STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065231	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Care Center	945 Desert Flower Blvd Pueblo, CO 81001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** 38185 Based on interviews and record review, the facility failed to honor resident choices for two (#25 and #84) of two out of 50 sample residents. Specifically, the facility failed to ensure an effective system was established to honor and allow residents to make choices regarding their daily care. Findings include: I. Facility policy and procedure The Resident Rights policy and procedure, reviewed September 2023, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. It revealed, in pertinent part, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The resident has the right to reside and receive services in the facility with reasonable accommodation of resident and preferences except when to do so would endanger the health or safety of the resident or other residents. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. II. Resident #25 status Resident #25, age 79, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included vascular dementia, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or inability to move one side of the body). The 3/27/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He was dependent upon staff for all activities of daily living (ADL). The assessment indicated that it was very important to him to choose what time he goes to bed. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A. Resident interview Resident #25 was interviewed on 6/5/24 at 4:04 p.m. Resident #25 said all he ever did was lay in bed. He said the staff never asked him when he wanted to get up or go to bed, they just did everything when they wanted to. He said is it too much to ask for them to ask me what I want for a change. He said he would like to be up and out of bed before lunch. He said the facility staff always came into his room too early to get him up and when he would tell them no, they would not come back to ask him to get up later. He said the facility never set up a time schedule for him for his daily routine. He said he did not remember ever being asked about what time he would like to wake up, go to bed, or anything about his preferences for daily activities. B. Record review The ADL self-care deficit care plan, revised on 3/12/24, documented the resident had a self-care deficit due to left hemiplegia following a CVA (cerebral vascular accident), dementia/cognitive impairment, debility, limited mobility and weakness. It indicated that the resident required total assistance by staff members for ADLs. The interventions included encouraging the resident to participate to the fullest extent possible, encouraging the resident to use the call light for assistance, praising all efforts made by the resident, a physical therapy and occupational therapy evaluation and treatment as ordered and observing for any changes. -The comprehensive care plan did not indicate the resident's daily preferences. The 1/26/24 activities evaluation documented the resident varied with times he preferred to wake up and go to bed. The resident s Kardex (quick reference for the resident's care) did not indicate the resident's preferences for his daily care. II. Resident #84 A. Resident status Resident #84, age 82, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included fracture of the right femur and major depression. The 5/14/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of nine out of 15. He was dependent upon staff for toileting, showering, dressing and required substantial assistance with personal hygiene. The resident exhibited daily episodes of physically and verbally aggressive behaviors directed at others. B. Record review The June 2024 CPO documented the following: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-CPAP/BIPAP (continuous positive airway pressure / bilevel positive airway pressure) settings at 16/10 on 3 liters (L); CPAP/BIPAP on while sleeping and off while awake, ordered 2/29/24. The behavioral care plan, initiated on 5/14/24, documented the resident could become verbally and physically aggressive towards staff, as well as resistive to care. The interventions included anticipating and meeting the resident's needs, assessing the resident for triggers for his behavior, explaining all procedures to the resident before starting and allowing the resident a few minutes to adjust when placing the BIPAP on the resident, letting him know you are placing the BIPAP and if he refuses, contact the resident's responsible party to speak with him on the phone. The 5/22/24 nursing progress note documented at 5:19 a.m. revealed the resident wore his CPAP without any issues and slept through the night until 4:55 a.m. when he requested to be changed and wanted the mask removed. The staff said his representative wanted him to wear it longer, however he responded, I don' t care, I want it off. The 5/27/24 nursing progress note documented at 5:53 a.m. revealed it took several times to get the resident to put his CPAP on last night. He told staff, No, I' m still watching tv (television) and don' t want it yet. It indicated the resident would only put on the mask when he was ready. Upon telling the resident that they were notifying his representative, the resident responded, What the [expletive] you calling her for, I will put it on when I' m ready. On 5/27/24 at 10:41 p.m. the nursing progress note documented the certified nurse aide (CNA) entered the resident's room to ask him if he was ready to put the CPAP on and he responded, No, it's too early, I' m watching the game. On 5/28/24 at 1:37 a.m. the nursing progress note documented the nurse went in twice to put the CPAP mask on the resident, however he continued to refuse saying it was too early and he was not ready yet. However, when the CNA approached the resident later on, he was agreeable. The 6/9/24 nursing progress note documented at 10:53 p.m. revealed the resident continued to refuse to put on the CPAP machine after staff attempted several times. The resident took the mask and threw it to the foot of the bed. The nurse contacted the resident's responsible party who said she would come over to assist. -At 11:36 p.m. the nurse documented the resident allowed the placement of the CPAP machine after he was done watching television. -The facility failed to identify Resident #84 preferred to stay awake and watch television late into the night and early morning and would consistently refuse to wear the CPAP when he was approached too early. -By failing to identify the resident's preference and put together a schedule that was agreeable for the resident, he exhibited verbally and physically aggressive behavior because he did not want to don the CPAP until he was ready. III. Staff interviews (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Registered nurse (RN) #2 and RN #7 were interviewed on 6/11/24 at 2:30 p.m. RN #2 said she was not sure who asked the residents about their preferences for waking up and going to bed. RN #7 said she was not aware of a system the facility had in place to determine each resident's preferences. RN #2 said the CNAs were responsible for getting residents up in the morning and putting them to bed. RN #2 said there was not an established schedule. RN #2 said the CNAs did what worked best for them. RN #2 and RN #7 said they had both worked with Resident #84. RN #2 said he had a lot of behaviors which included trying to bite staff, yelling and screaming at staff and non-compliance. RN #7 said Resident #84 was particularly non-compliant with the use of the CPAP machine. RN #7 said he would yell at the CNAs or nurses, using foul language because he was not ready to put it on his face. RN #2 said she had not realized the trend that the resident liked to go to bed late at night and that he would become upset and yell about the CPAP when he was approached to go to bed earlier in the night. RN #7 said it would be helpful if the facility had a system to determine resident preferences and it could potentially have a positive effect on Resident #84's behavior of non-compliance and yelling at staff. CNA #7 was interviewed on 6/11/24 at 3:25 p.m. CNA #7 said the CNAs were responsible for assisting residents with getting up in the morning and putting them to bed at night. She said she did not follow a schedule, but usually went room by room to help residents the quickest. CNA #7 said she worked with Resident #25 often. She said she did not know what time he liked to get up in the morning or what time he liked to go to bed. She said she was not aware of a system at the facility that documented or indicated a resident preference in getting up and going to bed. CNA #7 said she often worked with Resident #84. She said she did not work with him at night, but had heard from other staff that the resident would become verbally and physically aggressive late at night because he did not want to wear the CPAP machine. She said she was not aware if the resident liked to get up at a certain time or go to bed at a certain time. She said that information was not documented on the Kardex. The activity director (AD) was interviewed on 6/11/24 at 4:50 p.m. The AD said she conducted an activity assessment upon each resident's admission and annually. She said within the activity assessment, there was a section that included the preferences of the resident to rise and go to sleep. She said the assessments were found in the resident's medical record and in a binder in the activity office. The AD said she was not aware if the nursing staff read her assessment. She said the facility did not have a process to take that information and ensure the CNAs and nurses were aware so the residents' preferences were followed. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The NHA was interviewed on 6/11/24 at 5:32 p.m. The NHA said the activity staff were responsible for obtaining the resident preferences during their initial and annual assessment. She said the facility did not have a system in place to take that information and apply it to ensure the resident preferences were being honored.

