STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065254	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunny Vista Living Center	2445 E Cache LA Poudre St Colorado Springs, CO 80909

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure five (#63, #46, #73, #112 and #50) of nine residents were free from chemical restraints and were receiving the least restrictive approach for their needs out of 52 sample residents. Specifically, the facility failed to:-Ensure prescribed as needed (PRN) antipsychotic medication for Resident #63 had corresponding documentation of identified behaviors and use of non-pharmological interventions; -Ensure resident specific care approaches, to include medication specific target behaviors and person-centered interventions were documented and monitored for Resident #63, #46, #73, and #112's psychotropic medications; and,-Identify specific resident behaviors, conduct behavior monitoring and ensure the least restrictive intervention was used prior to administration of psychotropic medications for Resident #50's.Findings include: I. Facility policy and procedure The Psychotropic Medication Management policy, approved December 2024, was provided by the nursing home administrator (NHA) on 7/24/25 at 11:00 a.m. It revealed in pertinent part, Psychotropic medications include but are not limited to the categories of anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications. All medications included in this definition may affect brain activities associated with mental processes and behavior and may include medications such as central nervous system agents, mood stabilizers, NMDA receptor modulators and over the counter natural or herbal products. Antipsychotic medications may be indicated if: behavioral symptoms present a danger to the resident or others, expressions or indications that cause significant distress to the resident, or iff not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress. If antipsychotic medications are prescribed, documentation must show; indication for the antipsychotic medication, multiple attempts to implement care planned, non-pharmacological approaches, and ongoing evaluation of the effectiveness of the interventions with rationale for decisions.” II. Resident #63 A. Resident status Resident #63, over the age of 75, was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included anxiety, major depressive disorder and dementia. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 7/8/25 minimum data set (MDS) assessment revealed Resident #63 had severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15. The MDS assessment indicated the resident had behaviors of difficulty focusing his attention, disorganized thought processes, hallucinations, and delusions. B. Record review The behavior care plan, revised 4/16/25, revealed Resident #63 had a diagnosis of major depressive disorder, anxiety, and insomnia. The resident displayed behaviors of difficulty sleeping, irritability, tearful/sad, and anxiety with movement. Interventions included monitoring for intentional acts of harming self or others, refusing to eat or drink, refusing medications or therapies, a sense of hopelessness or helplessness, impaired judgment or safety awareness (initiated 4/7/25). -The behavioral care plan failed to document triggers for Resident #63’s behavior and provide person-centered interventions. The comprehensive care plan did not include documentation of Resident #63’s use of anti-psychotic medications. Review of Resident #63’s July 2025 CPO revealed the following physician’s orders: Trazodone (an antidepressant medication) 50 milligram (mg). Give 0.5 mg at bedtime for insomnia, ordered 6/29/25. Monitor behaviors for major depressive disorder and anxiety: difficulty sleeping, irritability, tearful/sad, anxious with movement, and can be abrasive. Non-pharmological interventions included: 1. Redirect. 2. Provide one-on-one. 3. Offer snacks or drinks. 4. Offer to come out of the room. 5. Contact family for additional support, ordered on 4/30/25 and discontinued on 7/23/25 (during the survey process). Haloperidol (an antipsychotic medication) liquid concentrate 2 mg/ml (milliliter). Give 0.25 ml every 12 hours as needed (PRN) for agitation.- ordered on 7/19/25 with an indicated end date of 8/1/25. The medication was discontinued 7/22/25 (during the survey process). Risperdal (an antipsychotic medication) 0.5 mg. Give one time a day for dementia with psychosis, ordered 7/23/25. Review of the medication administration record (MAR) and treatment admission record (TAR) from 7/1/25 to 7/22/25 revealed the following: Haloperidol was administered to Resident #63 on 7/19/25 and 7/22/25. Behavior monitoring reviewed for 7/1/25 to 7/22/25 failed to document the resident’s behaviors on 7/19/25 and 7/22/25. Review of Resident #63’s electronic medical record (EMR) from 4/1/25 to 7/23/25 revealed the following: (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note, dated 7/19/25 at 2:24 a.m., revealed the resident had been yelling and displaying restlessness due to pain. The resident pulled out his catheter, began hitting himself in the head and ribs, and tried to communicate his needs to the nurses. The resident calmed down briefly after the catheter had been reinserted but then began to hit himself again. The nurse called the responsible party and requested to administer anti-psychotic medication to the resident to calm him down. The nurse notified the physician who advised the inappropriateness of medication at this time (use of the anti-psychotic medication) and instructed the nurse to send the resident to the hospital for further evaluation of his expressed pain. The resident was transported to the hospital. A nursing note, dated 7/19/25 at 12:04 p.m., revealed the resident had returned from the hospital with orders for Amoxicillin (an antibiotic medication) twice a day for 10 days related to a diagnosis of a urinary tract infection (UTI). A readmission note, dated 7/19/25 at 1:21 p.m., revealed