STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065247	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Village Care Center	110 W Van Buren St Colorado Springs, CO 80907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good grooming and personal hygiene for one (#5) of three residents reviewed out of 16 sample residents. Specifically, the facility failed to ensure Resident #5 received timely incontinence care. Findings include: I. Facility policy and procedure The Urinary Incontinence-Clinical Protocol, revised March 2018, was received from the nursing home administrator (NHA) on 2/6/25 at 3:11 p.m. It read in pertinent part, As appropriate based on assessment of the category and causes of incontinence the staff will provide scheduled toileting, prompted voiding or other interventions to try to improve the individual's incontinence status. The Activities of Daily Living (ADL) policy, revised March 2018, was received from the NHA on 2/6/25 at 3:11 p.m. It read in pertinent part, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with: hygiene,. mobility and elimination (toileting). If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate. II. Resident #5 A. Resident status Resident #5, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO) diagnoses included wedge compression fracture of first lumbar vertebra, morbid (severe) obesity, pain in left knee, pain in right knee, unspecified symptoms and signs involving cognitive functions following cerebral infarction (also known as ischemic stroke). (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/8/25 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. The MDS showed the resident was dependent on staff for toileting hygiene, for lower body dressing and dependent for chair/bed-to-chair transfer. The MDS indicated the resident was not on a toileting program and that she was always incontinent of urine and bowel. B. Observations During continuous observation on 2/6/25, starting at 9:11 a.m. and ending at 1:15 p.m. the following was observed: At 9:11 a.m. Resident #5 was in the activity room working on an independent activity. At 10:51 a.m. Resident #5 was assisted by an unidentified activity assistant back to her room to see the dentist. At 11:04 a.m. the resident received care from the dentist. At 11:38 a.m. the resident was assisted out of the room by the dentist. An unidentified occupational therapist (OT) asked Resident #5 if she would participate in a therapy session and Resident #5 said she would after lunch. Resident #5 was assisted to the dining room by the unidentified OT. At 12:55 p.m. the resident was assisted to the therapy gym by an unidentified nurse. Her pants were visibly wet in the crotch area. She was met by the unidentified OT for a therapy session in the gym. Resident #5 said that her new dentures were hurting. The unidentified OT offered to take Resident #5 her to her room to put her new dentures in a cup and they could work on therapy in her room. At 1:00 p.m. the unidentified OT began their session. Upon prompting, the unidentified OT asked the resident if she needed to use the bathroom. Resident #5 said she already did. The unidentified OT said she would help the resident change as part of the therapy session. -Resident #5 was not checked for incontinence care for three hours and 49 minutes, and was visibly soiled. C. Resident and Resident #5's representative interview Resident #5 was interviewed on 2/10/25 at 12:50 p.m. Resident #5 said the staff did not check on her during the day to see if she needed incontinence care. Resident #5 said she enjoyed staying active and attending activities. She said she did not want to be interrupted during the activities. She said she would be agreeable to be checked for incontinence care before or after meals. Resident #5's representative was interviewed on 2/10/25 at 1:33 p.m. The representative said she had concerns about incontinence care not being completed timely. She said Resident #5 went through two to three pairs of pants daily. The resident's representative said she did Resident #5's laundry. She said she visited the resident every weekday at 4:30 p.m. and often found Resident #5 dripping wet. D. Record review (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The urinary incontinence care plan, initiated 10/6/24 and revised on 2/6/25, indicated Resident #5 had urinary incontinence due impaired mobility. Pertinent interventions included checking and changing the resident per facility protocol. The care plan was updated on 2/6/25 (during the survey process) and indicated the resident had declined to be checked and changed on a schedule and preferred to alert staff when she would like to be changed. -However, Resident #5 said she preferred to be toileted before and after meals (see interview above). The skin integrity risk for impairment care plan, initiated 10/6/24 and revised on 11/1/24, and again 2/6/25, had the potential for impaired skin integrity as evidenced by decreased