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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** 50690 Based on observations and staff interviews the facility failed to provide services for three (#24, #47, #157) of three residents out of 50 sample residents according to professional standards of practice. Specifically, the facility failed to: -Ensure safe medication administration practices were followed by administering medications immediately after preparation and not storing unadministered medications; and, -Ensure medications were not left at the bedside. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, page 606-607, retrieved on 6/12/24, It read in pertinent part, 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: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. Odberg, K. R., [NAME], B. S., and Wangensteen, S. (April 2019). Medication administration in nursing homes: A qualitative study of the nurse role. National Library of Medicine, was retrieved on 6/13/24 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6419124/. It read in pertinent part, The medication administration process consists of six stages: ordering and prescription, transcribing, dispensing, preparing, administering, and finally observing and documenting effects and side effects. Medication administration errors may occur anywhere along this chain and cause an adverse drug event. Many factors influence safe medication management. Some argue that nurses may have insufficient knowledge and skills to perform safe medication management, others point to normalization of risk inducing behavior and interruptions. II. Facility policy and procedure The Administration of Medications policy, dated 8/24/23, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. It read in pertinent part, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication error means the observed or identified preparation or administration of medications or biological which is not in accordance with accepted professional standards and principles which apply to professionals providing services. Right drug. Compare the label on the drug to the information on the medication administration record three times including before removing the container from the drawer, as the drug is removed from the container and at the bedside before administering it to the resident. Do not prepare unmarked drug containers or illegible containers. Be sure to verify drugs at the patients' bedside with the MAR and two patient identifiers. III. Resident #24 A. Resident status Resident #24, age 74, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (a lung condition causing breathing problems), venous insufficiency (causing swelling in the legs), chronic pain and fibromyalgia (a disorder causing widespread pain). The 4/5/24 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 and had no behaviors. She required supervision or touching assistance to perform bed mobility, transfers, toileting and bathing. B. Record review The June 2024 CPO revealed the following physician's orders: Torsemide 20 milligrams (mg), give one tablet by mouth one time per day for edema (swelling), ordered 4/16/24; and, Lidocaine External Patch 4%, apply to the upper back topically one time a day for pain, ordered 5/11/23. C. Observations During a continuous observation on 6/10/24 beginning at 7:51 a.m. and ending at 8:15 a.m. the following was observed: Licensed practical nurse (LPN) #1 was preparing and administering medications. LPN #1 retrieved the torsemide 20 mg from the medication cart and placed it in a medication cup. LPN #1 entered Resident #24's room to administer the medication. Resident #24 refused the torsemide medication during the administration. LPN #1 placed the cup with the torsemide in it, on the resident's table next to the bed, and then left the room. -LPN #1 left the medication in the resident's room unattended. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Additionally, LPN #1 removed a lidocaine patch 4% from the medication cart. She took it out of the packet, initialed and dated it, but did not place it on the resident. She put the lidocaine patch in the top drawer of the medication cart while she administered the rest of Resident #24's medications. D. Staff interviews LPN #1 was interviewed on 6/10/24 at 7:51 a.m. LPN #1 said Resident #24 often refused to take the torsemide medication. She said she put that medication in a separate cup so that if the resident declined it, she could waste the pill and mark it accordingly on the medication administration record (MAR). LPN #1 confirmed that after she had attempted to administer Resident #24's medications, she had left the torsemide in a cup at the resident's bedside. She said by leaving the medication at the resident's bedside, there was a risk of another resident entering the room and ingesting the medication. She said she would retrieve the medication immediately. LPN #1 said she typically waited until after Resident #24 took her shower before putting on the Lidocaine patch. She said she should have waited until after the resident showered before pulling the lidocaine patch to administer. She said medications should not be pre-pulled. Registered nurse (RN) #6 was interviewed on 6/10/24 at 9:00 a.m. RN #6 said medications should not be pre-pulled or pre-poured before administration. She said that was considered a safety issue. She said the lidocaine patch should not have been prepared beforehand and stored in the cart. She said this was a safety issue and medications that were pre-prepared could be confused between residents. The director of nursing (DON) was interviewed on 6/11/24 at 10:00 a.m. The DON said medications should not be left at the bedside. She said it was a safety concern for other residents potentially ingesting the medication. 47350 IV. Resident #47 A. Resident status Resident #47, age 77, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included dementia, gait abnormalities and tremors. The 5/21/24 MDS assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of three out of 15. She required set-up assistance with toileting and was independent with eating, personal hygiene, bed mobility and transfers. B. Observations On 6/11/24 at 5:15 p.m., on medication cart #2, the following was observed with LPN #2: -A medication cup, unlabeled, with multiple tablets in it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Resident #157 A. Resident status Resident #157, age 73, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included anoxic brain damage (brain damage due to lack of oxygen) and heart disease. The 6/4/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He required substantial/maximal assistance with toileting, personal hygiene, partial/moderate assistance with bed mobility, transfers and was independent with eating. B. Observations On 6/11/24 at 5:23 p.m., on medication cart #3, the following was observed with RN #5: -A medication cup, unlabeled, with crushed medication mixed into chocolate pudding. C. Staff interviews LPN #2 was interviewed on 6/11/24 at 5:18 p.m. LPN #2 said she had been unable to administer Resident #47's medications because activities staff were with her. She said she was waiting for them to finish and had placed the medications in the medication cup in the medication cart. The director of nursing (DON) was interviewed on 6/11/24 at 5:20 p.m. The DON said if medications could not be immediately administered they must be destroyed in the drug disposal system. She said medications could not be stored once they had been removed from their original container. She said medications should not be prepared or stored before residents were able to take them. She said interruptions in the medication preparation and administration process may contribute to human error and contribute to avoidable potential medication errors by administering wrong drugs to wrong residents and at wrong times. She said she would provide education to LPN #2 and RN #5 regarding preparing, pulling and storing drugs before residents were able to take them. RN #5 was interviewed on 6/11/24 at 5:23 p.m. RN #5 said Resident #157 had refused to take his medications until dinner time. She said she did not dispose of his medication because it had to be crushed and she did not want to waste the medication.