visits per his individualized plan of care. Findings include: I. Facility policy and procedure The Activity Programs policy, revised June 2018, was provided by the regional clinical resource (RCR) on 1/16/25 at 1:30 p.m. The policy read in pertinent part, The activities program is ongoing and includes facility-organized group activities, facility-sponsored individual activities (including one-on-one activities) and independent individual activities. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Activities are offered seven days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs. Activities are documented in the resident's medical record. II. Resident #16 A. Resident status Resident #16, age 77, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included diabetes, heart disease, dementia and epilepsy. The 10/10/24 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. Resident #16 was independent with eating, hygiene, dressing, transferring and walking. The 3/16/24 MDS assessment revealed it was very important to Resident #16 to keep up with news, participate in his favorite activities and go outside to get fresh air when the weather was good. The assessment further revealed Resident #16 did not consider it important to do things with groups of people or participate in religious activities. B. Observations and resident interviews On 1/12/25 at 4:26 p.m. Resident #16 was sitting in his chair and looking into the hallway. The resident had no reading materials present and there was no television (TV) or music on. (continued on next page)

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F 0679

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #16 said he had been sitting in his chair all day with nothing to do. He said the programming on TV was very limited and repetitive. Resident #16 said the facility had very few scheduled activities. He said the activities mainly consisted of Bingo and there were very few other activities provided to the residents. Resident #16 said an activities staff member rarely came into his room. Resident #16 said he had asked staff to tell him when there were activities, but he said they did not let him know.

Resident #16 removed a January 2025 activities calendar from his dresser drawer. Resident #16 said the calendar often was not accurate and the scheduled activities were often changed or did not happen. Resident #16 said he often sat near the nurses station waiting for activities and staff often told him there were no activities available on those days.

On 1/13/25 at 4:00 p.m., Resident #16 was sitting in a chair in his room looking into the hallway. The room was quiet with no TV or music on.

On 1/14/25 at 10:30 a.m., Resident #16 was sitting in a chair in his room looking into the hallway. Resident #16 said there were no activities that morning (1/14/25) and he had nothing to do.

On 1/14/25 at 12:32 p.m., Resident #16 was sitting in a chair in his room, and staring at the wall which had nothing on it. The room was quiet with no TV or music on.

On 1/14/25 at 2:15 p.m., Resident #16 was participating in an activity in the resident dining room.

Resident #16 was interviewed a second time on 1/14/25 at approximately 4:30 p.m. Resident #16 said the activity he participated in at 2:15 p.m. was jewelry making and was not the activity that had been originally scheduled on the activity calendar. (Review of Resident #16's activity calendar revealed a bean bag toss activity had originally been scheduled on 1/14/25 at 2:00 p.m.)

On 1/15/24 at 9:30 a.m., Resident #16 was sitting in a chair in his room. The room was quiet with no TV or music on. A new January 2025 activities calendar was hanging in Resident #16's room next to the door. The activities calendar had more activities scheduled than the initial January 2025 activities calendar that Resident #16 had removed from his dresser on 1/13/25 (see above).

Resident #16 was interviewed a third time on 1/15/25 at 10:14 a.m. Resident #16 said there were still very little activities occurring in the facility. Resident #16 was sitting in his chair and his room was quiet with no TV or music on.

On 1/16/25 at 1:15 p.m., Resident #16's door was open and he was lying in bed looking at the ceiling. Resident #16 was dressed and the room was quiet with no TV or music on.

C. Record review

(continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #16's activities care plan, initiated 2/17/24, revealed Resident #16 preferred independent activities and enjoyed watching a variety of TV and movies, listening to music with rhythm, group Bingo and painting. The care plan goals included Resident #16 pursuing independent leisure pursuits daily, including sitting in the common area, watching people, listening to music, watching TV news and sports as desired and tolerated. Goals for Resident #16 also included participation in one to two group activities weekly. The activity records for Resident #16 from 11/1/24 to 1/15/25 were provided by the RCR on 1/16/25 at 2:52 p. m. The November 2024 activity record documented five Bingo activities which Resident #16 had participated in on 11/1/24, 11/4/24, 11/8/24, 11/12/24 and 11/20/24. -There was no documentation of activity participation for Resident 16 for December 2024 or January 2025. The initial January 2025 activity calendar (posted prior to 1/14/25) and revised January 2025 activity calendar (posted on 1/14/25) were provided by the nursing home administrator (NHA) on 1/16/25 at 3:00 p. m. The initial activities calendar contained a daily 9:30 a.m. coffee and news activity which represented 50% of the activities for the month or 31 of 62 scheduled activities. The revised activities calendar had additional activities scheduled and changes to the initially scheduled activities from the initial calendar, including the change from the bean bag toss activity on 1/14/25 at 2:00 p. m. to jewelry making (see observations above). D. Staff interviews The activity director (AD) was interviewed on 1/15/25 at 9:40 a.m. The AD said she posted a revised January 2025 activity calendar which she created on 1/14/25. The AD said she did not know who had posted the initial January 2025 calendar. The AD said an example activity calendar had been left on her desk with notes. The AD said she did not know if Resident #16 had enough activities to meet his needs. The AD said she determined if residents were getting enough activities or the right activities by noting how many people attended an activity and speaking with residents about what activities they wanted. The AD said she began her role as the AD on 1/6/25 but she had previously worked at the facility as a certified nurses aide (CNA) for the previous three years. The AD said she was not aware of the requirements to be an activity director in a nursing facility and she did not have a current mentor. The administrator in training (AIT) and the NHA were interviewed together on 1/15/25 at 10:25 a.m. The AIT said he did not know who had created the initial January 2025 activities calendar. The NHA said the AD could not know what the residents' needs were based on their conditions because she had not had a mentor or appropriate activity director training. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cross-reference F680 for failure to meet the qualifications of an activity professional.