mobility, incontinence and morbid obesity. Pertinent interventions included providing the resident with prompt assistance with management of incontinence episodes. The care plan was updated on 2/6/25 (during the survey process) indicated the resident preferred to alert staff when she wanted or /needed to be changed rather than on a schedule. A review of the Resident #5's toileting schedule from 2/5/25 to 2/29/25 revealed the following: On 2/5/25 the resident was incontinent twice at 10:56 a.m. and 9:53 p.m. On 2/6/25 the resident was incontinent once at 10:29 a.m.; -On 2/7/25 the resident was incontinent two times at 12:19 a.m. and 9:40 p.m.; -On 2/8/25 there was no documentation indicating the resident was toileted; and, -On 2/9/25 the resident was incontinent twice at 12:05 a.m. and 8:39 p.m. -However, observations on 2/6/25 revealed the resident was not toileted from 9:11 a.m. until 1:00 p.m. (see observations above). E. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 2/6/25 at 12:35 p.m. LPN #2 said a resident should be checked and changed every two hours. LPN #2 said it was important to check a resident every two hours because it could put the resident at risk for developing pressure ulcers. LPN #2 said that Resident #5 sometimes refused to be changed because she did not like to leave an activity to be changed. The social services director (SSD) was interviewed on 2/10/25 at 1:49 p.m. The SSD said she was informed if a resident was noncompliant with care. She said she would then become involved to assist with reasons for the noncompliance and to assist with interventions. The SSD said she was not aware that Resident #5 had been noncompliant with incontinence care. The director of nursing (DON) was interviewed on 2/6/25 at 4:45 p.m. The DON said she expected the residents to be checked and changed every two hours. III. Facility follow up (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA provided additional information via email on 2/12/25 at 3:00 p.m. that included an on the spot education provided to and signed by 22 staff members regarding frequent checks for incontinent and immobile residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52309 Based on record review and interviews, the facility failed to manage pain in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for one (#4) of three residents out of 16 sample residents. Specifically, the facility failed to ensure Resident #4 was administered the correct pain medication per physician's orders and failed to provide non-pharmacological interventions prior to administering PRN pain medication. Findings include: I. Professional reference According to Treas, L. &, [NAME] K., & [NAME] M., (2022) Basic Nursing (3rd ed.) p. 1257, Medications administered PRN are given only when the patient meets certain conditions that were established in the medication prescription. II. Resident #4 A. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included quadriplegia, unspecified muscular dystrophy, unspecified pain and unspecified low back pain. The 1/26/25 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 on staff for all activities of daily living (ADL). The assessment indicated the resident occasionally had pain and he rated his pain level during the assessment period as a 6 out of 10, on a pain scale of 1 to 10. B. Record review The pain care plan, initiated 11/29/23 and revised 1/24/25 identified Resident #4 had increased risks for alteration in comfort due to generalized pain related to decreased mobility and decreased functional abilities. Pertinent interventions included providing pain medication as ordered, non-pharmacological pain approaches and repositioning. Review of Resident #4's February 2025 CPO revealed the following physician's order for pain medications: Tramadol HCL oral tablet 50 milligrams (mg) give one tablet by mouth every eight hours as needed for moderate to severe pain (6 to10). Document nonpharmacological pain management interventions, ordered 11/10/23. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #4's January 2025 and February 2025 medication administration records (MAR) revealed the Tramadol pain medication was administered outside of the physician ordered parameters on the following dates: -On 1/4/25 Tramadol was administered for a pain level of 5; -On 1/8/25 Tramadol was administered for a pain level of 5; -On 1/23/25 Tramadol was administered for a pain level of 5; and, -On 2/3/25 Tramadol was administered for a pain level of 5. -Review of Resident #4's January 2025 and February 2025 revealed there were no non-pharmacological interventions documented for pain. -Review of Resident #4's January 2025 and February 2025 progress notes did not identify documentation of attempted non-pharmacological interventions for the resident's pain. C. Staff interviews The director of nursing (DON) was interviewed on 2/6/25 at 3:43 p.m. The DON said physician ordered parameters for pain medications needed to be followed. She said if the parameters were not followed, a separate one-time physician's order should have been obtained prior to administering the medication for a pain level outside of the parameters.