the resident's mood had been pleasant with no behaviors witnessed. A nursing note, dated 7/19/25 at 2:50 p.m., documented due to Resident #63’s displayed behaviors of agitation the previous night, the on-call provider ordered Haloperidol 0.25 ml every 12 hours PRN for agitation. However, the nurses note on 7/19/25 at 2:24 a.m. documented the provider communicated the use of an anti-psychotic medication for Resident #63’s behavior was inappropriate. -Review of Resident #63's progress notes in the electronic medical record (EMR) failed to reveal behaviors on 7/19/25 and 7/22/25 when the Haloperidol had been administered for agitation. A nursing note, dated 7/23/25 at 8:32 a.m. (during the survey process), revealed Resident #63 was restless and agitated. He had ripped his nasal cannula off, removed some of his clothing and picked at his skin and catheter. The staff offered distractions and offered to call his family, but the resident remained agitated. A physician note, dated 7/23/25 at 9:45 a.m. (during the survey process), documented the physician’s order for Haloperidol was due to the resident’s fluctuating hospice care. It indicated the Haloperidol was used for delusions, self-harming behaviors and hallucinations. -However the CPOs revealed the PRN Haloperidol was ordered on 7/19/25, which was the date of Resident #63’s agitation due to his expressed pain from the catheter. The resident’s medical record failed to document any other behaviors of agitation prior to the start of the medication on 7/19/25. A review of the EMR failed to document Resident #63 had been receiving hospice care from his admission date of 4/1/25 to 7/23/25, when the resident’s responsible party was contacted (during the survey process) by the social services director (SSD) to consider hospice support for the resident. A review of the Resident #63's comprehensive care plan and behavior monitoring failed to document any behaviors of hallucinations or self-harm. III. Resident #46 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #46, over the age of 75, was admitted on [DATE]. According to the July 2025 CPOs, diagnoses included dementia and major depressive disorder. The 7/8/25 MDS assessment revealed Resident #46 had severe cognitive impairment with a BIMS score of seven out of 15. The MDS assessment indicated the resident had behaviors of hallucinations and rejecting care. B. Record review The behavior care plan, revised 11/13/24, revealed Resident #46 had a diagnosis of major depressive disorder, anxiety, and dementia. Behaviors included depressed mood, crying/tearfulness, self-isolation, verbal aggression, and visual hallucinations. Interventions included monitoring for signs and symptoms of hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing, negative statements, repetitive anxious or health-related complaints, tearfulness. Non-pharmological interventions included providing meaningful activities of interest, encouraging the resident to express their feelings, and providing adequate rest periods. The psychosocial care plan, initiated 11/13/24, revealed Resident #46 was prescribed an antipsychotic medication due to a diagnosis of dementia. Interventions included monitoring for adverse reactions (side effects), administering medication as ordered, and providing education to the resident and/or family regarding risks, benefits, and side effects. The mood care plan, revised 4/7/25, revealed Resident #46 was prescribed an antidepressant medication due to a diagnosis of dementia with behavioral disturbances. Interventions included monitoring for behavior/mood/cognition; hallucinations/delusions, social isolation, suicidal thoughts and withdrawn behaviors. A review of Resident #46’s July 2025 CPO revealed the following physician’s orders: Lexapro (an antidepressant medication) 5 mg. Give once a day for dementia- ordered 1/10/25. Monitor behaviors for depressed mood: crying/tearful, self-isolation, and hallucinations (believing staff are trying to kill her). If the behavior occurs, document in a behavior progress note the description of behavior, non-pharmacological interventions, and resident response. Interventions included repositioning, offering snacks or drinks, redirect to an activity, offer independent activities, assist outside, call a loved one, sit with the resident and provide active listening- ordered 11/28/23. Seroquel (an antipsychotic medication) 25 mg. Give 0.5 tablet twice a day for dementia with severe psychotic disturbances - ordered on 6/26/25. Mood charting for one month- Add a progress note at the end of each shift documenting overall mood. Examples: Positive mood, attending activities, happy demeanor, increased isolation, declining cares, increased hours of sleep, decreased appetite every shift, ordered on 6/26/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #46’s MAR and TAR from 6/1/25 to 7/23/25 did not reveal Resident #46 exhibited any behaviors Review of Resident #46’s EMR from 5/23/25 to 7/23/25 revealed the following: A nursing note, dated 7/7/25, revealed the resident refused pericare or a shower. -The resident’s EMR failed to reveal any additional documentation of behaviors displayed or mood charting had been completed as ordered by the physician. A psychologist progress note, dated 6/11/25, revealed the psychologist completed a diagnostic depression screening for Resident #46, which revealed a score of 10 out of 27, which indicated moderate depression. The psychologist documented the resident had symptoms of severe dementia with distressing delusional thinking and visual hallucinations. The recommended non-pharmological interventions included: behavioral and psychological interventions such as validation therapy with the resident by acknowledging feelings and perceptions rather than challenging delusions directly, with focus on empathy rather than confrontation; providing reminiscence therapy, such as using photos, music, or objects from the past to trigger positive memories and reduce anxiety or confusion that can