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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 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. 48458 Based on record review and interviews, the facility failed to ensure the activities program was directed by a qualified professional. Specifically, the facility failed to employ a qualified activities director in order to provide a program of activities for residents requiring activity and recreational support. Findings include: I. Professional reference According to the National Certification Council of Activity Professionals (NCCAP) (2025), retrieved on 1/22/25 from https://www.nccap.org/assets/docs/F-TAG%20680%20QUALIFICATION%20OF%20ACTIVITY%20DIRECTOR.pdf, The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist, or an activities professional who is licensed or registered if applicable by the state in which practicing; and, Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or, Has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or, Is a qualified occupational therapist or occupational therapy assistant; or, Has completed a training course approved by the State. An activity director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This includes completion of the activities component of the comprehensive assessment, contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities and interests/preferences of each resident. II. Resident interview Resident #16 was interviewed on 1/12/25 at 4:26 p.m. Resident #16 said he had been sitting in his chair all day with nothing to do. He said the programming on television (TV) was very limited and repetitive. Resident #16 said the facility had very few activities. He said activities mainly consisted of Bingo and there were very few other activities provided to the residents. Cross-reference F679 for failure to ensure activities meet the interest/needs of each resident. III. Record review (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The job description for the activities director (AD) was provided by the regional clinical resource (RCR) on 1/16/25 at 1:32 p.m. The job description read in pertinent part, The activities director will collaborate with an activities consultant regarding resident and department issues and implement any recommended changes, including development of monthly activity calendars and development and revision of activity care plans. Complete all activities related documentation in each residents' medical record, including assessments, progress notes, care plans and activity attendance records. The initial January 2025 activity calendar (posted prior to 1/14/25) and revised January 2025 activity calendar (posted on 1/14/25) were provided by the nursing home administrator (NHA) on 1/16/25 at 3:00 p. m. The initial activities calendar contained a daily 9:30 a.m. coffee and news activity which represented 50% of the activities for the month, or 31 of 62 scheduled activities. The revised activities calendar had additional activities scheduled and changes to the initially scheduled activities from the initial calendar. IV. Staff interviews The AD was interviewed on 1/15/25 at 9:40 a.m. The AD said the administrator in training (AIT) was her supervisor. The AD said she did not have anyone providing activities director training to her and she had no previous experience or qualifications for the activities director position prior to assuming the role on 1/6/25. The AD said she asked her supervisor if certification was required for her role and was told the facility would get back to her. The AD said she was told she would have a mentor for her position but had not been provided with the mentor's name or phone number. The AD said she was not aware what the experience or education requirements were for an AD in a nursing facility. The AD said the previous January 2025 activities calendar was removed and replaced with a calendar she created on 1/14/25. The AD said she did not know who had posted the previous January 2025 calendar. The AD said it was the first activities calendar she had created. The AD said she used an example calendar which was left on her desk to create the January 2025 calendar. The AD said she did not know if Resident #16 had enough or appropriate activities. The AD said the previous AD had worked in the facility's maintenance department prior to working in the AD role. She said the previous AD was in the role from September 2024 to December 2024. The AIT and the nursing home administrator (NHA) were interviewed together on 1/15/25 at 10:25 a.m. The AIT said the AD misunderstood and the AIT was not her supervisor. The NHA said the previous AD who was in the role from September 2024 to December 2024 was not a certified AD. The NHA said the facility had a contract with a certified AD who was a consultant. The NHA said the consultant was the direct supervisor for the previous AD and the current AD. The NHA said the consultant met with the previous AD on 12/18/24. (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said the consultant was at the facility once a month for eight hours and as needed. The NHA said monthly supervision was not sufficient for an AD who did not have experience and needed to learn the role. The AIT said he would ensure the AD had contact information for her mentor (the consultant). The NHA said the AD did not know what the residents' needs were based on their conditions because she had not had training in the role. The NHA said he did not know if anyone had informed the AD of the requirements for her role. The NHA said the consultant likely was not aware there was a new AD because the consultant would have contacted the AD to arrange training if the consultant was aware the new AD was hired.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853 Based on observations, record review and interviews, the facility failed to ensure the residents environment remained as free of accident hazards as possible and ensured residents received adequate supervision and assistance to prevent a fall with major injury for one (#38) of three residents reviewed for accidents/hazards out of 33 sample residents. Resident #38, who was at high risk for falls and had a history of a fall with a fracture, was admitted to the facility on [DATE] and readmitted on [DATE] after a hospital stay for repair of a right femur fracture. Per the resident's fall care plan, staff were instructed to anticipate and meet the resident's needs, keep the call light within reach and keep personal items within reach. Resident #38 experienced a witnessed fall on 12/20/24 while trying to walk to her sink to get a drink of water, resulting in a fracture of her right femur. The staff failed to implement new interventions after the resident's fall with major injury. Observations of Resident #38 during the survey revealed staff were not consistently