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on observations, record review, and interviews, the facility failed to ensure residents with a pressure ulcer received the necessary treatment and services according to professional standards of practice to prevent or heal pressure injuries for one (#2) of three residents reviewed for pressure ulcers out of 16 sample residents. Specifically, for Resident #2, the facility failed to: -Ensure there was a physician's order in place for treating the resident's left knee wound; -Ensure staff utilized knee protectors, per the resident's care plan, when repositioning the resident to offload pressure; -Ensure staff appropriately cleansed the resident's left knee wound during a dressing change; and, -Ensure staff followed appropriate techniques when removing the resident's old knee wound dressing to avoid causing potential damage to the wound bed. 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 2/17/25, 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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Pressure Ulcers/Skin Breakdown - Clinical Protocol policy, dated March 2014, was received on 2/10/25 from the nursing home administrator (NHA). It read in pertinent part, The physician will authorize pertinent orders related to wound treatments, including wound cleansing and debridement approaches, dressings (occlusive, absorptive) and application of topical agents if indicated for type of skin alteration. III. Resident #2 A. Resident status Resident #2, age less than 65, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included, pressure ulcer of sacral region, stage 4, paraplegia, unspecified, schizophrenia, and other chronic osteomyelitis, multiple sites. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/8/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15.The resident required extensive assistance from one staff member for activities of daily living (ADL). The MDS assessment indicated the resident had an unhealed stage 4 pressure ulcer. The MDS assessment revealed the resident did not refuse care. B. Observations On 2/10/25 at 3:27 p.m. Resident #2 was lying in bed. There were no pillows or wedges in bed to help offload pressure areas on his coccyx or knees. There were no pillow or wedges observed in the room other than the ones under Resident #2's head. -Resident #2 failed to have off loading interventions in place. On 2/10/25 at 3:49 p.m. Registered nurse (RN) #1 was observed providing wound care to Resident #2's left knee wound. RN # 1 applied gloves and removed the old dressing of Kerlix (rolled gauze) around the resident's knee. There was no abdominal (ABD) pad underneath the Kerlix dressing. There was visible wet and dry serosanguineous drainage on the dressing. The Kerlix was stuck to the wound bed and RN #1 pulled the dressing off the wound bed without attempting to moisten it to loosen it. RN #1 then took dry gauze pads and dabbed the open wound bed. RN #1 dabbed the wound four times with the same piece of gauze. After dabbing the resident's wound with the gauze, RN #1 removed her gloves and applied new gloves. RN #1 collected a cotton tipped applicator and a cup with medi honey gel (a treatment for wounds) and applied the medi honey to the wound bed using the cotton tipped applicator. RN #1 took an ABD and placed it over the wound bed, securing the ABD pad with Kerlix around Resident #2's leg to hold the dressing in place. The dressing was secured by RN #1 with tape. RN #1 dated and initialed the dressing. -RN #1 failed to remove the old dressing without potentially causing damage to healthy tissue and she failed to clean the wound bed. -RN #1 failed to perform hand hygiene when changing her gloves. C. Record review Review of the February 2025 CPO, on 2/6/25 at 6:30 p.m., failed to reveal a physician's order for wound care treatment for Resident #2's left lateral knee wound. On 2/10/25, at 7:30 p.m. upon discovery that Resident #2 did not have a physician's order for treatment of his left knee wound, the following physician's order was entered into the resident's electronic medical record (EMR): Cleanse wound with normal saline (NS) or wound cleanser, pat the wound dry after cleaning, apply MediHoney (specialized wound ointment), cover the wound with an abdominal pad (ABD) and wrap with Kerlex (rolled gauze) at hour of sleep (HS). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #2's care plan, revised 1/29/25, revealed the resident had chronic non-healing wounds and was admitted with chronic wounds. The resident had a history of pressure ulcers, immobility and paralysis. Pertinent interventions for chronic wound management included the use of a specialty air mattress, knee protectors, a wheelchair cushion for pressure relief, and encouragement of good nutrition and hydration to promote healing. -However, observation on 2/10/25 revealed there were no pillows or wedges in bed to help offload pressure areas on the resident's coccyx or knees (see observations above). The wound care physician's (WCP) progress note dated 1/28/25, documented a stage 3 full-thickness pressure wound to Resident #2's left knee. The WCP documented the wound was a chronic, recurring pressure wound due to the resident's contractures, inability to maintain repositioning, and compromised skin quality, making reoccurrence unavoidable. The dressing treatment plan included applying Leptospermum honey, a non-adherent pad (Telfa), and securing the wound with a gauze roll (Kerlix) and retention tape, all done once daily for 30 days. The note emphasized the need to offload the wound, reposition the resident, per facility protocol, and turn the resident side to side in bed every one to two hours if able. -However, observations of Resident #2's wound care on 2/10/25 revealed there was not a non-adherent Telfa pad underneath the resident's old wound dressing and RN #1 applied an ABD pad, which was not a non-adherent pad, to the resident's left knee wound when she applied a new dressing (see wound observations above). -Additionally, the physician's order entered into Resident #2's EMR on 2/10/25 (during the survey) indicated the use of an ABD pad and not a non-adherent Telfa pad, as was specified in the WCP's 1/28/25 progress note (see wound care order above). IV. Staff interviews RN #1 was interviewed on 2/10/25 at 4:06 p.m. RN #1 said she reviewed the wound care orders in the electronic medical record (EMR) system prior to completing Resident #2's treatment. RN #1 reviewed the resident's wound treatment orders again and said she was unable to locate a dressing order for the resident's left knee wound. RN #1 said she was unable to find the physician's order prior to providing care so she took it upon herself to find the order in the wound care physician's (WCP) orders from his last visit on 1/28/25. RN #1 said she completed the dressing change based on the WCP's wound visit notes. RN #1 said the wound dressing order should have been in the order section of the resident's EMR to ensure the nurses providing care were following the physician's orders. 47064

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52288 Based on observations, record review, and interviews, the facility failed to manage pain in a manner consistent with professional standards of practice for one (#13) of four residents reviewed for pain out of 16 sample residents. Specifically, the facility failed to: -Ensure a thorough pain assessment was completed for Resident #13 which included recognizing the onset, presence of and characteristics of pain; and, -Offer non-pharmaceutical interventions before administering as needed pain medication. Findings include: I. Facility policy and procedure The Pain-Clinical Protocol, revised October 2022, was received from the nursing home administrator (NHA) on 2/6/25 at 4:05 p.m. It read in pertinent part, The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity. Staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level. II. Resident #13 A. Resident status Resident #13, age 75, was admitted [DATE]. According to the January 2025 computerized physician orders (CPO), diagnoses included, pain in the right leg, mood disturbance, chronic obstructive pulmonary disease with acute exacerbation, and cerebral infarction without residual deficit (stroke). The 2/3/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The resident required extensive assistance from one staff member for all activities of daily living (ALDs). The MDS assessment documented Resident #13 was not on a scheduled pain medication regimen but did receive as needed pain medication. The resident did not receive any non-medication interventions for pain management. B. Observations On 2/5/25 at 2:00 p.m. the resident was lying in bed on her left side. She was crying and moaning while with her eyes closed. The registered nurse (RN) #1 was notified and went in to assess the resident. Registered nurse (RN) #1 assessed the resident for pain. The resident did not respond and she continued to cry and moan. RN #1 said she would inform the resident's nurse as she was not the licensed nurse for the resident. (continued on next page)

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	065247	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Village Care Center	110 W Van Buren St Colorado Springs, CO 80907