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to provide the necessary treatment and services to treat and prevent pressure injuries for one (#42) of two residents out of 50 sample residents reviewed for pressure ulcers. Resident #42, who was dependent on staff for all care and mobility and was known to be at risk for skin breakdown, developed a stage 3 pressure injury on 5/20/24 at the facility. The resident's care plan for skin breakdown failed to include interventions for repositioning the resident frequently to avoid potential pressure injuries. Observations during the survey revealed staff were not repositioning Resident #42 frequently in order to keep the resident from developing further pressure injuries. Additionally, the resident did not have the physician ordered wound treatment in place when the wound care physician (WCP) came to assess the resident's wound. Furthermore, the facility failed to accurately and consistently document the location of the resident's stage 3 pressure injury. Due to the facility's failures to ensure the resident's plan of care included appropriate pressure injury prevention interventions and ensure the resident was frequently repositioned by the staff, Resident #42 developed a stage 3 pressure injury to her left gluteal fold. Findings include: I. Professional reference According to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved from https://www.internationalguideline.com/guideline on 6/12/24, Pressure ulcer classification is as follows: Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage) Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate'at risk' individuals (a heralding sign of risk). Category/Stage 2: Partial Thickness Skin Loss (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. Category/Stage 3: Full Thickness Skin Loss Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable. Category/Stage 4: Full Thickness Tissue Loss Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable Unstageable: Depth Unknown Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as'the body's natural (biological) cover' and should not be removed. Suspected Deep Tissue Injury: Depth Unknown Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. II. Facility policy and procedure The Skin Integrity and Pressure Ulcer/Injury Prevention and Management policy and procedure, reviewed 3/31/23, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. It read in the pertinent part, (continued on next page)

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University Park Care Center	945 Desert Flower Blvd Pueblo, CO 81001

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 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide associates and licensed nurses with procedures to manage skin integrity, prevent pressure ulcer/injury, complete wound assessment/documentation, and provide treatment and care of skin and wounds utilizing professional standards of the NPIAP (National Pressure Injury Advisory Panel) and WOCN (Wound, Ostomy, Continent Nurses Society). A risk assessment tool (Braden Scale) determines the resident's risk for pressure injury development. The score is documented on the tool and placed in the resident's medical record using the appropriate form. A resident's risk may increase due to an acute illness or condition change (for example,upper respiratory infection, pneumonia, or exacerbation of underlying congestive heart failure) and may require additional evaluation. The frequency of assessment should be based upon each resident's specific needs. Certain risk factors have been identified that increase a resident's susceptibility to develop or impair healing of pressure injuries. Measures to maintain and improve the resident's tissue tolerance to pressure are implemented in the plan of care. All residents upon admission are considered to be at risk for pressure injury development due to medical issues requiring nursing care related to disease process and illness or need for rehabilitation services. Upon admission and throughout stay at a minimum a pressure redistribution surface (Group 1 mattress) is in use with turning and repositioning as needed with ADL care/assistance, incontinent care if needed to include skin barriers application as needed, preventative wheel chair cushion if indicated. Minimize injury due to shear and friction through proper positioning, transfers, and turning schedules (if indicated). Measures to protect the resident against the adverse effects of external mechanical forces, such as pressure, friction, and shear are implemented in the plan of care. Reposition at least every 2-4 (two to four) hours as consistent with overall patient goal and medical condition. Utilize positioning devices to keep bony prominences from direct contact. When positioned in a wheelchair, the resident is to be placed on a pressure reduction device and repositioned. When skin breakdown occurs, it requires attention and a change in the plan of care may (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	be indicated to treat the resident. III. Resident #42 A. Resident status Resident #42, over the age of 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included dementia, prediabetes, muscle weakness and anxiety. The 5/9/24 minimum data set (MDS) assessment documented the resident was rarely/never understood and the brief interview for mental status (BIMS) should not be performed. She had short and long term memory problems and her cognitive skills were severely impaired based on the staff assessment for mental status. She was dependent on staff for all care and mobility. The assessment indicated the resident did not reject care. B. Observations During a continuous observation on 6/6/24, beginning at 9:26 a.m. and ending at 11:35 a.m., the following was observed: At 9:26 a.m. Resident #42 was lying in bed on her back with her eyes closed. At 11:35 a.m. Resident #42 remained in bed on her back. -Staff did not enter the resident's room to reposition the resident during the continuous observation. During a continuous observation on 6/6/24, beginning at 1:07 p.m. and ending at 2:59 p.m., the following was observed: At 1:07 p.m Resident #42 was in bed on her back with her eyes closed. At 2:59 p.m., Resident #42 remained in bed on her back with her eyes closed. -Staff did not enter the resident's room to reposition the resident during the continuous observation. During a continuous observation on 6/11/24, beginning at 9:16 a.m. and ending at 11:51 a.m., the following was observed: At 9:16 a.m., Resident #42 was lying in bed on her back with her eyes closed. At 11:20 a.m., certified nurse aide (CNA) #7 entered the resident's room to provide incontinence care prior to the wound team's arrival. At 11:30 a.m. the wound team arrived to provide treatment to the resident's stage 3 pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-Staff did not enter the resident's room to reposition the resident during the continuous observation until just before the wound team's arrival. On 6/11/24 at 11:30 a.m. Resident #42's skin was observed with the wound care physician (WCP) and the assistant director of nursing (ADON). When the resident's brief was removed and she was rolled to the side, the physician ordered treatment was not on the wound. There was a small, open reddened area to the left gluteal fold. C. Record review Resident #42's skin integrity care plan, updated on 9/17/19, documented the resident was at risk for breaks in