ensuring Resident #38's call light was within reach when she was in her room. Findings include: I. Facility policy and procedure The Safety and Supervision of Residents policy, dated 12/19/16, was provided by the nursing home administrator (NHA) on 1/15/25 at 5:07p.m. It read in pertinent part, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Implementing interventions to reduce accident risks and hazards shall include the following: communicating specific interventions to all relevant staff via the resident's care plan, assigning responsibility for carrying out interventions, providing training, as necessary, ensuring that interventions are implemented and documenting interventions. Monitoring the effectiveness of interventions shall include the following: ensuring that interventions are implemented correctly and consistently, evaluating the effectiveness of interventions, modifying or replacing interventions as needed and evaluating the effectiveness of new or revised interventions. All direct care staff members are responsible to review and follow the resident's individualized care plan for safety and supervision. II. Resident #38 A. Resident status (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #38, age 80, was admitted on [DATE] and readmitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included fracture of the neck of the right femur, dementia, repeated falls and metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood). The 12/28/24 minimum data set (MDS) assessment revealed Resident #38 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. Resident #38 required supervision or touching assistance with personal hygiene and partial assistance with transfers. She was independent with mobility in a wheelchair. The assessment documented Resident #38 had clear speech and was always able to make herself understood. She was occasionally incontinent of urine and required partial assistance with getting on and off the toilet. B. Observations and interview On 1/12/25 at 5:30 p.m. Resident #38 was lying in bed. The call light button was on the floor under the head of the bed, out of the resident's sight and reach. On 1/13/25 at 9:50 a.m. Resident #38 was lying in bed. The call light was on her pillow above her head, out of her sight. A continuous observation was conducted on 1/13/25, beginning at 2:09 p.m. and ending at 4:09 p.m. The following was observed: At 2:09 p.m. Resident #38 was lying in bed. The call light button was under the pillow above her head, out of sight and reach. At 2:35 p.m. an unknown certified nurse aide (CNA) stopped and looked into Resident #38's room, then continued to walk down the hall. The unidentified CNA did not enter the resident's room to ensure the resident's call light was within her reach. At 2:50 p.m. an unknown CNA delivered ice water to Resident #38's roommate but did not check the call light placement for Resident #38. The call light button was still under the pillow above the resident's head. At 3:42 p.m. the call light button remained under the pillow above her head. At 4:09 p.m. the call light button remained under Resident #38's pillow above her head. On 1/13/25 at 4:32 p.m. registered nurse (RN) #1 observed Resident #38's call light placement. RN #1 said call lights should be placed beside the residents where they could reach them. RN #1 said the cord had a clip so it could be clipped to the resident's shirt. RN #1 moved Resident #38's call light from under the pillow to the top of her comforter. On 1/14/25 at 8:54 a.m. Resident #38 was lying in bed. The call light cord was clipped to the top corner of the sheet above Resident #38's head. The call button was on the floor under the head of the bed, out of sight and reach. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA #6 was interviewed on 1/14/25 at 9:21 a.m. He said Resident #38's call light should be placed on the bed where she could reach it. He said she could not reach it on the floor where it was currently laying. CNA #6 picked up Resident #38's call light from the floor and placed it on top of the comforter on her chest. CNA #6 said it was important to keep the call lights where the residents could reach them so they could get help when they needed it. On 1/15/25 at 9:16 a.m. Resident #38 was lying in bed. The call bell cord was clipped to the top corner of the sheet above Resident #38's head. The call button was on the floor under the head of the bed, out of sight and reach of the resident. C. Record review The activities of daily living (ADL) care plan, initiated 2/27/24, included an intervention to encourage Resident #38 to use the call bell for assistance. The communication care plan, initiated 2/27/24, included an intervention to keep the call light in reach. Resident #38's fall care plan, initiated 3/13/24, revealed the resident was at risk for falls. Pertinent interventions included anticipating and meeting the resident's needs, keeping the call light within reach and encouraging the resident to use it, ensuring the resident had shoes or non-skid socks on when walking, ensuring the resident's bed was in the low position when in bed, keeping personal items in reach and keeping the floor free of spills and clutter. The 8/16/24 fall risk evaluation documented Resident #38 was a high fall risk related to balance problems while standing and walking, gait problems, use of an assistive device, high risk medications and diagnoses. The 12/20/24 nursing progress note documented Resident #38 was observed trying to walk to her sink to get a drink of water and fell to the floor. The 12/20/24 change in condition hospital transport report documented Resident #38 experienced a witnessed fall with a suspected serious injury related to pain in her right leg and hip and inability to bear weight. The facility's physician ordered x-rays which revealed a fracture. Resident #38 was sent to the hospital where she underwent surgical repair to the right femur and returned to the facility on [DATE]. -Resident #38's fall care plan was not updated with any new interventions after the fall with fracture on 12/20/24. D. Additional staff interviews RN #2 was interviewed on 1/12/25 at 6:04 p.m. RN #2 said Resident #38's call light should be placed within her reach. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Kiowa Hills Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 924 W Kiowa St Colorado Springs, CO 80905	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 1/15/25 at 6:07 p.m. The DON said resident's call lights should be within the residents' reach, clipped on the pillow or blanket if they were in bed. The DON said the call light being clipped on the top corner of the bed would not be within reach of most residents due to their lack of dexterity and range of motion. The DON said Resident #38 was a high fall risk and was not safe to transfer without staff assistance.