lead to delusions; environmental modifications to reduce triggers such as identifying and removing triggers of hallucinations or delusions such as e.g., shadows, mirrors, noisy rooms; and providing sensory based interventions such as music therapy with personalized playlist or familiar soothing music to reduce agitation, anxiety, and delusional thinking. A psychologist progress note, dated 7/9/25, revealed the psychologist received historical details from the nursing staff regarding Resident #43’s behavior. The behaviors included on 6/29/25, the resident appeared withdrawn; on 6/27/25, the resident had episodes of hallucinations; on 7/3/25, the resident refused and tried to swat at a nurse; and on 7/4/25, the resident had episodes of hallucinations throughout the night. -A review of the progress notes and behavior monitoring in Resident #46’s EMR failed to reveal documentation of the behaviors communicated to the psychologist, descriptions of the behaviors, and any effective non-pharmacological interventions. A psychologist progress note, dated 7/7/25, revealed the resident had exhibited symptoms of non-compliance with care, hallucinations, delusions, and withdrawn behavior. -Review of Resident #46's EMR failed to reveal the individualized non-pharmological interventions recommendations made by the psychologist had been incorporated into the comprehensive care plan or behavior monitoring. The trauma screening, dated 10/9/24, documented Resident #46 did not suffer from any indicators of trauma responses. The trauma screening, dated 4/2/25, revealed Resident #46 suffered from sleep disturbances, upsetting thoughts or memories that were intrusive related to trauma, and acted as though the event was happening. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	It did not provide additional documentation to indicate the specifics of the resident’s experienced trauma, nor how it had changed from 10/9/24 to 4/2/25. The trauma screening, dated 7/8/25, revealed Resident #46 suffered from upsetting thoughts or memories that were intrusive related to the trauma, upsetting dreams/nightmares regarding the trauma, acting as though the event was happening, bodily reactions such as fast heartbeat, dizziness, sweatiness, or stomach churning when reminded of the event, irritability or outbursts of anger, heighten awareness of potential dangers to self (hypervigilance), and being jumpy and easily startled. -Review of Resident #46's EMR failed to reveal that the increase of trauma responses were incorporated into the comprehensive care plan or behavior monitoring. IV. Resident #73 A. Resident status Resident #73, under the age of 65, was admitted on [DATE]. According to the July 2025 CPOs, diagnoses included intellectual disability and anxiety. The 5/12/25 MDS assessment revealed Resident #73 had mild cognitive impairments with a BIMS score of 11 out of 15. The MDS assessment indicated the resident did not have behaviors. B. Record review The behavior care plan, revised 8/12/24, revealed Resident #73 had behaviors of verbal and physical aggression, yelling, making sexually inappropriate statements/comments, angry outbursts when his personal belongings were misplaced, self-isolation, and being worrisome. Interventions included providing a room change to a quieter environment to assist the resident in being calm and relaxed. -There were no additional person-centered interventions documented for the resident's identified behaviors in the behavior care plan. Review of Resident #73’s July 2025 CPO revealed the following physician’s orders: Duloxetine (an antidepressant medication) 60 mg. Give once a day for depression- ordered 6/23/24. Monitor for behaviors of angry outbursts when he felt his personal belongings (toys) were moved or lost, withdrawn, self-isolating behaviors, worries, sexually inappropriate comments to staff and homicidal statements, ordered 11/18/22. Monitor for behaviors for antidepressant use of angry outbursts when he felt his personal belongings (toys) were moved or lost, withdrawn, self-isolating behaviors, worries, sexually inappropriate comments to staff and homicidal statements. Interventions included providing redirection, offering one to one support, offering activities, returning the resident to his room, offering toileting, offering food and fluids, adjusting the room temperature, calling the family for support and providing medications as ordered - ordered 7/22/25 (during the survey process). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of Resident #73’s July 2025 CPO revealed non-pharmological interventions were not included in the behavior monitoring as a least restrictive alternative until 7/22/25 (during the survey process). Review of Resident #73’s MAR and TAR from 5/1/25 to 7/23/25 revealed Resident #73 did not exhibit any documented behaviors except on 7/8/25 and 7/23/25,. -The behavior monitoring did not indicate the specific behaviors Resident #73 displayed. A review of Resident #73’s EMR from 5/23/25 to 7/23/25 revealed the following: A nursing note, dated 5/23/25, revealed that due to blood sugar levels, the physician instructed the nurse to hold the resident's insulin. When the resident was informed, he became upset, told the nurse he would end up in the hospital, it would be the nurses fault and her job would be on the line. A behavior note, dated 6/5/25, revealed the resident had been frustrated with his glucose monitor when the display read 'high' instead of displaying numbers. As a result, the resident threw the monitor at the wall. The note failed to include the non-pharmacological interventions provided and Resident #73's response. A nursing note, dated 7/3/25, indicated the resident had made negative comments to a certified nurse aide (CNA), however it failed to include a description of the behavior, the non-pharmacological interventions attempted and Resident #73's response. A risk management note, dated 7/10/25, revealed the resident became frustrated and communicated in a manner that may have