STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065240	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Care Center	2025 E Egbert St Brighton, CO 80601

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on record review and interviews, the facility failed to ensure one (#79) of four residents received treatment and care in accordance with professional standards of practice out of 42 sample residents. Specifically, the facility failed to correctly assess and care plan the progression of Resident #79's wound. Findings include: I. Facility policy and procedure The Skin and Wound Monitoring and Management policy was provided by the nursing home administrator (NHA) on 11/7/24 at 9:22 a.m. The policy read in pertinent part, It is the policy of this facility that a resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable, and a resident having pressure injuries receives necessary treatment and services to promote healing, prevent infection and prevent new avoidable pressure injuries from developing. Current evidence documents that in certain circumstances the development of pressure injury is an avoidable occurrence. In accordance with the guidance issued by the National Pressure Ulcer Advisory Panel (March 2010), the facility recognizes that an unavoidable pressure injury is one that developed even though the provider evaluated the individual's clinical condition and pressure injury risk factors; defined and implemented interventions that are consistent with individual needs, goals and recognized standards or practice and monitored and evaluated the impact of the interventions; and revised the approaches as appropriate. Facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors related to the development of unavoidable pressure injury. This identification and implementation of a plan of care will begin at admission with the initial care plan and be completed throughout the assessment process for developing a comprehensive plan of care. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pressure injuries are staged to indicate the extent of tissue damage. The National Pressure Ulcer Advisory Panel (NPUAP) has the following staging definitions: Medical Device Related Pressure Injury: This describes an etiology and uses the staging system to stage. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the patterns or shape of the device. The injury should be staged using the staging system. II. Resident #79 A. Resident status Resident #79, over the age of 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), the diagnoses included fractured left tibia (shin bone), displaced bimalleolar (of the ankle joint) fracture of left lower leg, type 2 diabetes mellitus with diabetic neuropathy (nerve condition causing pain, tingling and numbness), acute kidney failure and depression. The 10/17/24 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. She was dependent on staff for total assistance for dressing, putting on and taking off footwear, bathing, toileting hygiene, bed mobility and transfers. She needed set up assistance with personal and oral hygiene and was independent while dining. The MDS assessment documented she did not reject care and had a stage 3 pressure ulcer. -The assessment did not document the resident had a diabetic foot ulcer. B. Resident interview Resident #79 was interviewed on 11/4/24 at 2:43 p.m. Resident #79 said she had a wound on the back of her left heel as well as two surgical incisions on her left leg. She said she was told her heel wound was common with people who are put in a brace and likely resulted from her leg rubbing on the brace. Resident #79 said her goal was to walk again and discharge home but she was concerned the wounds delayed her healing. III. Record review A. Resident assessments The 4/15/24 initial admission assessment, completed by licensed practical nurse (LPN) #1, documented Resident #79 had a brace, but no splint or cast and was non weight bearing to her lower left extremity. There were no open areas noted, and no areas of concern noted and no skin condition was noted to her left heel. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/16/24 physician's assistant (PA)/nurse practitioner (NP) note documented the resident's lower left extremity (LLE) was in an immobilizing splint. Her surgical sites were covered by a splint, and clean, dry dressings and compression wraps (see the above admission assessment detail that documented the resident had a brace but no splint). B. Care plan Resident #79's pressure ulcer care plan, initiated on 4/16/24, documented she had the potential for pressure ulcer development related to impaired mobility, obesity, hypothyroidism (decreased thyroid function), and major depression. Pertinent interventions included administering treatments as ordered and monitoring for effectiveness, monitoring nutritional status, serving the diet as ordered, monitoring and recording meal intake, and monitoring, documenting and reporting to the physician as needed (PRN) changes in skin status that included appearance, color, wound healing, signs and symptoms of infection, wound size and stage. Resident #79's pressure ulcer care plan was revised on 8/11/24 to include that she had an unstageable pressure ulcer with the potential for an additional pressure ulcer related to impaired mobility, obesity, hypothyroidism, and major depression. -See progress notes below for wound progression. C. Progress notes