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F 0761

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

50853

Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in two of four medication carts and one of one medication storage room.

Specifically, the facility failed to:

-Ensure expired medications were removed from the medication carts and medication storage room; and,

-Ensure over the counter medications intended for use by a single resident were labeled with the resident's name.

Findings include:

I. Professional reference

The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 1/22/25 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part,

Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.

II. Manufacturer's recommendations

The manufacturer's recommendations for latanaprost eye drops were retrieved on 1/22/25 from https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf. It read in pertinent part, Latanaprost sterile ophthalmic solution is indicated for the reduction of intraocular pressure in patients with open angle glaucoma. Once a bottle is open for use it may be stored at room temperature for six weeks.

III. Observations

On 1/14/25 at 1:17 p.m. the medication storage room was observed with the director of nursing (DON). The following items were found:

-Seven tubes of activon medical grade honey (a wound treatment) with an expiration date of December 2024; and,

(continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-One box of phos-nak dietary supplement 100 count with an expiration date of April 2024. On 1/14/25 at 9:25 a.m. the medication cart on the 100 hallway was observed with registered nurse (RN) #1. The following item was found: -One bottle of cetirizine (allergy medication) 10 milligrams (mg) with an expiration date of December 2024. On 1/14/25 at 2:06 p.m. the medication cart on the 100 hallway was observed again with RN #1. The following items were found: -One bottle of latanaprost eye drops opened 10/1/24; -One bottle of buproprion (antidepressant medication) ER 150 mg with an expiration date of 9/17/24; -One bottle of amlodipine (medication used to treat high blood pressure) 10 mg with an expiration date of 10/12/24; and, -One bottle of citalapram (antidepressant medication) 20 mg with an expiration date of 11/30/24. On 1/15/25 at 10:56 a.m. the medication cart on the 600 hallway was observed with the DON. The following items were found: -One box of Genteal tears containing two tubes of ointment, opened 1/9/25, with no pharmacy label or resident name on either tube or the box; and, -One bottle of saline nasal spray opened 1/13/25 with no pharmacy label or resident name on the bottle. IV. Staff interviews RN #1 was interviewed on 1/14/25 2:15 p.m. RN #1 said she would dispose of the expired medications in the drug buster (a drug disposal system that breaks down unwanted medications into a non-toxic liquid that can be safely disposed of in the trash). RN #1 said she was not sure how long latanaprost should be used after opening. RN #1 said the risks of giving medication that was expired were unexpected side effects or decreased effectiveness of the medications. The DON was interviewed on 1/15/25 at 3:25 p.m. The DON said the medication carts and medication storage room should be examined every week by the assistant director of nursing (ADON) or the DON. The DON said she did not know why the bottles of expired medications were left in the medication cart. The DON said it was not advisable to use expired medications because their potency could be reduced.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen, satellite kitchen, and one of two nourishment refrigerators. Specifically, the facility failed to: -Ensure ready to eat foods were handled in a sanitary manner to prevent cross contamination in the main kitchen; -Ensure safe and appropriate storage of food items in the kitchen and nourishment room refrigerators; -Ensure proper hair restraints were worn in the kitchen; -Ensure the kitchen and food service areas were kept clean; and, -Ensure frozen meats were thawed in a safe manner. Findings include: I. Failed to ensure ready-to-eat foods were handled in a sanitary manner A. Professional reference The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 1/23/25. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. (3-301.11) B. Facility policy and procedure The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy and procedure, dated 12/19/16, was received from the nursing home administrator (NHA) on 1/26/25 at 2:38 p.m. It read in pertinent part, Gloves are considered single-use items and must be discarded after completing the task for which they are used. C. Observations (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

During a continuous observation of the lunch meal service on 1/15/25, beginning at 9:42 a.m. and ending at 12:46 p.m. the following was observed:

At 11:00 a.m. dietary aide (DA) #1 washed her hands, donned gloves and left the kitchen. DA #1 returned to the kitchen with four heads of lettuce and a plastic bag of shredded carrots. With the same gloved hands, DA #1 removed the outer layer of leaves of two lettuce heads, used her gloved hands to touch the faucet head to move it so she could rinse the lettuce and moved the faucet head back. Using the same gloved hands, DA #1 began slicing lettuce for salad. At 11:04 a.m. DA #1 repeated this process for the other two heads of lettuce using the same gloved hands.

At 11:25 a.m. DA #1 donned gloves, used her gloved hands to open the refrigerator and retrieved a bag of shredded cheese wrapped in cling film. Using the same gloved hands, DA #1 unwrapped the bag of cheese shreds and opened it. DA #1 then used the same gloved hands to grab three handfuls of cheese and sprinkled it onto the salad she was preparing.

From 11:59 a.m. to 12:35 p.m. DA #2 wore a pair of gloves. DA #2 used these gloves to handle meal tickets, serving utensils and meal trays. DA #2, using the same gloved hands, picked up cookies and put them onto plates to be served to the residents throughout lunch service.

At 12:22 p.m. DA #3 placed the palm of her gloved hands on the surface of two plates before serving food on them. DA #3 had previously used the same gloved hands to handle serving utensils. DA #3, using the same gloved hands, opened a plastic bag containing hot dog buns, grabbed two buns and separated the halves of the buns using her gloved hands.

At 12:25 p.m. DA #3 repeated the process of opening the plastic bag of hot dog buns, selecting two buns and separating the halves of the buns using the same gloved hands. DA #3 repeated this process at 12:35 p.m. with the same gloved hands.

D. Staff interview

The dietary manager (DM) was interviewed on 1/16/25 at 9:13 a.m. The DM said ready to eat foods should be handled with gloves. The DM said gloves were single use and single task. He said the dietary staff should remove their gloves and wash their hands between tasks. The DM said the dietary aides should have taken off their gloves and put on fresh gloves between tasks during the lunch service observation.