unintentionally come across as unpleasant. The facility moved the staff member to another unit. The progress note failed to include a description of the behavior, the non-pharmacological interventions tried and Resident #73's response to the non-pharmacological intervention of removing the staff member from his care and care unit. A nursing note, dated 7/19/25, revealed the resident was upset when he asked for a condiment that was unavailable. The resident threw his plate on the floor, breaking the plate. The resident went to his room and began yelling at the nurse and throwing items out of a bag onto the floor. The nurse left the resident alone in his room. Approximately 20 minutes later, the resident appeared to be calm, but refused to eat. -A review of Resident #73's progress notes in the EMR failed to reveal any additional behaviors displayed or behaviors on 7/8/25 or 7/22/25 when the TAR indicated behaviors had occurred. V. Resident #112 A. Resident status Resident #112, age of 69, was admitted on [DATE]. According to the July 2025 CPO, diagnoses included schizoaffective disorder, major depressive disorder and cognitive communication deficits. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/29/25 MDS assessment revealed Resident #112 was cognitively intact with a BIMS score of 15 out of 15. The MDS assessment indicated the resident did not have behaviors. B. Record review The behavior care plan, revised 8/12/24, revealed Resident #112 had a diagnosis of schizoaffective disorder and depression with manifested behaviors such as self-isolation, delusions, false beliefs, crying and withdrawn. Interventions included monitoring for withdrawing, displaying delusions and false beliefs, and crying; encouraging the resident to express her feelings and attempt to determine the underlying cause of the behavior such as to consider the location, time of day, persons involved, and situation surrounding the behavior and document the potential causes; providing re-positioning; offering a snack or drink; redirecting to an activity; offering independent activity supplies; offering to call a loved one; assisting the resident to go outside; sitting with the resident as needed; and providing active listening and validation (initiated 10/29/21). A review of Resident #112’s July 2025 CPO revealed the following physician’s orders: Lexapro (an antidepressant medication) 10 mg. Give once a day for depression, ordered 2/8/25. Lamotrigine (an anticonvulsant medication used as a mood stabilizer) 25 mg. Give once a day for schizoaffective disorder, ordered on 2/27/25. Monitor for behaviors related to schizoaffective disorder: withdrawn to room, delusions, false beliefs, crying/tearful, and depression. If behavior occurred, document in the behavior progress note description of behavior, non-pharmacological interventions used and the resident’s response. Interventions included offering repositioning, snacks, fluids; redirecting the resident to an activity; offering independent activities; offering to call a loved one; assisting the resident outside; and sitting with the resident, ordered on 11/01/2020. A review of Resident #112’s MAR and TAR from 5/1/25 to 7/23/25 revealed the resident did not exhibit any behaviors from 5/1/25 to 7/23/25. A review of Resident #112’s EMR from 5/1/25 to 7/23/25 revealed the following: A social services summary note, dated 5/14/25, revealed the resident had a recent depression screen with a score of six out of 27, which indicated mild depression and the resident expressed feeling down, depressed and hopeless. A social services note, dated 5/23/25, revealed a staff member reported the resident was acting out of character and said she did not want to be at the facility any longer. The SSD followed up and the resident, who denied suicidal ideations but could not explain why she made those statements. The resident signed a safety agreement. -A review of Resident #112's progress notes in the EMR did not reveal any additional behaviors displayed or mood charting. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The trauma screening, dated 10/9/24, revealed Resident #112 did not suffer from any indicators of trauma responses. The trauma screening, dated 4/20/25, revealed Resident #112 suffered from sleep disturbances, upsetting thoughts or memories that were intrusive related to trauma, upsetting dreams/nightmares regarding the trauma, feeling upset about reminders of the trauma, difficulty with concentrating, heighten awareness of potential dangers to self (hypervigilance), and being jumpy and easily startled. However, the trauma screening did not provide details regarding the resident’s experienced trauma, nor any documentation in the EMR to indicate an event had occurred between 10/9/24 and 4/20/25 to explain the difference in the trauma screenings. The facility failed to ensure trauma informed care was included in the comprehensive plan of care and behavior monitoring. A psychologist progress note, dated 7/7/25, revealed the psychologist completed a depression screen with Resident #112 and the score was an eight out of 27 and documented the resident had displayed behaviors of non-compliance with care and appetite disturbances. -The 7/7/25 psychologist visit note depression screen indicated Resident #112’s depression screen score had increased from a six on 5/14/25 (see above) to a eight, however, updated and changes were not made to Resident #112's comprehensive care plan or behavior monitoring. A psychologist progress note, dated 7/9/25, revealed Resident #112 had displayed behaviors of visual and auditory hallucinations intermittently. The psychologist recommended the following non-pharmological interventions: providing psychoeducation on the nature of schizoaffective disorder and depressive symptoms with early warning signs of relapse; enhancing the family’s ability to support the resident’s recovery and avoid relapse triggers; providing wellness interventions of regular exercise to improve depressive symptoms and cognitive