On 4/22/24 Resident #79's orthopedic physician note documented the resident had a left heel ulcer with unspecified severity present. Foam padding was added to her posterior splint due to the heel ulcer with a recommendation to keep pressure off the heel. The 5/25/24 physician progress note documented Resident #79 had a left heel decubitus (pressure) ulcer related to use of a splint after surgery. -The facility failed to update Resident #79's pressure ulcer care plan with her new wound status until 8/11/24 more than three months after the new wound was initially documented, although her left heel ulcer was first documented on 4/22/24. Resident #79's pressure ulcer care plan interventions were not updated until 10/9/24. Resident #79's pressure ulcer care plan and interventions were revised again on 10/9/24 to document she had an unstageable pressure ulcer to her left heel with the potential for additional pressure ulcer development related to impaired mobility, obesity, hypothyroidism and major depression. -However, a review of Resident #79's wound tracking documentation completed by the wound physician (WP) revealed Resident #79's left heel wound was documented on 10/2/24 (prior to the 10/9/24 care plan update) as a stage 3 pressure ulcer to her left heel. -The facility failed to update Resident #79's pressure ulcer care plan to indicate she had a stage 3 pressure ulcer to her left heel until 11/4/24 (during the survey). The pressure ulcer care plan interventions were not updated on 11/4/24. D. Progress notes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/25/24 physician progress note (see above) documented Resident #79 had a left heel decubitus ulcer related to splint after surgery. -Resident #79's pressure ulcer care plan failed to include prior heel drainage or the use of the splint as a potential risk factor for developing a pressure injury. Resident #79's nutrition and dietary notes documented Resident #79 had a stable stage 4 pressure ulcer on the following dates in her electronic medical record: 5/26/24, 6/2/24, 6/9/24, and 6/16/24. On 6/21/24 the nutrition and dietary notes documented Resident #79 had a pressure ulcer SDTI (suspected deep tissue injury) to her left heel. -However, facility documentation failed to show Resident #79 was assessed to have a stage 4 pressure ulcer and during staff interviews, the staff were unsure where the documentation originated from that Resident #79 had a stage 4 pressure ulcer (see interviews below). E. Physician's orders A review of the April 2024 CPO revealed Resident #79 was prescribed the following orders: Avoid pressure on the left heel, a heel ulcer was present every shift for new padding placed by the orthopedic physician, ordered on 4/22/24. Elevate heels while in bed every shift, ordered on 4/24/24. Monitor the wound to the left heel and notify the physician of any changes every shift, ordered on 4/24/24. -The April 2024 CPO failed to include orders upon admission for the resident to elevate her heels or avoid pressure on her heels and the orders were started on or after 4/22/24 when the heel ulcer was documented in the orthopedic visit notes 4/22/24. The April 2024 CPO did not include an order to not remove the splint until 4/22/24. A review of Resident #79's CPO for May 2024, June 2024 and July of 2024 documented a physician's order of wound care to the left heel for a stage 4 pressure ulcer, and to apply skin prep daily every day shift, ordered on 5/24/24 and discontinued on 7/10/24. F. Chart review The NHA provided a chart review on 11/7/24 at 3:30 p.m. completed by Resident #79's primary care physician (PCP) on 11/6/24 (during the survey). The chart review referenced a podiatry note documented on 4/9/24 during the resident's hospital stay (prior to admission to the facility) that with assistance supporting Resident #79's limb, the distal dressing ace wraps were removed and there was some drainage into the heel. The chart review also referenced a podiatry note on 4/9/24 mentioned adding more padding which would have been for the posterior splint. The PCP documented he felt her left heel DTI started on 4/9/24 (in the hospital) as Resident #79 had severe pain starting then, but it took some time (a few weeks) for that injury to become visible at the surface. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the 4/16/24 daily skilled nursing note also documented Resident #79 had surgical wounds only upon her admission to the facility. There was no documentation Resident #79 had a skin injury/ulcer (examples: pressure, diabetic, arterial, vascular). IV. Staff interviews The director of nursing (DON) was interviewed on 11/6/24. The DON said Resident #79 was admitted with a hard cast which was a non removable brace to her lower left extremity upon admission. The DON said when the resident was admitted to the facility the cast was from her toes to bottom of her knee cap and covered her heel which was why the DTI was found during the visit to the orthopedic office on 4/22/24. The DON said the facility staff were unable to see the resident's left heel. The DON said the facility's wound provider's specialty was to handle pressure ulcers or DTI and was easier provide Resident #79 wound care at the facility. The DON said Resident #79's heel has always been a DTI. The DON said from 4/15/24 to 5/24/24 Resident #79 was seen by orthopedic physicians for her DTI to the left heel before her wound care transferred to their