skin integrity due to limited mobility, weakness and incontinence. The interventions included keeping the skin clean and dry and performing weekly skin checks. -The care plan did not address the resident's risk for pressure injury or document the resident had a stage 3 pressure injury. -The care plan failed to include an intervention for repositioning and turning of the resident. The weekly skin check completed on 5/10/24 documented Resident #42 had no skin issues. The Braden Scale assessment completed on 5/17/24 documented Resident #42 was at high risk for developing pressure ulcers with a score of 11 out of 18. A late entry progress note dated 5/17/24 documented an area to the right gluteal fold with redness and a small open area. A referral was made to the in house WCP and notifications were made to the resident's provider and the DON. -The progress note documented the wound was on the resident's right gluteal fold, however, the wound was on the resident's left gluteal fold (see observation above and WCP note below). -The weekly skin check completed on 5/18/24 documented the skin check was not performed due to the resident sleeping. A progress note dated 5/21/24 documented the resident was seen by the wound care team regarding the left gluteal fold. The weekly skin check completed on 5/25/24 documented an issue with the right gluteal fold. -The weekly skin check documented the wound was on the resident's right gluteal fold, however, the wound was on the resident's left gluteal fold (see observation above and wound tracker note below). The wound observation tool completed on 5/28/24 documented the resident had a stage 3 pressure injury that was facility acquired on 5/20/24 to the left gluteal fold. Treatment included an air mattress and washing the wound with wound wash, and apply substance P (a wound healing treatment, honey and foam daily. The weekly skin check completed on 6/1/24 documented an ongoing issue with the right gluteal fold. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	-The weekly skin check documented the wound was on the resident's right gluteal fold, however, the wound was on the resident's left gluteal fold (see observation above and wound tracker note below) A review of the June 2024 CPO documented the following physician's orders: Cleanse area to right gluteal fold every day and as needed for soiling with wound wash, pat dry, apply medihoney and cover with foam dressing until resolved, ordered 5/28/24. -The physician's order, started on 5/28/24, documented the wound was on the resident's right gluteal fold, however, the wound was on the resident's left gluteal fold (see observation above and wound tracker note below) The wound tracker documentation on 5/28/24 identified a stage 3 pressure wound to the left gluteal fold, measuring 1.2 centimeters (cm) by 1.4 cm by 0 cm, with minimal serous drainage (drainage that forms as a clear, thin and watery fluid). The plan of care recommendations indicated the wound was to be washed with wound wash, and apply substance P, honey and foam daily. E. Staff interviews The WCP was interviewed on 6/11/24 at 11:38 a.m. The WCP said Resident #42's wound was a stage 3 pressure injury most likely caused by the edge of the incontinence brief on the resident. He said the resident should not have developed the wound. The WCP said he wanted the staff to reposition the resident frequently and offload when in bed. The ADON was interviewed on 6/11/24 at 11:38 a.m. The ADON said Resident #42 had a pressure injury and she was surprised it had developed. She said the staff should be repositioning the resident frequently and offloading the resident when she was in bed. CNA #4 was interviewed on 6/11/24 at 4:00 p.m. CNA #4 said residents with pressure injuries or who were at risk for pressure injuries should be repositioned every two hours to prevent further injuries and assist with healing. The director of nursing (DON) was interviewed on 6/11/24 at 4:00 p.m. The DON said all residents with pressure injuries or who were at risk of developing pressure injuries should be repositioned every two hours to prevent and help heal pressure injuries.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960 Based on observations, record review and interviews, the facility failed to ensure two (#26 and #25) of two residents with limited mobility reviewed for range of motion (ROM) out of 50 sample residents received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, the facility failed to: -Apply splints to ensure Resident #26 did not have a worsening contracture; and, -Ensure Resident #25 was placed on a restorative nursing program program, which was recommended by physical therapy. Findings include: I. Facility Policy The Splints and Braces policy and procedure, dated 1/16/24, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. The policy documented in pertinent part, The facility will provide splints and braces to upper extremities in accordance with professional standards of practice. The Restorative Nursing policy and procedure, reviewed 9/11/23, was provided by the NHA on 6/11/24 at 7:41 p.m. The policy documented in pertinent part, To promote the resident ' s optimum function, a restorative program may be developed by proactively identifying, care planning and monitoring of a resident ' s assessments and indicators. Nursing assistants must be trained in the techniques that promote resident involvement in restorative activities. Restorative programs may be initiated by nursing and/or therapy. Procedure 1. Accurate and thorough assessment of the patient is fundamental in determining the patient ' s need for restorative services. 2. Restorative indicators are patient specific information that when alone or combined with other indicators establish the level of patient ' s restorative potential. 3. Restorative indicators may be identified by multiple disciplines utilizing various assessments, physician orders, progress notes, environmental factors, caregiver conversations, and any other means of communication. 4. Restorative Nursing Functions can be within one of the following categories: a. Range of Motion (Active and Passive) (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Splint or brace assistance c. Bed mobility d. Transfers e. Walking f. Dressing and/or grooming g. Eating and/or swallowing h. Amputation/prosthesis care i. Communication j. Toileting program k. Bladder retraining 5. Communicate the restorative care plan and care directives to other members of the interdisciplinary team. 6. Provide resident/caregiver teaching regarding the restorative care plan. 7. The trained CNA will document provided techniques per the restorative care plan in the medical record. 8. The licensed nurse will conduct an evaluation on a routine basis, to include progress towards goal and response to the program. Any changes will be documented in the medical record. The restorative care plan and care directive will be reviewed/revised as indicated. 9. Restorative Nursing does not require a physician order. It only requires a physician order when combined with therapy services or when it is a state specific requirement. 10. The Restorative Nursing Program is based on the RAI (resident assessment instrument) User ' s Manual. Individual states may apply more specific rules regarding implementation of the program and documentation requirements. Refer to your state specific requirements as indicated. II. Resident #26 A. Resident status Resident #26, over the age of 65, was admitted on [DATE]. According to the June 2024 computerized physicians orders (CPO), diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (paralysis) following cerebral infarction (stroke) affecting right dominant side, contracture of the right elbow, contracture of unspecified joint and dementia. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/1/24 minimum data set (MDS) assessment revealed the brief interview for mental status (BIMS) should not be conducted due to the resident rarely/never understanding. Resident #26 was identified with short and long term memory problems, cognitive skills that were severely impaired through staff assessment. The resident was dependent on staff for dressing, personal hygiene and transfers. The assessment indicated the resident had verbal behavioral symptoms directed towards others one to three days during the review that did not include rejection of care. B. Observations On 6/5/24 at 11:02 a.m. Resident #26 was sitting in his wheelchair with his right arm contracted to his chest. He was not wearing any contracture therapy devices on his right hand to protect his palm. His right hand was balled up with his fingers touching his palm. On 6/6/24 at 11:26 a.m. Resident #26 was sitting in his wheelchair with his right arm contracted to his chest. He was not wearing any contracture therapy devices on his right hand to protect his palm. His right hand was balled up with his fingers touching his palm. On 6/11/24 at 11:06 a.m., Resident #26 was sitting in his wheelchair with his right arm contracted to his chest. He was not wearing any contracture therapy devices on his right hand to protect his palm. His right hand was balled up with his fingers touching his palm. C. Record review A review of the care plan revised on 5/1/24 revealed a focus for an alteration in musculoskeletal status related to contractures to the right shoulder and hand. The care plan specified interventions included cleansing the right hand with soap and water, patting dry, folding a washcloth and placing the thumb, fingers and palm as he allowed. A review of Resident #26 ' s behavior tracking revealed the resident did not refuse care or have any behaviors on the days he was observed without the splint (6/5/24, 6/6/24 and 6/11/24). D. Staff interviews The director of nursing (DON) was interviewed on 6/11/24 at 1:20 p.m. The DON said the staff on the secured unit, particularly the nurse on shift, should be placing the washcloth on Resident #26 daily and she would provide the staff an inservice immediately. The MDS nurse was interviewed on 6/11/24 at 2:15 p.m. The MDS nurse said Resident #26 had used a brace in the past but he removed it, causing an increase in the severity of his contracture so they switched to the washcloth. The MDS nurse said Resident #26 continued to remove the washcloth at times and the only solution left for him was to have surgery. 38185 III. Resident #25 A. Resident status (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25, age 79, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included hemiplegia and hemiparesis. The 3/27/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was dependent upon staff for all activities of daily living (ADL). B. Resident interview Resident #25 was interviewed on 6/5/24 at 4:04 p.m. He said all he ever did was lay in bed. He said the facility staff did not get him up or provide any range of motion exercises. He said all he wanted to do was to get up and move around. He said he had received physical therapy a couple of months prior, however he had not had any for a while. He said he was not placed on a range of motion (ROM) maintenance program after the physical therapy was discontinued. C. Record review The ADL self-care deficit care plan, revised on 3/12/24, documented Resident #25 had a self-care deficit due to left hemiplegia following a CVA (cerebral vascular accident), dementia/cognitive impairment, debility, limited mobility and weakness. It indicated the resident required total assistance by staff members for ADLs. The interventions included encouraging the resident to participate to the fullest extent possible, encouraging the resident to use the call light for assistance, praising all efforts made by the resident, a physical therapy and occupational therapy evaluation and treatment as ordered and observing for any changes. The therapy services care plan, initiated on 2/24/24, documented the resident required therapy services to maintain or attain his highest level of function. The interventions included assisting with mobility and ADLs as needed and providing therapy services as ordered. The 4/12/24 physical therapy discharge summary documented the resident was to be placed on a restorative program to include a restorative ROM program and a restorative bed mobility program. It indicated the restorative aide was trained to provide the recommended programs to Resident #25. D. Staff interviews The MDS nurse was interviewed on 6/11/24 at 2:21 p.m. The MDS nurse said she was responsible for overseeing the restorative program. She said each resident was assessed every quarter and placed on a restorative program for four weeks. She said the restorative program also placed residents on the restorative program from referrals by physical and occupational therapy. The MDS nurse said Resident #25 was placed on a restorative program on 6/7/24 (during the survey process). She said he was assessed because he was due for his quarterly assessment. She said she was aware he had received physical therapy in April 2024. She said she had no knowledge that the physical therapist had recommended the resident be placed on a restorative program at the completion of his therapy on 4/12/24. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS nurse was interviewed again on 6/11/24 at 2:45 p.m. The MDS nurse said she was unable to locate a referral from therapy to her to place Resident #25 on a restorative program. She said there must have been a breakdown in their system. She said all referrals were provided either via email or verbally.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not five percent (%) or greater. Specifically, the medication administration observation error rate was 5%, or two errors out of 40 opportunities for error. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607, retrieved on 6/12/24, 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: the right medication, the right dose, the right patient, the right route, the right time, the right documentation and the right indication. II. Facility policy and procedure The Medication Administration policy, dated 8/24/23, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. It read in pertinent part, Staff who are responsible for medication administration will adhere to the Ten Rights of Medication Administration . right drug, dose, route, time and frequency, documentation, assessment, right to refuse, evaluation/response, education and information. Right Dose-Check the MAR (Medication Administration Record) and the doctor's order before medicating. Use standard measuring devices such as syringes, graduated cups, or scaled droppers. If there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering. III. Observations On 6/10/24 at 7:22 a.m. registered nurse (RN #4) was observed during medication administration for Resident #47. RN #4 checked Resident #47's order of Dorzolamide HCL Ophthalmic Solution 2%, one drop in the left eye, three times per day. RN #4 entered Resident #47's room and administered Dorzolamide HCL ophthalmic solution 2% to Resident #47. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-RN #4 administered one drop of the Dorzolamide solution in both of the resident's eyes when the physician's order indicated to put one drop in the left eye. On 6/10/24 at 7:57 a.m. licensed practical nurse (LPN #1) was observed during medication administration for Resident #24. LPN #1 checked Resident #24's insulin order of Basaglar insulin 35 units. LPN #1 dialed up 35 units of Basaglar insulin into the KwikPen (insulin pen) and attempted to administer it to Resident #24. -LPN #1 did not prime (a process of drawing up two units of insulin and then dispensing an insulin pen plunger prior to drawing up an ordered amount of insulin) the pen first with two units of insulin, which was necessary to ensure any air was removed from the needle/cartridge and the resident received the entire dose of 35 units. V. Staff interviews LPN #1 was interviewed on 6/10/24 at 7:51 a.m. LPN #1 said insulin pens should be primed with two units of insulin prior to administering the insulin to ensure the resident was administered the full dose. She said she did not prime the insulin pen prior to attempting to administer the insulin. The director of nursing (DON) was interviewed on 6/11/24 at 10:00 a.m. She said insulin pens should be primed with at least two units of insulin before dialing up the dose of insulin to be administered. She said insulin pen priming was done to remove any air from the needle to ensure the correct dose of insulin was administered. The DON said she would provide education to the nurses on ensuring insulin pens were primed prior to administration. The DON was interviewed on 6/11/24 at 5:53 p.m. The DON said the nurses should follow the physician's orders as directed when administering medications. The DON said the eye drops for Resident #47 should have been administered with one drop in the left eye only, as directed by the physician.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on observations, record review and interviews, the facility failed to ensure one (#24) of five residents out of 50 total sample residents was free from a significant medication error. Specifically, the facility failed to ensure the insulin pen was primed prior to insulin administration for Resident #24. Findings include: I. Facility policy and procedure The Medication Administration policy, dated 8/24/23, was provided by the nursing home administrator (NHA) on 6/11/24 at 7:41 p.m. It read in pertinent part, Staff who are responsible for medication administration will adhere to the Ten Rights of Medication Administration . right drug, dose, route, time and frequency, documentation, assessment, right to refuse, evaluation/response, education and information. Right Dose- Check the MAR (medication administration record) and the doctor's order before medicating. Use standard measuring devices such as syringes, graduated cups, or scaled droppers. If there is any doubt about the dose on the MAR or if there is a question on the drug, stop and verify all information before administering. II. Manufacturer's guidelines According to [NAME] Lilly and Company (2022) Instructions for use Basaglar KwikPen, retrieved on 6/20/24 from https://pi.lilly.com/ca/basaglar-80u-ca-ifu-kp.pdf, guidelines for the Basaglar KwikPen state the following step should be taken prior to administering the medication: Prime before each injection. Priming means removing the air from the needle and cartridge that may collect during normal use. It is important to prime your pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select two units. III. Resident #24 A. Resident status Resident #24, age 74, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included severe obesity and type II diabetes with neuropathy (nerve damage due to diabetes). (continued on next page)

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University Park Care Center	945 Desert Flower Blvd Pueblo, CO 81001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/10/24 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. B. Record review The June 2024 CPO documented the following physician's order: Basaglar KwikPen Subcutaneous solution pen-injector 100 units/ml (Insulin Glargine), inject 35 units subcutaneously (under the skin) two times a day for diabetes mellitus, ordered 6/27/23. C. Observation Licensed practical nurse (LPN) #1 was observed preparing and administering medications to Resident #24 on 6/10/24 at 7:57 a.m. -LPN #1 dialed up 35 units of Basaglar insulin into the KwikPen for Resident #24 without first priming the pen with two units of insulin and attempted to administer the medication. IV. Staff interviews LPN #1 was interviewed on 6/10/24 at 7:51 a.m. LPN #1 said she should have primed the insulin pen prior to administration to ensure the resident received the entire dose. Registered nurse (RN) #6 was interviewed on 6/10/24 at 9:00 a.m. She said insulin pens should be primed with two units prior to dialing in the correct dose of insulin to be administered. She said this process was completed to ensure the resident received the correct dose of insulin. The director of nursing (DON) was interviewed on 6/11/24 at 10:00 a.m. She said insulin pens should be primed with at least two units of insulin before dialing up the dose of insulin to be administered. She said priming the insulin pen was done to remove air from the needle to ensure the correct dose of insulin was administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47350 Based on observations and interviews, the facility failed to ensure all drugs and biologicals were properly stored and labeled in accordance with professional standards on two of four units. Specifically, the facility failed to: -Ensure medications were stored in their original containers; and, -Ensure medications were stored in a sanitary manner, separately from food items. Findings include: I. Professional reference World Health Organization (WHO) (2023) Global burden of preventable medication-related harm in health care settings. Retrieved on 6/12/24, from https://iris.who.int/bitstream/handle/10665/376203/9789240088887-eng.pdf?sequence=1. It read in pertinent part, Medication errors are one of the leading causes of patient harm in health care, in additional therapeutic management, surgical procedures, healthcare related infections and diagnosis. Medication errors can occur throughout the use of medicines which usually includes the prescribing, dispensing, administration and monitoring stages. II. Facility policy and procedure The Storage and Expiration Dating of Medications and Biologicals policy and procedure, reviewed 8/7/23, was provided by the nursing home administrator (NHA) on 6/12/24 at 3:52 p.m. It read in pertinent part, Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored. Facility should ensure that resident medication and biologicals for each resident are stored in the containers in which they were originally received. III. Observations On 6/11/24 at 5:04 p.m. unit medication cart #1 was observed with registered nurse (RN) #3. The following items were observed: -A plastic medication cup with five white tablets and the word sodium was written in black ink on the side of the medication cup. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Multiple unopened pudding cups were stored in a drawer with medications. On 6/11/24 at 5:15 p.m. unit medication cart #2 was observed with licensed practical nurse (LPN) #2. The following items were found: -Multiple unopened pudding cups were stored in a drawer with medications. IV. Staff interviews RN #3 was interviewed on 6/11/24 at 5:08 p.m. RN #3 said she did not have sodium tablets on her cart so she borrowed them from another cart and put them in a medication cup for later use for a resident. She said she was not aware this was not safe practice. She said she labeled them so she knew what they were. She said the pudding cups were for medication administration and they were stored in her medication cart for that purpose. LPN #2 was interviewed on 6/11/24 at 5:18 p.m. LPN #2 said the pudding cups were stored in the medication carts for use during medication administration. The director of nursing (DON) was interviewed on 6/11/24 at 5:20 p.m. The DON said all medications must be stored in the original labeled container with the medication name, strength and expiration date. She said this was important to prevent potential medication errors during medication administration. She said storing medications with food items was not a sanitary practice. She said she would provide education for RN #3 and LPN #2.