function; promoting healthy diet and sleep hygiene to stabilize mood and energy levels; and providing stress management techniques to include meditation, relaxation training and journaling. A psychologist progress note, dated 7/15/25, revealed recommendations monitoring any changes in mood and behavior i.e., cognitive functioning, psychosis, depression, sleep disturbance, irritability, low frustration and stress tolerance, sensory dysregulation, mental and physical fatigue, and behavioral disturbance; encouraging adherence to daily schedules; and providing opportunities during the day for cognitive and mental stimulation. -A review of Resident #112's EMR failed to reveal documentation of resident specific behaviors to monitor and individualized non-pharmological intervention recommendations made by the psychologist had been incorporated into the comprehensive care plan (last updated in 2024) or behavior monitoring (last updated in 2020). VII. Staff interviews (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #2 was interviewed on 7/22/25 at 12:20 p.m. RN #2 said when administering an as needed or PRN psychotropic medication, the nurse should document the observed behaviors, attempt non-pharmacological interventions, and then document if the interventions were effective or ineffective prior to medication administration. She said behaviors were documented TAR but the TAR did not always include non-pharmacological interventions. RN #2 said when the non-pharmacological interventions were not included on the TAR, the interventions were generic. She said the facility staff would do trial and error interventions, but the behavior monitoring on the TAR was not always updated with resident specific interventions. RN #2 said Resident #63 exhibited behaviors related to trying to express unmet needs. She said effective non-pharmacological interventions for that resident included siting with him and encouraging him to reminisce about his daughter and providing him snacks, especially soda. She said she had not seen an increase in agitation for Resident #63 and did not know why he was prescribed Haloperidol. RN #2 said Resident #46 had cognitive deficits with moments of agitation. She said effective non-pharmacological interventions included offering to decrease the stimulation in her room such as adjusting the lights and sounds as well as offering her favorite candies. RN #2 said Resident #73 displayed behaviors of anger, inappropriate comments and requests from female staff, and childish expressions. She said effective non-pharmacological interventions included encouraging or complimenting him on his crafts. She said he enjoyed making jewelry. She said when Resident #73 had strong feelings, he would express those feelings immediately, like a child. RN #2 said he had requested staff get into bed with him and he had also attempted to make inappropriate requests towards visiting family members he did not recognize. She said Resident #73 was able to be redirected without an angry outburst if the staff member reminded him how his inappropriate comments and requests made others feel. RN #2 said Resident #112 she was not aware of any exhibited behaviors and was social with staff and other residents. CNA #3 was interviewed on 7/22/25 at 12:30 p.m. She said the CNAs documented resident behaviors in the CNA charting system, but it only identified a list of generic behaviors and interventions. She said if the intervention was not listed, the CNA informed the nurse and the nurse documented the intervention in a progress note. CNA #3 said Resident #63 only displayed behaviors when he was in pain. She said when he was in pain, Resident #63 would become agitated, strike out at staff, or refuse care. She was not aware of any effective non-pharmacological interventions other than pain management. CNA #3 said Resident #46 did not exhibit any behaviors. CNA #3 said Resident #73 exhibited verbally inappropriate behaviors toward staff and other residents as well as anger outbursts. She said the effective non-pharmacological interventions included allowing the resident to calm down and offering him specific activities he enjoyed, such as art. CNA #3 said Resident #112 did exhibit any behaviors. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #4 was interviewed on 7/22/25 at 1:00 p.m. CNA #4 said nurse management would verbally communicate any newly displayed resident behaviors. She said interventions were not communicated by nursing management, however the CNAs talked amongst themselves to determine interventions that worked for each resident CNA #4 said Resident #63 had not exhibited behaviors lately, but used to strike out at staff when attempting to provide care if he was in pain. She said the resident had not done this for the past month. She said effective interventions included singing and providing him space when he was upset. CNA #4 said she was not aware of any behaviors for Resident #46 or Resident #112. CNA #4 said Resident #73 had behaviors of being sexually inappropriate toward staff and when he was told these comments or requests were inappropriate, he would become verbally abusive. She said she was not aware of any non-pharmological interventions that worked for him. Licensed practical nurse (LPN) #4 was interviewed on 7/22/25 at 1:12 p.m. LPN #4 said behaviors were documented in the nursing progress notes of the resident's EMR. She said she did not know where to find the resident specific behaviors or individualized non-pharmological interventions for behaviors. LPN #4 Resident #63 exhibited behaviors of agitation recently when he was diagnosed with a urinary tract infection but had calmed down after being treated with antibiotics. LPN #4 said he was prescribed Haloperidol for agitation PRN, but she was unable to locate any monitoring with indicators of agitation to administer the Haloperidol. LPN #4 said Resident #46 did exhibit any behaviors but could become agitated and refuse care. LPN #4 said effective non-pharmological interventions