facility wound care provider. The food and nutrition resource (FNR) was interviewed on 11/7/24 at 10:00 a.m. The FNR said she was not aware Resident #79's heel wound was documented as a stage 4 pressure ulcer in the May and June 2024 nutrition and dietary notes. LPN #1 was interviewed on 11/7/24 at 1:00 p.m. LPN #1 said he completed Resident #79's initial admission assessment. LPN #1 said when he did Resident #79's initial skin assessment he did check her heels. LPN #1 said if Resident #79 was wearing an ankle brace he would have removed the brace to check her skin and do a total assessment. The director of rehabilitation (DR) was interviewed on 11/7/24 at 1:15 p.m. The DR said typically if a resident was admitted to the facility wearing a splint, the facility would not remove the splint without orders to do so. The DR said Resident #79 initially had a splint with a sterile dressing on for two weeks that was not to be removed. The DR said Resident #79's initial therapy documentation did not include her foot in their notes because she was admitted with a fracture, and they were trying to assess if the facility could provide therapy for Resident #79's knee. The DR said the type of splint Resident #79 wore upon admission was one that could be unwrapped (like an ace bandage) and the splint underneath could be removed. The DON was interviewed on 11/7/24 at 2:00 p.m. The DON said she was the facility's wound nurse from April 2024 to September 2024 prior to becoming the DON. The DON said if a resident was admitted with a non removable brace or splint the facility should look for break through bleeding and damage to the brace or splint and monitor the resident to ensure they have good circulation. The DON said Resident #79 had a visible surgical wound on her lower left leg, a second non visible surgical wound to the ankle under the splint and regular redness to the buttocks from being incontinent. The DON she was not aware that Resident #79 had anything on her heel upon admission to the facility. The DON said if a resident was admitted with a splint, the splint should be mentioned in the initial care plan. The DON said Resident #79's care plan only documented to monitor her surgical sites and failed to include her splints or immobilizing device. The DON said as a best practice it should be in a resident's care plan to mention the cast or splint so that the facility could make sure all precautions can be followed by all the staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said when staff asked a resident about pain they may be experiencing, the staff ask for the resident to describe the pain using a number from 1 to10, ask where the pain was located, how the resident described the pain and what made the pain worse or better. The DON said she was not sure why the facility documented Resident #79 had a stage 4 pressure ulcer. She said as the facility wound nurse she used to document a resident's wound status in her notes and provide the physician with her notes weekly. V. Facility follow up The NHA provided documentation from the WP on 11/8/24 (after the survey) at 3:45 p.m. The documentation included the WP became involved in the care of Resident #79 at the end of April 2024 at which time she already had a wound to her left heel which had been followed by her Orthopedic surgeon previously. Unfortunately, the patient's surgeon had an order in place not to remove her post surgical dressings and when the facility was finally able to visualize the left heel, a wound was present. It is likely this wound is diabetic in origin given the patient's limited mobility in the setting of diminished sensation. I feel this is an unavoidable wound as preventive offloading was being performed and the facility was not able to monitor the status of her skin or heel under the dressing which they were prevented from removing by a physician's order. -However, Resident #79's diagnosis of type 2 diabetes mellitus and her diminished sensation, splint or non removable dressings were not listed as a risk factor on the resident's pressure ulcer care plan. The wound physician also documented Resident #79's wound from 5/24/24 to 11/8/24 was an unstageable pressure ulcer and from 10/2/24 to 10/30/24 the wound was documented as a stage 3 pressure ulcer.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47151 Based on observations, record review and interviews the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure dietary staff wore intact gloves over artificial fingernails with nail polish when working with exposed food; and, -Maintain the kitchen in a sanitary condition. Findings include: I. Ensure staff wore intact gloves over artificial fingernails with fingernail polish A. Professional reference The Colorado Retail Food Establishment Regulations (3/16/24), were retrieved on 11/13/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough. Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food. B. Observations During a continuous observation of the dinner meal on 11/5/24, beginning at 4:50 p.m. and ending at 5:45 p. m., the following was observed in the kitchen: At 5:03 p.m cook (CK) #1 began assembling meal plates to be served to residents. CK #1 assembled and served resident meal plates through the entire service until 5:45 p.m. while wearing artificial nails with nail polish. CK #1 did not wear gloves during the meal service. C. Staff interviews The dietary manager (DM) and the food and nutrition resource (FNR) were interviewed together on 11/7/24 at 10:00 a.m. The DM said she knew that staff that were wearing false nails should wear gloves covered when handling exposed food but she was unsure if CK #1 was aware. The DM said she noticed CK #1 had artificial nails and the nails were painted. The FNR said CK #1 was the only dietary staff member who wore artificial nails in the kitchen and she would be educated on proper glove use while handling exposed food with artificial nails. II. Ensure kitchen was maintained in a sanitary condition (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Professional reference The Colorado Retail Food Establishment Regulations (3/16/24), were retrieved on 11/13/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Physical facilities shall be cleaned as often as necessary to keep them clean, except for cleaning that is necessary due to a spill or other accident, and cleaning shall be done during periods when the least amount of food is exposed such as after closing. B. Facility policy and procedure The Kitchen Sanitation and Cleaning policy, revised August 2021, was provided by the nursing home administrator (NHA) on 11/7/24 at 12:05 p.m. The policy revealed in pertinent part, Food and nutrition services staff will maintain the sanitation of the kitchen through compliance with a written comprehensive cleaning schedule. Cleaning and sanitation tasks for the kitchen will be outlined in a written cleaning schedule. Tasks will be assigned to be the responsibility of specific positions. Frequency of cleaning for each task will be defined. On the cleaning schedule, employees will initial and date the tasks when completed. Deep cleaning tasks will be assigned periodically and as needed. C. Observations A tour of the kitchen was completed on 11/424 at 9:15 a.m. and revealed the following: -The floor under the coffee machine table and ice machine was soiled with spilled coffee that collected in the corner of the kitchen, under the table and behind the ice machine. Pieces of debris and a yellow towel were in the spilled coffee behind the ice machine. -The floor under the side preparation tables was soiled with crumbs, dust and food debris. -The floor under the dry storage shelves had dry pasta and two portion control cups filled with brown liquid stuck in a dried, brown liquid on the floor, hard taco shells inside a clear plastic bag, packages of crackers and a can of green chiles. -A drawer that stored clean utensils was lined with a shelf liner that was stuck to the bottom of the drawer and had a thin layer of dark crumbs underneath. -A plastic pump out of its bottle and a can of kitchen cleaner were on the floor under the three compartment sink. -The can opener blade had dried red substance on it. -The bottom shelf of the three door reach-in freezer had food crumbs throughout. -The vent in the dry storage room was covered with dirt and lint. -A dirty mop head was on the floor under the dirty side of the dish machine table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The dry food bin lids and containers were covered in dust and the handles of two of the dry bins were filled with crumbs. -A baking rack stored in the walk-in cooler had crumbs on each shelf; two baking sheets of ready to eat pumpkin pie were stored uncovered on the shelves in the baking rack. -Two tubs of clean utensils stored on the top shelf of a preparation table had crumbs inside the bottom of the tubs. A second observation of the kitchen was conducted on 11/5/24 at 4:10 p.m. Observations identified the same concerns as identified on 11/13/23 during the initial tour. Additional items observed included: -A gray bus tub that contained cleaned built up utensils had a brown sticky substance in the bottom of the tub. -The floor under the back preparation table was brown and sticky and spots of a dried brown liquid were on the kitchen wall next to the prep table. -The shelf above the back prep table had brown splatter on the underside of the shelf. -Cleaned and sanitized mixer attachments were stored in food crumbs on a tray. C. Staff interviews The DM was interviewed on 11/7/24 at 10:00 a.m. The DM said she cleaned the utensil drawer and shelf liner during the survey. The DM said the utensil drawers were on the cleaning list and the dietary staff were supposed to empty the drawers and clean them out. The DM said the utensil drawers and dry bins were scheduled to be cleaned twice a month. She said she checked the cleaning list and completed a kitchen walk through almost daily to ensure staff completed tasks timely. The DM said she cleaned the utensil drawers during the survey. The DM said the side preparation tables do not move and they were connected to the wall. She said the floors underneath the shelves and the tables were swept and mopped twice a day. The DM said she had a cook that typically cleaned the floor under the tables, shelves and equipment. The DM said the coffee spill in the corner resulted from a spout that was left open while the coffee was brewing and then spilled onto the floor. The DM said the dry food bins were included on the cleaning list to be cleaned every two weeks and had been cleaned (during the survey). The DM said the baking rack in the walk in refrigerator usually got taken outside and power washed. She said twice a month one of the cooks would also do kitchen deep cleaning, but some of the deep cleaning could not happen during the day because too many things were moved. She said the staff have discussed moving some items from the monthly cleaning schedule to the bi-weekly cleaning schedule. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietary aide (DA) #1 was interviewed on 11/7/24 at 2:15 p.m. DA #1 said she felt the staff could successfully get their cleaning tasks done. DA #1 said the staff tried to always clean if there was extra time and the staff noticed something really needed to be cleaned. DA #1 said kitchen cleanliness should be maintained over time. DA #1 said staff performed an extra cleaning task if they identified an item that needed to be cleaned.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37166 Based on record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to: -Ensure staff donned appropriate personal protective equipment (PPE) when providing care to a resident on enhanced barrier precautions (EBP); -Ensure staff followed appropriate infection control practices during vaccination administration; and, -Ensure staff disinfected vital signs equipment before and after each use. Findings include: I. Failure to ensure staff donned appropriate PPE when providing care to a resident on enhanced barrier precautions (EBP) A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) About Enhanced Barrier Precautions (EBP) In Nursing Homes (6/28/24) retrieved on 11/12/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html, EBP are an infection control strategy that involves wearing gowns and gloves during high-contact resident care activities. Enhanced Barrier Precautions are recommended for residents with any of the following: infection or colonization, or a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a multi drug resistant organism (MDRO). B. Observations On 11/7/24 at 9:25 a.m. the wound care nurse (WCN) was observed performing wound care for Resident #79. The sign on the door to the resident's room indicated that the resident was on EBP and the required PPE included wearing gloves and a protective gown when providing high contact direct resident care. The WCN entered the resident's room and proceeded to perform the resident's wound care. -The WCN did not put on a protective gown prior to entering Resident #79's room and performing the wound care. C. Staff interviews (continued on next page)

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Brighton Care Center	2025 E Egbert St Brighton, CO 80601

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The WCN was interviewed on 11/7/24 at 9:45 a.m., after she completed the wound care for Resident #79. The WCN said she forgot to don a gown prior to performing the wound care. She said the resident was on EBP and she should have donned a gown prior to performing the wound care. The infection preventionist (IP) was interviewed on 11/7/24 at 10:42 a.m. The IP said the WCN should have followed the appropriate PPE recommendations for EBP and donned a gown prior to performing the wound care for Resident #79. II. Failure to ensure staff followed appropriate infection control practices during vaccination administration A. Professional reference According to the CDC Vaccine Administration (6/20/23), retrieved on 11/12/24 from https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/administration.html, Persons administering vaccinations should follow appropriate precautions to minimize risk for disease exposure and spread. Hands should be cleansed with an alcohol-based waterless antiseptic hand rub or washed with soap and water before preparing vaccines for administration and between each patient contact. B. Observations On 11/4/24 at 1:48 p.m. a vaccination clinic was observed in the facility's lobby area. At 1:49 p.m. an unidentified technician (TECH) administered a vaccination to a resident. The unidentified TECH wore gloves to administer the vaccine injection to the resident. After administering the injection, and without removing her gloves, the unidentified TECH pushed the resident in her wheelchair back to the waiting area in the center of the lobby. -The unidentified TECH did not remove her gloves prior to touching the resident's wheelchair and she did not perform hand hygiene after she removed her gloves once she was finished pushing the resident's wheelchair. At 1:53 p.m. an unidentied TECH administered a vaccination to the next resident. After the vaccination was administered, she applied an alcohol swab to the resident's bleeding injection site. After the bleeding stopped, the unidentified TECH placed the alcohol swab, which was saturated with blood, on the receptionist's table and proceeded to administer a second vaccination to the resident. After she completed the resident's second vaccination, The unidentified TECH collected the alcohol swab from the receptionist's table and disposed of it by placing it in the sharps container. Without removing her gloves, the unidentified TECH pushed the resident in her wheelchair to the center of the lobby. When she returned to her station, she removed her gloves. The unidentified TECH did not remove her gloves prior to touching the resident's wheelchair and she did not perform hand hygiene after she removed her gloves once she was finished pushing the resident's wheelchair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 2:13 p.m. another unidentified TECH was administering two vaccinations to a resident. After the unidentified TECH administered the first vaccination