II. Failure to safely and appropriately store food items

A. Professional reference

The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 1/23/25. It revealed in pertinent part, Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees celsius (41 degrees fahrenheit (F)) or less for a maximum of seven days. The day of preparation shall be counted as day one.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (3-501.17) B. Observations During an initial tour of the kitchen on 1/12/25 at 2:38 p.m., the following items were observed in the refrigerators: -A container of cottage cheese, with an expiration date of 12/27/24; -A container of hot dogs, with a date of 1/4/25; -An opened container of sauerkraut, unlabeled and undated; -A container of fruit salad, unlabeled and undated; -Five individual containers of diced fruits, unlabeled and undated; -A block of cheese slices, unlabeled and undated; and, -Two containers of raw chicken wings, unlabeled and undated. At 2:38 p.m. in the food preparation area, a container of sugar was observed with no lid on it. The sugar had several dark pieces of debris in it. On 1/13/25 at 3:35 p.m. observations of the contents of the Glacier Peak neighborhood nourishment refrigerator revealed the following: -A deli meat sandwich labeled 1/7/25; -A damp cardboard fast food container in a plastic bag dated 12/5/24 with a resident's name; and, -Two unlabeled undated containers of sliced fruit. On 1/15/25 at 9:42 a.m. the lid to the sugar bin in the kitchen was askew and not covering the bin. C. Staff interview The DM was interviewed on 1/16/25 at 9:13 a.m. The DM said the dietary staff went through the refrigerators in the kitchen each day and threw away items that were out of date. The DM said once opened, items in the refrigerator should only be kept for a range of one to seven days, depending on what the item was. He said the sandwiches should only be held for two to three days. The DM said items in the refrigerators should always be labeled and dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM said he did not know the nourishment refrigerators were part of the kitchen's responsibility to maintain. The DM said he checked the nourishment refrigerators in the nurse's stations briefly each day to make sure there were enough snacks in them. The DM said the fast food container in the nourishment refrigerator (see above) was very old and needed to be thrown away. III. Ensure kitchen staff were wearing appropriate hair restraints while preparing and serving food A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 1/23/25. It revealed in pertinent part, Food 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 to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens. (2-402.11) B. Facility policy and procedure The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy and procedure, dated 12/19/16, was received from the NHA on 1/26/25 at 2:38 p.m. It read in pertinent part, Hair nets or caps/hats and beard restraints (as indicated) must be worn to keep body hair from contacting exposed food, clean equipment, utensils and linens. C. Observations On 1/15/25 cook (CK) #1 was observed during a continuous observation of the lunch service, beginning at 9:42 a.m. and ending at 12:46 p.m. CK #1 was preparing food for residents throughout the observation period. -CK #1 had a goatee and mustache approximately 1.5 inches long and was not wearing a beard net or other facial hair covering throughout the observation period. D. Staff interview The DM was interviewed on 1/16/25 at 9:13 a.m. The DM said the facility's kitchen did not have any beard nets available. The DM said he was working on getting beard nets for CK #1. IV. Failure to ensure kitchen and food service areas were kept clean A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 1/23/25. It revealed in pertinent part, Floors, floor coverings, walls and wall coverings shall be designed, constructed, and installed so they are smooth and easily cleanable. (6-201.11) Non-food-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. (4-601.11) B. Facility policy and procedure (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dietary Sanitization policy and procedure, dated 12/19/16, was received from the NHA on 1/26/25 at 2:38 p.m. It read in pertinent part, All kitchens and kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. C. Observations and staff interviews An initial tour of the main kitchen was conducted on 1/12/25 at 2:38 p.m. and revealed the following: -The deli meat slicer that was not actively in use had visible debris along the slicer surface; and, -The floors throughout the kitchen were soiled with dirt and crumbs. On 1/13/25 at 3:41 p.m. the floor of the satellite kitchen used for meal service had dirt and debris throughout the room. On 1/15/25 at 9:28 a.m. the tile floor of the main kitchen had several cracked tiles and was missing a large patch of tiles approximately three feet by four feet near the food prep island with crumbs and debris stuck in the cracks of the missing tiles. There was dirt, debris and crumbs throughout the floor in the kitchen. At 11:59 a.m. in the satellite kitchen there was grime, debris and food crumbs throughout the floor. Seven ants were observed near the trash can in the satellite kitchen near a spill. At 12:06 p.m. the DM was alerted about the presence of ants in the satellite kitchen and began using a broom to sweep them up. The DM moved the trash can and revealed approximately ten more ants. DA #2 said the ants liked the crumbs in the kitchen. D. Staff interviews On 1/13/25 at 3:41 p.m. DA #2 said the kitchen and satellite kitchen were deep cleaned once a month and the floors were mopped and swept every night. The DM was interviewed on 1/16/25 at 9:13 a.m. The DM said the facility did not have any issues with pests to his knowledge. The DM said the dietary staff only saw ants in the kitchen when they were not cleaning properly. The DM said the dietary staff should be sweeping and mopping the satellite kitchen after every meal and the main kitchen once a day. The DM said deep cleaning was performed once a month. The DM said the dietary staff sometimes used a deep cleaning checklist but that they did not have one at the moment. The DM said the dietary staff had checklists for cleaning the satellite kitchen but did not use them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DM said the missing tiles in the kitchen had not been fixed yet because the facility still occasionally had plumbing issues in that area. The DM said the tiles had been missing for several months. The DM said he had brought the issue up with the management team