included calming her down, ensuring she was compliant with care, providing positive affirmations, and offering her pudding. LPN #4 said Resident #73 exhibited behaviors of yelling, using profanity, racial slurs, and making threats towards staff. LPN #4 said effective non-pharmological interventions included offering his favorite juice or coffee and providing him a private space, like his room, to yell and vent. LPN #4 said Resident #112 did not exhibit any behaviors and she was not aware why she was prescribed Lamotrigine. The social services director (SSD) #1, the NHA, and the assistant director of nursing (ADON) were interviewed together on 7/22/25 at 2:33 p.m. The NHA said resident behaviors were discussed in the morning and afternoon interdisciplinary (IDT) meetings every day. He said the floor nurses attended and contributed to those meetings. The NHA said he was not aware of the facility process for behavior monitoring. The ADON said she had been in her role as of February 2025 and there was no current DON in the facility. The ADON said when a resident admitted on a psychoactive medication or had been prescribed a psychoactive medication after admission, a behavior monitoring order was put into the CPO by the nurses. She said behaviors and non-pharmological interventions on the order should be resident specific and not generic. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SSD #1 said he had worked at the facility for approximately six weeks. He said behavior monitoring was reviewed during the psychoactive medication management meeting every quarter. The medical director (MD) was interviewed on 7/23/25 at 11:39 a.m. The MD said behavior monitoring should be documented in the EMR and reviewed during the quarterly psychotropic medication management meeting. He said behavior monitoring was utilized to determine

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure one (#4) of two residents who required respiratory support received care consistent with professional standards of practice out of 52 sample residents. Specifically the facility failed to obtain a physician ordered bilevel positive airway pressure (BiPAP) machine (a type of non-invasive ventilation that helps people breathe by providing pressurized air through a mask or nasal plugs) for Resident #4 to use during sleep hours.Findings include: I. Resident #4A. Resident statusResident #4, age [AGE], was admitted on [DATE] and discharged on 7/23/25 to the community. According to the July 2025 computerized physician orders (CPO), diagnoses included acute respiratory failure, obstructive sleep apnea (breathing stops during sleep) and tachycardia (heart beats too fast). The 5/22/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He had no behaviors and did not reject care. He required assistance with toileting, dressing, bathing and transferring. He required supervision with eating and oral hygiene. The MDS assessment indicated the resident utilized a BiPAP.B. Resident representative interviewResident #4's representative was interviewed on 7/21/25 at 10:30 a.m. The representative said Resident #4 was admitted to the facility in mid-May 2025 and did not have access to his BiPAP device from the time of his admission to the facility until 7/18/25. She said that the BiPAP machine was lost during the resident's hospitalization prior to admission, and although this information was communicated to facility staff upon admission, no replacement device was obtained until 7/18/25. The representative said the current BiPAP machine was a loaner device and he would still need his own personal machine upon his discharge to home. The representative said that the BiPAP machine replacement fell through the cracks with the nursing home facility and the facility did not follow up on obtaining a BiPAP machine in a timely manner. The representative said that Resident #4 did not experience any adverse effects or medical complications during the time he was without the BiPAP machine, however, she expressed concern that the lack of BiPAP therapy may have affected his memory or cognitive functioning.C. ObservationsOn 7/22/25 at 11:08 a.m. Resident #4 was speaking with social services director (SSD) #1 in the common area of the facility. During the conversation, the resident asked SSD #1 for an update on his BiPAP machine. SSD #1 responded that he was working on the resident's BiPAP.On 7/23/25 at 10:40 a.m. Resident #4 was being discharged from the facility, leaving with his wife while facility staff carried his belongings. Resident #4 said the facility had taken care of ordering his new BiPAP machine for home and he would receive it in the mail. D. Record reviewA review of the hospital discharge paperwork which accompanied Resident #4 upon admission to the facility, dated 5/22/25, revealed that several medications were check marked by facility nursing staff. -However, the order for the resident to have a BiPAP at bedtime did not have a checkmark. Review of Resident #4's July 2025 CPO revealed the resident had a physician's order for oxygen at 4 liters/minute via BiPAP at night only, ordered 5/22/25.-However, Resident #4 did not have access to a BiPAP machine from admission [DATE]) until 7/18/25 (see resident representative interview above and staff interviews below). Review of Resident #4's care plan, dated 5/23/25, identified the resident's need for nighttime BiPAP use related to ineffective gas exchange. Interventions included oxygen therapy and monitoring for signs and symptoms of respiratory distress. -However, the facility did not ensure Resident #4 had access to a BiPAP machine for almost two months after his admission to the facility (see resident representative interview above and staff interviews below).II. Staff interviewsRegistered nurse (RN) #2 was interviewed on 7/23/25 at 9:15 a.m. RN #2 said the facility had a few ways to ensure residents had a BiPAP machine for use upon admission. RN #2 said the facility checked for a physician's order, some residents brought their own devices, and