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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** 47350 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection on two of four units. Specifically, the facility failed to ensure glucometers were cleaned in a sanitary manner. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Considerations for Blood Glucose Monitoring and Insulin Administration (2024), was retrieved on 6/18/24 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Unsafe%20practices%20during%20assisted%20monitoring,for%20more%20than%20one%20person. It read in pertinent part, Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, human immunodeficiency virus (HIV) and other infections. Unsafe practices include: using fingerstick devices for more than one person, using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. II. Manufacturer' s guidelines The Assure Prism Blood Glucose Meter manufacturer cleaning and disinfecting guidelines. (April 2023), were retrieved on 6/17/24 from https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-prism-multi/. It included the following recommendations in pertinent part, Each time the cleaning and disinfecting procedure is performed, two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter. Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from meters. Meter surfaces must remain wet according to contact times listed on the wipe manufacturer' s instructions. Once complete, wipe the meter dry. The PDI Super Sani Cloth disinfecting wipes manufacturer guidelines (2024), were retrieved on 6/17/24 from https://pdihc.com/in-service/super-sani-cloth-disinfecting-wipes/. It included the following recommendations in pertinent part, Bactericidal, Tuberculocidal and Virucidal, effective for 30 microorganisms with a contact time of two minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	III. Observations On 6/10/24 at 11:02 a.m. registered nurse (RN) #4 took an unlabeled glucometer out of medication cart #1. He was using the unlabeled glucometer to check Resident #64' s lunchtime blood glucose. He took the glucometer to the resident' s room and completed the blood glucose check. He returned the glucometer back to the medication cart and placed it into the drawer. -RN #4 did not clean or disinfect the glucometer. On 6/11/24 at 11:37 a.m. licensed practical nurse (LPN) #1 took an unlabeled glucometer out of medication cart #2 to check Resident #22' s lunchtime blood glucose. She took the glucometer to the resident' s room and completed the blood glucose check. She returned to the medication cart and used a PDI Sani Cloth disinfecting wipe and wiped off the glucometer. She then placed the glucometer in a cup to dry. -The glucometer was not visibly wet for two minutes. IV. Staff interviews LPN #1 was interviewed on 6/10/24 at 11:45 a.m. LPN #1 said glucometers must be cleaned after every use. She said the glucometers were wiped off with the PDI Sani Cloth wipes. She said after they were wiped off, glucometers needed to be allowed to dry for two minutes. The director of nursing (DON) was interviewed on 6/10/24 at 1:09 p.m. The DON said nursing staff had been following the [NAME] guidance (a nursing resource for nursing procedures) for cleaning and disinfection of glucometers. She said nursing staff should be cleaning and disinfecting glucometers after each use between residents. She said the [NAME] had recommended not wrapping glucometers with towelettes to keep the glucometer wet. She said glucometer manufacturer guidelines should be used for the cleaning and disinfection of the glucometer. She said the manufacturer guidelines should be used for contact disinfection times for PDI Sani Cloth disinfection wipes. She said she would provide education regarding the manufacturers' recommendations to RN #4 and LPN #1, as well as the day shift nursing staff and the oncoming nursing staff.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on record review and staff interviews, the facility failed to implement an effective antibiotic stewardship program that included an effective system of identification of newly prescribed antibiotics, tracking prophylactic antibiotic use and tracking infections that were prescribed antibiotics for four (#103, #84, #73, #60) of four residents out of 50 sample residents. Specifically, the facility failed to: -Track and monitor the use of short-term antibiotics which were prescribed for Resident #103 and Resident #84; and, -Track and monitor the use of long-term/prophylactic antibiotics which were prescribed for Resident #73 and Resident #60. Findings include: I. Professional reference According to The Centers for Disease Control and Prevention (CDC) The Core Elements of Antibiotic Stewardship for Nursing Homes (3/19/24), retrieved on 6/17/24 from https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-b-508.pdf, Completeness of clinical assessment documentation at the time of the antibiotic prescription. Incomplete assessment and documentation of a resident's clinical status, physical exam or laboratory findings at the time a resident is evaluated for infection can lead to uncertainty about the rationale and/or appropriateness of an antibiotic. Completeness of antibiotic prescribing documentation. Ongoing audits of antibiotic prescriptions for completeness of documentation, regardless of whether the antibiotic was initiated in the nursing home or at a transferring facility, should verify that the antibiotic prescribing elements have been addressed and recorded. These elements include: dose (including route), duration (start date, end date and planned days of therapy), and indication (rationale and treatment site) for every course of antibiotics. II. Facility policy and procedure The Antibiotic Stewardship policy and procedure, reviewed 5/19/23, was provided by the nursing home administrator (NHA) on 6/11/24 at 3:00 p.m. It read in pertinent part, The antibiotic stewardship program promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance. This means that the antibiotic is prescribed for the correct indication, dose, and duration to appropriately treat the resident while also attempting to reduce the development of antibiotic resistant organisms and/or other adverse events. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Antibiotic time out. At 72 hours after antibiotic initiation or first dose in the facility, each resident should be reassessed for consideration of antibiotic need. Interventions for syndrome specific antibiotic use and antibiotic prophylaxis. The AST (antibiotic stewardship team) will identify actions to directly impact inappropriate antibiotic use for specific syndromes and for prophylactic indications. Tracking. Process measures for tracking antibiotic stewardship track how and why antibiotics are prescribed. Process measures include review of SBAR's (situation, background, assessment, recommendation) and other clinical documentation during clinical meetings and ongoing reviews of the completeness of prescribing documentation to include dose, route, duration and indication for use. III. Resident #103 A. Resident status Resident #103, age 67, was admitted on [DATE] readmitted [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included atrial fibrillation (irregular heart beat), type II diabetes mellitus and pulmonary nodule. B. Record review The June 2024 CPO documented the following physician's order: Amoxicillin (antibiotic) oral tablet 500 mg (milligrams), one tablet by mouth three times a day for a urinary tract infection (UTI) for 10 days, ordered 6/4/24 and discontinued 6/14/24. The 6/4/24 nursing progress notes documented Resident #103 was readmitted from the hospital with a diagnosis of UTI and dehydration after being transferred for confusion and blood in his urine catheter bag. It documented the resident had received antibiotics while at the hospital. It documented the resident was readmitted with a new order for Amoxicillin. The 6/4/24 facility antibiotic checklist indicated Resident #103 had been started on Amoxicillin for a diagnosis of UTI and the results of the laboratory work were at the hospital. -However, there was no documentation in the resident's electronic medical record (EMR) to indicate a urinalysis (UA) or cultures and sensitivity (C&S) (a laboratory test which identifies bacteria type and what antibiotics are best used to effectively treat the infection) were completed at the hospital. There was no documentation in the EMR to indicate the facility had followed up with the hospital in order to determine the appropriateness of the prescribed antibiotic to effectively treat the resident's UTI. -There was no infection surveillance line listing report provided for June 2024 that indicated the facility had monitored Resident #103's antibiotic use to ensure the resident's signs/symptoms of UTI, laboratory work or McGeer's criteria were met for the prescribed Amoxicillin. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #84 A. Resident status Resident #84, age 82, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included right femur fracture, pulmonary embolism (blood clot) and Hodgkin's lymphoma (cancer). B. Record review The June 2024 documented the following physician's order: Keflex (antibiotic) oral capsule 500 mg four times a day for prophylaxis (prevention) for an infection due to a superficial venous thrombosis, ordered 6/7/24 and discontinued 6/14/24. The 6/7/24 nursing progress note documented Resident #84's sister had requested an antibiotic prescription for Keflex to be started as a prescription for the antibiotic had been sent to a local pharmacy. It documented a discussion by the facility with the emergency department (ED) regarding recommendations for the oral Keflex. The recommendations were discussed with the sister but she wanted the Keflex to be prescribed at the facility because a prescription had been sent to the pharmacy. The physician informed the sister/power of attorney (POA) the Keflex would be prescribed. -There was no documentation in Resident #84's EMR to indicate an antibiotic checklist for the Keflex had been completed. -There was no infection surveillance line listing report provided for June 2024 that indicated the facility had monitored Resident #84's antibiotic use to ensure the resident's signs/symptoms of infection, laboratory work or McGeer's criteria were met for the prescribed Keflex. V. Resident #73 A. Resident status Resident #73, age 66, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included Parkinson's disease (involuntary movement disorder) asthma and type II diabetes mellitus. B. Record review The June 2024 CPO documented the following physician's order: Nitrofurantoin (antibiotic) capsule 50 mg by mouth once a day for UTI prophylaxis, ordered 4/6/24. The 4/5/24 nursing progress/order note documented the Nitrofurantoin capsule 50 mg once a day for UTI prophylaxis failed a general dose range check based on drug and patient information provided. The drug dose needed to be adjusted based on renal function and manual screening was required. The 4/8/24 physician progress note documented Resident #73 was on Nitrofurantoin for urinary retention. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was no documentation in Resident #73's EMR to indicate an antibiotic checklist for Nitrofurantoin had been completed. -The April 2024 infection surveillance line listing report documented Resident #73 was on Nitrofurantoin for prophylaxis and did not meet McGeer's criteria, which included a fever of 100.4 degree Fahrenheit, new or increased burning when urinating, urgency and frequency, new pain/tenderness in flank or suprapubic area, change in urine appearance, foul smell, blood in urine or a decline in mental or functional status. .-The May 2024 infection surveillance line listing report failed to document Resident #73 continued on Nitrofurantoin or if the resident's signs/symptoms of infection, laboratory work and McGeer's criteria were met (see criteria listed above). -The June 2024 infection surveillance line listing report failed to document Resident #73 continued on Nitrofurantoin or if the resident's signs/symptoms of infection, laboratory work and McGeer's criteria were met (see criteria above). VI. Resident #60 A. Resident status Resident #60, age 81, was admitted on [DATE] and readmitted on [DATE]. According to the June 2024 CPO, diagnoses included hemorrhagic cerebral vascular accident (stroke), dementia and hypertension (high blood pressure). B. Record review The June 2024 CPO documented the following physician's order: Nitrofurantoin oral capsule 50 mg by mouth once a day for recurrent UTI prophylaxis, ordered 3/4/23 and discontinued 5/2/24. The 4/24/24 UA report documented the resident was negative for nitrites (produced by bacteria in a UTI) and had white blood cells present (may indicate presence of an infection). It documented no further culture and sensitivity workup was required. The 5/2/24 urine C&S documented the resident had greater than 100,000 Escherichia Coli (a bacteria) that was resistant to Nitrofurantoin. -There was no documentation in Resident #60's EMR to indicate an antibiotic checklist for Nitrofurantoin had been completed. -The March 2024 infection surveillance line listing report failed to document Resident #60 was on Nitrofurantoin or if the resident's signs/symptoms of infection, laboratory work and McGeer's criteria, which included which included a fever of 100.4 degree Fahrenheit, new or increased burning when urinating, urgency and frequency, new pain/tenderness in flank or suprapubic area, change in urine appearance, foul smell, blood in urine or a decline in mental or functional status, were met. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The April 2024 infection surveillance line listing report failed to document Resident #60 continued on Nitrofurantoin or if the resident's signs/symptoms of infection, laboratory work and McGeer's criteria were met. -The May 2024 infection surveillance line listing report failed to document Resident #60 continued on Nitrofurantoin or if the resident's signs/symptoms of infection, laboratory work and McGeer's criteria were met. VII. Staff interviews The director of nursing (DON), who was the infection preventionist (IP), was interviewed on 6/11/24 at 9:03 a.m. The DON said the facility followed the McGeer's criteria for antibiotic stewardship. She said when an antibiotic was ordered, an antibiotic checklist was filled out by the nurse and turned into the IP, so it could be reviewed and input into the facility's infection surveillance computer portal. She said the portal was the facility's line item tracking system that documented the checklists regarding signs/symptoms, laboratory work, if the infection was reportable and whether it met the McGeer's criteria. The DON said if a resident was on an antibiotic for more than 30 days she did not track it. She said to track trends in infections and antibiotic use, she previously used a mapping system where she color coded the infection and antibiotics. She said she no longer used mapping to track trends, she just followed the infection surveillance line listing on the facility's computer portal. She said after it was identified that antibiotics were started without a checklist completed or received by the IP there was not accurate tracking of who was on antibiotics. She said the facility's current system in place was not a good system. Registered nurse (RN) #5 was interviewed on 6/11/24 at 11:15 a.m. RN #5 said when a new antibiotic was ordered it was placed on the alert log book and the IP, DON and assistant director of nursing (ADON) were notified. She said the log book was reviewed during morning meetings with staff and managers. She said she was not aware of an antibiotic checklist form that needed to be filled out and returned to the IP. She said when a resident presented with UTI or upper respiratory infection (URI) symptoms or any other infection, she notified the provider and followed their directions. Licensed practical nurse (LPN) #1 was interviewed on 6/11/24 at 11:20 a.m. LPN #1 said when a resident presented with symptoms of a UTI, URI or other possible infection she would call the provider. She said if an antibiotic was ordered, the antibiotic checklist with the McGeer's criteria was completed and turned into the IP to be reviewed. She said documentation of the symptoms and notification of the provider was documented in the EMR. The nursing home administrator (NHA) was interviewed on 6/11/24 at 5:32 p.m. The NHA said the facility's infection control program, which included antibiotic stewardship, was reviewed monthly during the facility quality assurance (QA) meeting. She said the percentage of infections for the month were reviewed and compared to previous months. The NHA said the DON had recently taken the position of DON, but had been the IP for a while. She said when the DON took over her new position, the facility hired an IP, who left the position abruptly in April 2024. (continued on next page)

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