and thought they were making progress in getting the tiles fixed. V. Failure to ensure frozen meats were thawed in a safe manner A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 1/23/25. It revealed in pertinent part: Time/temperature control for safety food shall be thawed completely submerged under running water with sufficient water velocity to agitate and float off loose particles in an overflow. (3-501.13) B. Facility policy and procedure The Food Preparation and Storage policy and procedure, dated 12/16/19, was received from the NHA on 1/16/25 at 2:38 p.m. It read in pertinent part, Thawing procedures include completely submerging the item in cold running water that is running fast enough to agitate and remove loose ice particles. C. Observations During a continuous observation of the lunch meal service on 1/15/25, beginning at 9:42 a.m. and ending at 12:46 p.m. the following was observed: At 10:01 a.m. a container of raw frozen chicken cutlets and a container of raw frozen beef were submerged in water in metal bins in the kitchen sink under two separate streams of running water. Both the chicken and the beef were in their original plastic packaging. There was a section approximately twelve inches by five inches of frozen beef which sat above the water and was not under running water. At 10:26 a.m. the faucet directing water over the frozen chicken was moved to rinse something during food preparation and not replaced until 10:39 a.m. At 11:15 a.m. the DM adjusted the beef in the metal bin so that the previous section sitting above the water was now submerged, but a new section of beef approximately the same size was above the waterline and not exposed to the running water. D. Staff interview The DM was interviewed on 1/16/25 at 9:13 a.m. The DM said frozen raw meat should be thawed under cool running water or in the refrigerator overnight. The DM said the dietary staff tried to keep the frozen raw meat submerged under water during the thawing process as much as possible. The DM said he was aware that the dietary staff needed to remove the frozen meat from the plastic packaging prior to thawing it in the sink, but said they kept the plastic on because it was too difficult to take it off.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure the hospice services provided met professional standards and principles that applied to individuals providing services in the facility for one (#17) of two residents reviewed for hospice services out of 33 sample residents. Specifically, for Resident #17, the facility failed to: -Obtain a physician's order for hospice care; -Ensure the hospice agency's notes were easily accessible to the facility staff and had consistent communication and documentation of hospice care visits and updates; and, -Initiate a hospice care plan timely. Findings include: I. Facility policy and procedure The Hospice Program policy, dated October 2016, was provided by the regional clinical resource (RCR) on 1/16/25 at 3:40 p.m. It read in pertinent part, When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other comfort symptoms and a delineation of the services that the hospice company is responsible to provide. The care plan shall be revised and updated as necessary to reflect the resident's current status. The director of nursing (DON) of the facility shall serve as the facility's designated hospice liaison. II. Resident #17 A. Resident status Resident #17, age less than 65, was admitted on [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included diabetes, atherosclerosis of arteries of extremities (blood vessels hardened and narrowed in legs), respiratory failure, heart failure, cellulitis (skin infection) lower leg, kidney cancer and right leg above the knee amputation. The 10/29/24 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. Resident #17 was dependent on staff for hygiene, repositioning in bed and transferring. The assessment revealed Resident #17 was receiving hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #17 was interviewed on 1/16/25 at 11:50 a.m. Resident #17 said she had not seen a hospice nurse for four or five weeks. Resident #17 said she wanted to continue receiving visits from the hospice nurse. C. Observation and staff interview Hospice binders, which contained resident information and communication from hospice visits, were observed at the nurses station with registered nurse (RN) #2 on 1/16/25 at 12:10 p.m. There were multiple binders labeled with residents' names. The binders represented two different hospice agencies. RN #2 was unable to locate a binder for Resident #17. RN #2 said she would look for Resident #17's hospice binder. RN #2 said she had not seen a representative from hospice visit Resident #17 this week (week of 1/12/25). RN #2 said she thought a hospice certified nurses aide (CNA) had visited the resident the previous week. D. Record review -A review of Resident #17's electronic medical record (EMR) did not reveal a physician's order for hospice care. Review of Resident #17's hospice care plan, initiated 10/24/24, included information and a hospice plan of care for Resident #17's previous hospice agency. -Review of Resident #17's EMR revealed the facility failed to initiate a hospice care plan for the current hospice agency, which assumed care of the resident in November 2024. Documentation of a hospice agency visit with Resident #17 was provided by the RCR on 1/16/25 at 12:45 p. m. The documentation included a hospice nurse practitioner (NP) visit completed on 12/30/24. The RCR said she had requested documentation from the hospice agency (during the survey) because the facility did not have a hospice binder for Resident #17 that contained documentation of the resident's hospice nurse visits. -The documentation provided by the RCR did not include documentation of the nurse visits from the hospice agency. E. Staff interviews The RCR was interviewed on 1/16/25 at 12:50 p.m. The RCR said Resident #17's hospice care plan had not been updated since a previous hospice agency was managing her care in October 2024. The RCR said the new hospice agency had been providing services since the end of November 2024, however, she said there was not an active physician's order for hospice services in Resident #17's EMR until 1/16/25 (during the survey).The RCR said the facility should have obtained a new hospice care plan and hospice order for Resident #17 when she began receiving services from the new hospice agency in November 2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Kiowa Hills Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 924 W Kiowa St Colorado Springs, CO 80905	