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At approximately 11:30 a.m. certified nurse aide (CNA) #2 assisted Resident #13 out of the facility for dialysis. As she left the room, she continued to moan as she was being transported by staff. On 2/6/25 at 9:14 a.m. Resident #13 was lying in bed and was moaning and crying. C. Record review The baseline care plan, dated 1/28/25, revealed the resident experienced intermittent pain located in the bilateral legs and feet. The interventions included providing opioids for pain management. -The baseline care plan did not include any non-pharmaceutical interventions or a scheduled pain management regimen. Review of the resident's electronic medical record (EMR) did not reveal a pain assessment was completed to identify the potential for pain, recognizing the onset, presence of pain and failed to assess the characteristics of pain upon admission. Review of the February 2025 CPO did not reveal a physician's order to indicate what type of pain scale was to be used to assess the resident's pain. Further review of the February 2025 CPO revealed the following physician's order for pain control included: -Oxycodone HCL Oral tablet 5 milligrams (mg) by mouth every 12 hours as needed for pain start with a start date of 2/5/25. Review of the February 2025 (2/5/25 to 2/6/25) medication administration record (MAR) revealed the resident was administered Oxycodone HCL 5 mg on 2/5/25 and 2/6/25. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 2/6/25 at 1:15 p.m. LPN #1 said Resident #13 was moaning and crying related to discomfort on 2/5/25 (see observations above). He said the resident had discomfort from a sacral wound and other comorbidities. LPN #1 said repositioning the resident was difficult due to the sacral wound. He said the resident frequently cried out in discomfort. LPN #1 said the resident was receiving rehabilitation care and the family had expressed interest in starting hospice services for improved pain management. LPN #1 said pain assessments should be completed at admission, with a change in condition and at least quarterly. -However, review of the resident's EMR did not reveal a pain assessment was completed since the resident's admission on 1/28/25 (see record review above). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 2/6/25 at 3:43 p.m. The DON said pain assessments should be completed upon admission, with a change in condition and at least quarterly. The DON said there was a lot of redundancy in pain assessments. The DON said the MAR was more accurate and reliable for tracking pain assessments. The DON said she would look into the issue and ensure that all aspects of pain assessments, such as pain level, tolerable pain level, and factors that improve or worsen pain were consistently reviewed and documented. The DON said there was no documented pain goal for Resident #13. The DON reviewed Resident #13's MAR and said there was no documentation that non-pharmaceutical interventions were attempted. She said prior to the administration of an as needed pain medication, a non-pharmaceutical intervention should be offered. She said non-pharmaceutical interventions should be assessed upon admission and included in the care plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47064 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infections. Specifically, the facility failed to: -Ensure proper infection control practices were followed for wound care; and -Ensure hand hygiene was performed appropriately. Findings include: I. Facility policy and procedure The Wound Care policy and procedure, revised October 2010, was received from the director of nursing (DON) on 2/10/25 at 6:50 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Use disposable cloth (paper towel is adequate) to establish a clean field on the residents' overbed table. Place all items to be used during the procedure on the clean field. Arrange supplies so they can be easily reached. Wash and dry your hands thoroughly. Position resident. Place disposable cloth next to the resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Put on exam gloves. Loosen tape and remove dressing. Pull the glove over the dressing and discard the dressing into the appropriate receptacle. Wash and dry your hands thoroughly. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. Remove disposable cloth next to the resident and discard into the designated container. Remove disposable gloves and discard them into designated containers. Wash and dry your hands thoroughly. The Handwashing/Hand Hygiene policy and procedure, revised October 2023, was received from the DON on 2/10/25 at 6:50 p.m. It revealed in pertinent part The facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hand hygiene is indicated: immediately before touching the resident; before performing an aseptic task; after contact with blood, body fluids, or contaminated surfaces; after touching the resident; after touching the resident environment; before moving from work on a soiled body site to a clean body site on the same resident; and immediately after glove removal. The use of gloves does not replace hand washing/ hand hygiene. II. Observations On 2/10/25 at 3:27 p.m. registered nurse (RN) #1 was providing wound care to Resident #2. RN #1 entered Resident #2's room after applying personal protective equipment (PPE). RN #1 cleared Resident #2's bedside table