if not, the facility worked with companies to obtain a BiPAP machine. RN #2 said once a BiPAP machine was in place, the nurses assessed the settings to ensure they were correct and functioning properly. RN #2 said the nurses also asked the resident if they were comfortable and observed them to ensure they were comfortable using the device. RN #2 said the BiPAP machine notified staff if it did not have a good seal on the resident's face so they could adjust it. RN #2 said she did not know why Resident #4 did not receive his BiPAP machine when he was admitted to the facility. RN #2 said she typically referred those situations to social services to see if they could get a loaner BiPAP machine. RN #2 said she did not know the reason for the delay for Resident #4's BiPAP. SSD #1 was interviewed on 7/23/25 at 10:52 a.m. SSD #1said that if a resident needed respiratory equipment, nursing handled the process of obtaining it. SSD #1 said that if the resident

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing for one (#12) of six residents out of 52 sample residents. Specifically, the facility failed to:-Ensure individualized care approaches were provided and monitored with ongoing assessment for Resident #12 in order to meet the emotional and psychosocial needs of the resident;-Ensure Resident #12, who had expressed suicidal ideations with intent and a history of trauma, was monitored for signs and symptoms of suicidal ideation; and, -Ensure expressions of suicidal ideations were addressed in a timely manner in order to secure Resident #12's safety.Findings include:I. Facility policy and procedureThe Psychosocial Evaluation Procedure policy, dated December 2024, was provided by the nursing home administrator (NHA) on 7/24/25 at 11:00 a.m. It revealed in pertinent part, If a member of the interdisciplinary team (IDT) notices the resident has element(s) of psychosocial unmet needs, such as but not limited to: self-injurious behavior or suicide ideation that IDT member initiates the psychosocial evaluation and notifies supervisor, each IDT member completes their section of the evaluation (if appropriate), the social services member completes the evaluation, and the psychosocial evaluation is used when reviewing psychotropic medications. II. Resident #12A. Resident statusResident #12, age [AGE], was admitted on [DATE]. According to the July 2025 computerized physician orders (CPO), diagnoses included post traumatic stress disorder (PTSD) and major depressive disorder. The 6/25/25 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 resident's depression screen assessment, dated 6/25/25, revealed Resident #12 had indicated she was moderately depressed with a score of 10 out of 27.B. Resident interview and observationResident #12 was interviewed on 7/21/25 at 1:46 p.m. Resident #12 said her depression was her own fault because she was struggling to adjust to placement in the facility. She said she had previously lived in an assisted living facility and had to move to long term care and leave all her close friends. Resident #12 said she made the decision to move to her current facility to be closer to her daughter, but she said she did not see her daughter often and the two of them fought frequently. She said the fighting triggered her depression and reminded her of what she had lost (former friends and independence). Resident #12 was evasive to answering questions regarding previous threats of self harm but did share a history of suicide attempts made by her mother. She said she was aware of how traumatic it would be for her family if she killed herself, but she said she still could not help thinking about it at times. During the interview, Resident #12 denied a current plan or intent to self harm. During the interview, Resident #12's window was observed to have a bar which prevented the window from opening more than approximately four inches. C. Record reviewThe mood care plan, revised 12/24/24, revealed Resident #12 had a diagnosis of PTSD and major depressive disorder. The resident suffered from childhood trauma manifesting as isolating in bed, declining activities of enjoyment, perseverations of childhood trauma and hallucinations. Interventions, initiated 9/18/24, included monitoring for signs and symptoms of hopelessness, anxiety, sadness, insomnia, anorexia, negative statements, and tearfulness. -The care plan failed to reveal any revisions to include threats of self harm after the 12/21/24 or 7/10/25 incidents (see psychologist visit notes and progress notes below).Review of Resident #12's July 2025 CPO revealed the following physician's orders:Effexor (an antidepressant) 75 milligrams (mg). Give 75 mg to equal 225 mg (three capsules) in the morning for major depressive disorder, ordered 9/18/24 and decreased 6/25/25 (see physician's order below).-Resident #12's dosage of the antidepressant was decreased on 6/25/25, despite recommendations by the physician managing the resident's psychoactive medications to not make reductions and instead add another antidepressant (see psychologist visit notes below). Effexor 150 mg. Give 150 mg to equal 225 mg (two capsules) in the morning for PTSD, ordered 9/21/24 and discontinued 7/9/25. Effexor 37.5 mg. Give one capsule in the morning for major depressive disorder, ordered 6/25/25. Behavior monitoring for depressed mood, self-isolating in bed, perseverations on trauma, perseverations on spouse and hallucinations. Non-pharmological interventions included to offer food/fluids, offer to call a loved one, take for a walk, validate feelings and encourage an activity, ordered 9/18/24. -The July 2025 CPO did not include a physician's order to monitor for potential signs and symptoms of suicidal ideation.Progress notes reviewed from 12/21/24 to 7/22/25 revealed the following:A nursing note, dated 12/21/24, revealed the nurse had followed up with Resident #12 regarding