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The hospice clinical supervisor (HCS) was interviewed on 1/16/25 at 1:53 p.m. The HCS said Resident #17 was scheduled for RN case manager visits once weekly until this week (week of 1/12/25), when visits were changed to twice weekly.The HCS said Resident #17 did not have CNA visits scheduled since she began receiving these services. The HCS said the RN case manager visits were completed in December 2024 on 12/2/24, 12/9/24, 12/16/24, 12/23/24, 12/30/24, and in January 2025 on 1/9/25 and 1/14/25. The HCS said the hospice social worker visited Resident #17 on 12/6/24, 12/17/24 and 1/8/25. The HCS said the RN case manager communicated with Resident #17's nurse at each visit and the HCS said the facility was able to reach the hospice agency 24 hours per day. The HCS said there should have been a communication binder at the facility for Resident #17. The HCS said the hospice agency sent documentation of nursing visits to the facility via fax and to the assistant director of nursing's (ADON) email every two weeks. The HCS said if the facility had difficulty with the receipt of fax or email, the hospice company would provide a copy to the facility when the RN case manager was present at visits. The HCS said she was not aware the facility had issues with the receipt of hospice documentation for Resident #17.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 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 possible development and transmission of infectious disease. Specifically, the facility failed to: -Wear the appropriate personal protective equipment (PPE) when entering transmission based precaution rooms; -Offer updated COVID-19 vaccinations and document consent or declination for vaccination for Residents #16, #36, #205 and #255; -Ensure staff followed proper hand hygiene practices during meal delivery; -Ensure staff followed proper infection prevention practices during wound care for Resident #37; and, -Ensure resident's glucometers were disinfected after each use. Findings include: I. Failure to wear personal protective equipment A. Professional reference According to the Centers for Disease Control and Prevention (CDC), Infection Control Guidance: SARS-CoV-2, (6/24/24), retrieved on 1/22/25 from https://www.cdc.gov/covid/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, HCP (healthcare personnel) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to standard precautions and use a NIOSH (National Institute for Occupational Safety and Health) approved particulate respirator with N95 filters or higher, gown, gloves and eye protection (goggles or a face shield that covers the front and sides of the face). B. Facility policy and procedure The Initiating Transmission Based Precautions policy, revised February 2023, was provided by the regional clinical resource (RCR) on 1/14/25 at 2:19 p.m. It read in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	When transmission based precautions (TBP) are implemented, the infection preventionist or designee shall ensure that protective equipment (gloves, gowns, masks, etc.) based on the specific type of TBP is maintained near the resident's room so that everyone entering the room can access what they need. C. Observations and staff interviews On 1/12/25 at 2:49 p.m. an unidentified certified nurse aide (CNA) entered room [ROOM NUMBER], which had a sign on the door indicating droplet precautions should be followed including an N95 mask, eye protection, gown and gloves. The unidentified CNA entered the room without wearing eye protection. On 1/13/25 at 11:35 a.m. the isolation cart supplies outside of room [ROOM NUMBER] were observed with licensed practical nurse (LPN) #1. The sign on the door revealed droplet precautions should be followed including eye protection (goggles or face shield) prior to entering the room. There were no eye protection supplies present in the isolation cart outside of the room. LPN #1 said she had been in the resident's room earlier that morning and said she had forgotten to wear eye protection. On 1/13/25 at 11:40 a.m., registered nurse (RN) #1 entered room [ROOM NUMBER] without eye protection. D. Staff interview The assistant director of nursing (ADON) was interviewed on 1/13/25 at 3:00 p.m. The ADON said she acted as the infection preventionist (IP). She said the residents in room [ROOM NUMBER] and room [ROOM NUMBER] were on transmission based precautions and were positive for COVID-19, required droplet precautions and staff should use googles or face shields when they entered the resident's rooms. -However, residents who are positive for COVID-19 require transmission based precautions. The ADON was interviewed a second time on 1/16/25 at 9:20 a.m. The ADON said in-the-moment training was provided to staff when staff were not wearing face shields as required on 1/12/25 and 1/13/25 (during the survey). She said she would continue to provide training to all of the staff. II. Failed to offer updated COVID-19 vaccinations and document consent or declination A. Professional reference According to theCDC, Staying Up to Date with COVID-19 Vaccines, revised 1/7/25, retrieved on 1/23/25 from https://www.cdc.gov/covid/vaccines/stay-up-to-date.html, Everyone ages six months and older should get a 2024-2025 COVID-19 vaccine. The COVID-19 vaccine helps protect you from severe illness, hospitalization , and death. It is especially important to get your 2024-2025 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The COVID-19 Vaccine policy, revised 6/5/23, was provided by the RCR on 1/15/25 at 12:49 p.m. It read in pertinent part, The facility shall encourage all staff and residents to remain up-to-date with COVID-19 vaccines, but residents and staff may refuse the COVID-19 vaccine. The infection preventionist is primarily responsible to securely track and document COVID-19 vaccination status for all staff and residents. C. Record review A review of Resident #16's electronic medical record (EMR) immunization tracking section revealed the resident last received the COVID-19 vaccination on 12/28/23. -The EMR did not include documentation for Resident #16's COVID-19 vaccination status for the 2024-2025 season. A review of Resident #36's EMR immunization tracking section revealed the resident last received the COVID-19 vaccination on 12/28/23. -The EMR did not include documentation for Resident #36's COVID-19 vaccination status for the 2024-2025 season. A review of Resident #205's EMR immunization tracking section revealed the resident last received the COVID-19 vaccination on 1/26/23. -The EMR did not include documentation for Resident #205's COVID-19 vaccination status for the 2024-2025 season. A review of Resident #255's EMR immunization tracking section revealed the resident last received the COVID-19 vaccination on 12/28/23. -The EMR did not include documentation for Resident #255's COVID-19 vaccination status for the 2024-2025 season. D. Staff interviews The ADON and the RCR were interviewed together on 1/16/25 at 10:01 a.m. The ADON said she did not know if the COVID-19 vaccinations were offered to residents during the 2024-2025 season. The ADON said she had not offered COVID-19 to the residents. The RCR said COVID-19 2024-2025 vaccines were available at the facility and should have been offered to residents. The RCR and ADON said the immunization section in the EMR was not up to date for the residents. III. Failed to ensure staff followed proper hand hygiene practices during meal delivery A. Professional reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the CDC Clinical Safety, Hand Hygiene for Healthcare Worker (2/17/24), retrieved on 1/23/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety, Know when to clean your hands: immediately before touching a patient, before performing an aseptic task such as placing an indwelling device or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or patient's surroundings, after contact with blood, body fluids or contaminated surfaces and immediately after glove removal. B. Observations and staff interview On 1/12/25 at 5:45 p.m., CNA #4 was delivering meal trays to residents on the 100 hall CNA #4 delivered a tray to room [ROOM NUMBER]. CNA #4 did not perform hand hygiene, went back to the dining room and poured drinks into cups and placed them on a room tray. She pushed the room tray cart down the hall. Without performing hand hygiene, she took a tray and delivered it to room [ROOM NUMBER]. She came out of the room, got another tray from the cart and delivered it to room [ROOM NUMBER] without performing hand hygiene. CNA #4 got another tray from the cart and delivered it to the other resident in room [ROOM NUMBER] without performing hand hygiene. CNA #4 then washed her hands at the sink and dried them with paper towels. She took another tray from the cart, with the paper towels still in her left hand in her hand (and holding the room tray with both hands), and delivered it to room [ROOM NUMBER]. She delivered another tray to room [ROOM NUMBER], did not perform hand hygiene and still had the paper towels in her left hand. She pushed the room tray cart to the end of the hall and delivered a tray to room [ROOM NUMBER]. She threw the paper towels in the trash can and brought a dirty cup out of room [ROOM NUMBER], then pushed the cart back to the other end of the hall. She did not perform hand hygiene and delivered the last tray to room [ROOM NUMBER]. On 1/14/25 at 12:52 p.m., CNA #5 was delivering meal trays. CNA #5 delivered a room tray to room [ROOM NUMBER] then pushed the meal tray cart down the hall. She did not perform hand hygiene, obtained the next meal tray and delivered it to room [ROOM NUMBER]. CNA #5 was interviewed on 1/14/25 at 12:56 p.m. She said she forgot to use hand hygiene and she should have performed hand hygiene between passing the two room trays. On 1/14/25 at 1:02 p.m., CNA #4 was delivering meal trays on the 600 hall. CNA #4 pushed the meal tray cart down the hallway, then delivered a tray to room [ROOM NUMBER]. CNA #4 pushed the cart further down the hall and delivered a tray to room [ROOM NUMBER]. She did not perform hand hygiene and delivered a third tray to room [ROOM NUMBER]. C. Staff interview The ADON was interviewed on 1/16/25 at 9:20 a.m. The ADON said staff should be using hand hygiene or hand sanitizer before and between each meal delivery and offer hand hygiene to the residents. The ADON said hand hygiene education was provided at least weekly in the dining area by herself and the dining room manager on duty. IV. Failure to ensure proper infection control practices during wound care A. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Wound Care policy, revised 12/19/16, was provided by the RCR on 1/17/25 at 7:13 a.m. It read in pertinent part, -Use disposable barrier to establish clean field on resident's overbed table or other flat surface. -Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached. -Wash and dry your hands thoroughly. -Position resident. Place a disposable barrier next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. -Put on exam gloves and any other PPE indicated based on wound type (e.g. gown if resident has enhanced barrier precautions in place). Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely. -Loosen tape and remove dressing if indicated. -Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. -Put on gloves. -Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers when part of the treatment order. -Pour liquid solutions directly on gauze sponges on their papers. -Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. -Consideration should be given to wearing sterile gloves when performing invasive wound care (packing a tunneling wound) or working with heavily exudating wounds as an infection mitigation measure. -Dress wound in accordance with physician order. [NAME] dressing with initials and date and apply to dressing. Be certain all clean items are on clean field. -Remove the disposable cloth next to the resident and discard into the designated container. -Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly. B. Record review Review of Resident #37's January 2025 computerized physician's orders (CPO) revealed the following physician's order for wound care: (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