of personal items, wiped the table down with a disinfectant wipe and allowed it to air dry. RN #1 returned to the room doorway where she left the treatment cart. She began collecting packages of gauze, abdominal pads (ABDs), a medicine cup with Medi Honey gel (specialized ointment used for wounds), package of long cotton tip applicators (similar to a Q-tip) and packages of scissors. RN #1 returned to the resident's bedside table and placed all supplies onto the table. -RN #1 failed to put a barrier pad onto the bedside table and failed to change her gloves and perform hand hygiene after touching the treatment cart. RN #1 was assisted by certified nurse aide (CNA) #1 to roll the resident onto his right shoulder. RN #1 removed the old dressing to the residents buttock area which was soiled with serosanguinous (clear and bloody mix of fluids) drainage and placed it into the trash can. RN #1 removed her gloves and applied new gloves without washing her hands. She then went to the treatment cart and opened two packages of drain sponges to which she applied wound cleanser to. RN #1 returned to the resident's bedside. She took one drain sponge and cleaned the larger wound to the buttock. RN #1 dabbed the same piece of sponge over the entire wound dabbing the wound eight times with the same sponge. RN #1 then took a second sponge and cleaned two other open areas on the resident buttock, dabbing each wound four times. -RN #1 failed to place a barrier pad under the resident for wound care. RN #1 failed to perform hand hygiene between glove changes. RN #1 failed to use a clean sponge for each site and failed to only wipe once with each sponge used. RN #1 then removed her gloves, applied new gloves and went to the treatment cart again. She opened a bottle of half strength Dakins (specialized wound liquid treatment) and opened the drawers to the treatment cart to locate a package of Kerlex (rolled gauze). RN #1 opened a package of Kerlex and applied the Dakins to the Kerlex. RN #1 returned to the resident and opened the package of sterile scissors. RN #1 measured the rolled gauze and cut to fit the larger wound on the buttock. RN #1 applied the Dakins soaked gauze on the two other sites on the buttock. RN #1 opened two packages of ABD dressing placing them over the large wound and taped them down with CNA #1 assisting to hold the ABDs in place. RN #1 then opened a third ABD dressing to cover the smaller wounds. -RN #1 failed to perform hand hygiene after removing her gloves. RN #1 opened the treatment cart drawers, dressing packages and the Dakins bottle with the same gloves she used to apply the dressing to the resident's wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN #1 removed her gloves and applied new gloves. RN #1 said she was going to complete the left knee dressing. -RN #1 failed to complete hand hygiene after removing her gloves and prior to applying the new set. RN #1 removed the old dressing to the resident's left knee. There were visible areas of wet and dry serosanguinous drainage dried on the Kerlex when she removed it. RN #1 then took dry gauze to the wound bed dabbing the wound four times with the same piece of gauze. RN #1 removed her gloves and put on new gloves. -RN #1 failed to place a barrier pad under the resident's left knee. RN #1 failed to clean the wound and failed to perform hand hygiene after removing her gloves and prior to applying the new set of gloves. III. Staff interviews RN #1 was interviewed on 2/10/25 at 4:06 p.m. RN #1 said she should have placed a barrier pad under each wound to prevent contamination of drainage onto linens or into the resident's wound. RN #1 said she should have at least used hand sanitizer when changing her gloves during wound care. RN #1 said hand hygiene was important to prevent the spread of infection. RN #1 said she was not aware that she did not clean the left knee wound with anything. The DON was interviewed on 2/10/25 at 4:49 p.m. She said the nurse should have placed a barrier pad on the bedside table after wiping it down with disinfectant to establish a clean working field. The DON said the nurse should have prepared all the items needed for the dressing change, so she would not need to go back to the treatment cart. The DON said having all supplies ready would decrease the possibility of infection. The DON said the nurses needed to complete hand hygiene with soap and water or alcohol based hand sanitizer when removing or changing gloves. The DON said hand hygiene was important to prevent the spread of infection. The DON said the nurses should only use a gauze once when cleaning a wound to prevent the spread of infection from one site to another. The DON said using the same piece of gauze multiple times increased the risk of infection. The wound care physician (WCP) was interviewed on 2/10/25 at 6:20 p.m. The WCP said Resident #2 had a history of osteomyelitis and infection prevention was a key component to maintaining current wound healing measures.