to the resident, he placed a used syringe in his chest pocket. After the second vaccine was administered, he disposed of both syringes into a sharps container. At 2:18 p.m. the unidentiifed TECH was observed collecting timers from residents while wearing the same gloves he used to administer other residents' vaccinations. He placed the timers in a basket without sanitizing them. The timers were then reused for other residents. C. Staff interview The IP was interviewed on 11/7/24 10:42 a.m. The IP said staff who conducted vaccination clinics were contracted from an outside company. She said the staff administering the vaccinations should have followed appropriate infection control practices when administering vaccinations to the residents. The IP said gloves should be immediately removed after the administration of a vaccination and hands should be sanitized. She said used syringes should not be stored in pockets, but disposed of into sharps containers immediately after use. She said the timers should have been disinfected before offering them to the next resident. 50315 III. Failure to ensure staff disinfected vital signs equipment before and after each use A. Professional reference According to the CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, (2024), retrieved on 11/12/24 from https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html#:~:text=Ensure%20that%2C%20at%20a%20minimum,once%20daily%20or%20once%20weekly, Clean medical devices as soon as practical after use. Perform either manual cleaning or mechanical cleaning. Perform low-level disinfection for noncritical patient-care surfaces and equipment (blood pressure cuffs) that touch intact skin. B. Observations On 11/6/24 at 2:45 p.m. certified nurse aide (CNA) #1 took the vital signs cart into room [ROOM NUMBER] and asked the resident in bed A if he could measure her vital signs. The resident agreed and CNA #1 utilized the equipment on the vital signs cart to obtain the resident's blood pressure, temperature, heart rate and oxygen saturation (level of oxygen in a person's blood). After obtaining the vital signs for the resident in room [ROOM NUMBER], CNA #1 moved the vital signs cart into room [ROOM NUMBER] and woke up the sleeping resident to ask if he could measure her vital signs. The resident agreed and CNA #1 utilized the equipment on the vital signs cart to obtain the resident's blood pressure, heart rate, temperature and oxygen saturation. After obtaining the vital signs for the resident in room [ROOM NUMBER], CNA #1 moved the vital signs cart into the hallway and left it there for approximately five minutes. CNA #1 returned to the vital signs cart, wrapped the cords up and put the cart into a clean utility room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA #1 did not disinfect the vital signs equipment between use for each resident or before putting the vital signs cart away in the clean utility room. C. Staff interview The director of nursing (DON), the IP and the clinical resource nurse (CRN) were interviewed on 11/7/24 at 12:00 p.m. The IP said staff were supposed to sanitize medical equipment, such as vital signs equipment, with sanitation wipes or bleach wipes after each use.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program to monitor for antibiotic use for two (#60 and #50) of seven residents reviewed for antibiotic use out of 42 sample residents. Specifically, the facility failed to effectively track and monitor the use of long-term antibiotics for Resident #60 and Resident #50. Findings include: I. Professional reference According to The Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes, (2024), retrieved on 11/11/24 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html, To track how and why antibiotics are prescribed, (providers) perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians. II. Facility policy and procedure The Antibiotic Stewardship policy and procedure, revised August 2021, was received from the nursing home administrator (NHA) on 11/7/24 at 12:40 p.m. It documented in pertinent part, The program includes antibiotic use protocols and a system to monitor antibiotic use. Antibiotic use protocols include: -Nursing staff shall assess residents who are suspected to have an infection and complete a change in condition form prior to notifying the physician; -Laboratory testing shall be in accordance with current standards of practice; -The facility uses the McGeer's criteria to define infections; -The McGeer's criteria are used to determine whether or not to treat an infection with antibiotics; and, -All prescriptions for antibiotics shall specify the dose, duration, and indication for use. Monitoring antibiotic use includes: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness. Antibiotic use shall be measured by monthly prevalence, antibiotic starts, and/or antibiotic days of therapy. At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facility's infection control risk assessment and other infection surveillance data. Examples include: tracking C. difficile (clostridium difficile) infections, antibiotic resistance, and adverse drug events related to antibiotic use, or costs related to antibiotic use. III. Resident #60 A. Resident status Resident #60, age 81, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included cellulitis (infection) of the right lower limb, urinary tract infection (UTI), benign prostatic hyperplasia (enlarged