-Cleanse right perineal wound and pack with wound cleanser saturated gauze twice daily, ordered on 10/3/24

-Clean right buttocks wound with wound cleanser and apply barrier cream to surrounding skin, cover open areas with skin dressing, change weekly and as needed, ordered on 1/3/25.

C. Observations

RN #1 was performing wound care on Resident #37's wounds on 1/14/25 at 11:18 a.m. RN #1 cleaned the buttocks wound, then removed the soiled packing from the perineal wound and cleaned the perineal wound with gauze and wound cleanser, packed and redressed the perineal wound.

-RN #1 did not change gloves after removing the soiled perineal dressing, nor did she change gloves between wound sites. RN #1 did not place a clean barrier under the resident, and left the resident on a visibly soiled disposable pad.

RN #1 did not change gloves or perform hand hygiene after cleansing the wounds and before packing the perineal wound. RN #1 applied barrier cream to the surrounding skin wearing the same soiled gloves, squirting it directly from the tube to her soiled gloves. RN #1 applied the new dressing over the perineal wound wearing the same gloves. RN #1 then removed the soiled disposable pad under the resident and replaced it with a clean one. RN #1 removed her gloves and applied clean gloves without performing hand hygiene.

D. Staff interview

RN #1 was interviewed on 1/14/25 at 11:40 a.m. RN #1 said she did not know that the wounds should be treated separately and that she should change her gloves between treatments. RN #1 said she thought it was important to avoid cross contamination. RN #1 said she should have changed gloves after cleaning each wound, and before packing the perineal wound and applying the clean dressing. She said it would be important to have a clean disposable pad under the wound so it would not contaminate the wound after it was cleaned.

The ADON was interviewed on 1/16/25 at 10:01 a.m. The ADON said RN #1 should have performed hand hygiene and changed her gloves between the removal of the soiled dressing and the application of the clean one. The ADON said gloves should be changed between wounds if there were multiple wounds. The ADON said the nursing staff received wound care education upon hire, annually and whenever issues arise. The ADON said she was going to provide education to the nursing staff regarding wound dressing change procedures.

V. Failure to disinfect glucometers after use

A. Professional reference

According to the CDC, Consideration for Blood Glucose Monitoring and Insulin Administration (8/7/24) retrieved on 1/23/25 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html,

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Blood glucose meters are portable devices that measure blood glucose levels and aid in diabetes self-management. Healthcare providers use these types of devices in a variety of clinical settings. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. Dedicated meters should be cleaned and disinfected per the manufacturer's instructions. B. Observations On 1/12/25 at 5:08 p.m., RN #2 checked Resident #28's blood sugar. RN #2 removed Resident #28's glucometer from the case in the medication cart. RN #2 then used the glucometer for testing Resident #28's blood and then returned the glucometer to the case. -RN #2 did not clean the glucometer after use and prior to returning to the case. On 1/12/25 at 5:20 p.m., RN #2 checked Resident #6's blood sugar. RN #2 removed Resident #6's glucometer from the case in the medication cart. RN #2 then used the glucometer for testing Resident #6's blood and then returned the glucometer to the case. -RN #2 did not clean the glucometer after use and prior to returning to the case. C. Staff interviews RN #2 was interviewed on 1/12/25 at 5:35 p.m. RN #2 said she should have cleaned the glucometers after use and should clean them every time the glucometer was used with sanitizing wipes. RN #2 said each resident had their own glucometer. The ADON was interviewed on 1/13/25 at 3:00 p.m. The ADON said RN #2 should have cleaned the glucometers with sanitizing wipes after each use.