prostate) and retention of urine. The 8/9/24 minimum data set (MDS) assessment revealed that Resident #60 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. He required complete assistance with bathing, hygiene, toileting, and transfers and substantial/maximum assistance with dressing. B. Record review Review of Resident #60's November 2024 CPO revealed the following physician's order: Macrodantin oral capsule 50 milligrams (mg). Give one capsule by mouth one time a day for UTI prophylaxis (prevention), ordered 7/2/24. -The physician's order for the Macrodantin failed to indicate the duration for the use of the antibiotic. A 7/2/24 infection surveillance progress note revealed Resident #60 was on Macrodantin daily for UTI prophylaxis prior to his hospitalization , but the physician's order was only continued for four days after admission. Resident #60 was prescribed Macrodantin oral capsule 50 mg, give one capsule by mouth one time a day for UTI prophylaxis. The note documented that the facility would continue to monitor at this time and the resident did not have an active UTI. A physician's progress note, dated 6/5/24, revealed Resident #60 took Macrodantin 50 mg daily and the facility was to monitor for signs and symptoms of a UTI and the resident was to follow-up with urology. It documented the resident was at a high-risk for a UTI and if he were to develop signs and symptoms of a UTI, staff was to obtain laboratory results and begin another antibiotic. -The resident did not have a risk versus benefit statement for the long-term use of an antibiotic. -The resident did not have a care plan to address the need for a long-term use of an antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #60's electronic medical record (EMR) revealed no documentation to indicate the facility's infection preventionist (IP) completed an antibiotic use assessment or documented the McGeer's criteria met to justify the physician's order for Macrodantin. A review of the IP infection surveillance documents revealed the facility identified facility residents with active infections. -However, the IP failed to document and monitor Resident #60's long-term use of Macrodantin on the infection surveillance documents. IV. Resident #50 A. Resident status Resident #50, age greater than 65, was admitted on [DATE]. According to the November 2024 CPO, diagnoses included Alzheimer's disease, anxiety and history of UTIs. The 7/18/24 MDS assessment revealed that Resident #50 had severe cognitive impairment with a BIMS score of five out of 15. She required substantial/maximum assistance with hygiene, showering and bathing, dressing, and transferring. B. Record review Review of Resident #50's November 2024 CPO revealed the following physician's order: Macrodantin macrocrystal oral capsule 50 mg. Give one capsule by mouth one time a day for UTI prophylaxis, ordered 9/24/24. -The physician's order for the Macrodantin failed to indicate the duration for the use of the antibiotic. A 5/17/24 note from the pharmacist to the physician revealed the pharmacist recommended a risk versus benefit statement of Macrodantin for prophylaxis and to consider discontinuation of the antibiotic for Resident #50. -However, there was no documentation from the physician in response to the pharmacist's recommendation to determine risk versus benefit in order to justify the use of a long-term antibiotic. V. Staff interviews The director of nursing (DON), the IP and the clinical resource nurse (CRN) were interviewed on 11/7/24 at 12:00 p.m. The IP said the facility's process for monitoring and tracking infections and antibiotic use included making sure the McGeer's criteria was met when there was a new antibiotic started or a new resident came in on an antibiotic. She said she discussed antibiotic usage with the medical director once a month. She said Resident #60 came into the facility on Macrodantin to prevent UTIs because he got frequent UTIs. She said he was followed by a urologist and they put him on the Macrodantin. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, there was no documentation from Resident #60's urologist which indicated the reason the resident needed to be on the antibiotic long term. The IP said Resident #50 went to the hospital for a UTI on 7/17/24 and the Macrodantin order was decreased from 100 mg to 50 mg once daily. She said the facility's protocol for residents on prophylactic antibiotics included a monthly review from the pharmacy, a call to the physician to confirm the order and to go through the antibiotic surveillance. -However, the physician did not provide a response to the 5/17/24 pharmacist's recommendation to consider discontinuing Resident #50's antibiotic (see record review above). The DON was interviewed a second time on 11/7/24 at 4:00 p.m. The DON said Resident #50 was trialed off Macrodantin on 9/30/24 and failed the trial. She said Resident #50 developed another UTI during the trial and that was how they determined she failed the trial and needed to be on the antibiotic long-term. She said monitoring antibiotics included monitoring every resident who started a new antibiotic for 72 hours to determine if there were any adverse reactions to the antibiotics. -However, there was no documentation in Resident #50's EMR to indicate the resident had failed a trial off of Macrodantin or a physician's note to justify the long-term use of the antibiotic due to the failure of the trial.