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observations, record review and interviews, the facility failed to ensure proper storage of medications in two of four medication storage rooms and three of five medication carts.Specifically, the facility failed to:-Ensure medications were labeled with the date they were opened;-Ensure expired medications were removed and discarded from medication carts and storage refrigerators; and,-Ensure the temperature in a medication storage refrigerator was maintained within an acceptable temperature range. Findings include:I. Facility policy and procedureThe Medication Storage policy, dated January 2025, was received by the nursing home administrator (NHA) on 7/24/25 at 11:00 a.m. It read in pertinent part, Medications requiring refrigeration or temperatures between 2 degrees celsius (C)/(36 degrees fahrenheit (F) and 8 degrees C (46 degrees F) are kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place may be refrigerated unless otherwise directed on the label as cool temperatures are those between 8 degrees C (46 degrees F) and 15 degrees C (59 degrees F). A temperature log or tracking mechanism is maintained to verify that temperature has remained within accepted limits. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists.II. Failed to ensure medications were labeled with the date they were openedA. Observations and staff interviewsOn 7/23/25 at 3:23 p.m. the [NAME] 1 medication cart was observed with LPN #5. The following items were found:-An opened bottle of Lastacaft (allergy itch relief) 0.25% eye drops was labeled with a resident's name, but was not labeled with the date opened.LPN #5 said dates should be labeled on medications so staff were aware of when they were opened and when they needed to be discarded.On 7/23/25 at 4:39 p.m. the East 2 medication cart was observed with LPN #8. The following items were found:-An opened bottle of Flonase 50 microgram (mcg) nasal spray (steroid nasal spray) was labeled with a resident's name but was not labeled with the date opened. The pharmacy issue date listed on the bottle was 5/13/25. LPN #8 said Flonase nasal spray should be discarded 60 days after being opened.III. Failed to ensure expired medications were removed and discarded from medication carts and storage refrigeratorsA. Observations and staff interviewsOn 7/23/25 at 3:10 p.m., the [NAME] 1 medication storage room and medication refrigerator were observed with licensed practical nurse (LPN) #7. The following items were found:-A Bisacodyl 10 milligrams (mg) suppository (laxative) with an expiration date of April 2024.-Two individually packaged Bisacodyl 10 mg suppositories were labeled with a current resident's name. The suppositories had expiration dates of 12/16/24 and 4/11/25.LPN #7 said any nurse on duty could clean out the medication refrigerator. LPN #7 said expired medications could potentially harm and cause damage to a resident. -A box of DexcomG6 (glucose monitoring) sensors was not labeled with a resident's name and had an expiration date of 5/31/25.LPN #7 said the sensors were not kept as floor stock and should have a resident label. On 7/23/25 at 4:39 p.m. the East 2 medication cart was observed with LPN #8. The following items were found:-An opened bottle of Nighttime Relief lubricant (moisturizing) eye drops labeled with a resident's name. The product box instructed staff to discard the medication 30 days after opening. The open date labeled on the bottle was 5/15/25. LPN #8 confirmed the eye drops should have been discarded 30 days after the open date.-An opened Advair Diskus 250 mcg - 50 mcg inhaler was inside an Advair Diskus box labeled with a resident's name. The Advair Diskus containing the medication was labeled with the resident's name. The open date on the inhaler was 5/6/25.LPN #8 said the Advair Diskus medication should have been discarded 30 days after opening.-Additionally, an opened Albuterol inhaler was inside the Advair Diskus box alongside the Advair Diskus medication. The albuterol inhaler had a resident's room number written on it, which matched the room number written on the Advair Diskus box, but the inhaler was not labeled with the resident's name. The Albuterol inhaler did not have an open date labeled on it. LPN #8 confirmed the Albuterol inhaler should not have been in the box with the Advair Diskus. She confirmed the inhaler should have had a resident's name and an open date on it. LPN #8 said she would discard both inhalers and have them reordered. LPN #8 said the night shift nurse primarily audited the medication carts, however, she said all nurses should perform audits when passing medications to look for unlabeled and expired medications.-An opened tube of Equate anti-itch cream with an expiration date of May 2024.-An opened tube of Terbinafine hydrochloride 1% (antifungal) cream with an expiration date of June 2025.-An opened bottle of Ultra sunscreen lotion sun protection factor (SPF) 30 with an expiration date of 7/1/24.IV

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record review, the facility failed to store, distribute and serve food in a sanitary manner in the main kitchen. Specifically, the facility failed to:-Ensure kitchen equipment was stored in a clean and sanitary manner; and, -Ensure perishable foods were discarded after the date of expiration. Findings include: I. Failure to ensure stored kitchen equipment were clean and sanitary A. Professional referenceThe Colorado Department of Public Health and Environment (2021) The Colorado Retail Food Establishment Rules and Regulations, retrieved 7/30/25 revealed in pertinent part, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. (4-501.12) Non food-contact surfaces of equipment shall be kept free of accumulation of dust, dirt, food residue, and other debris. Non food-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. (4-601.11).B. ObservationsThe initial kitchen tour was conducted on 7/21/25 at 8:15 a.m. The following was observed-Eight stacks of steam table pans were on a metal storage shelf and had moisture in between the pans.-Three red , two green and two white cutting boards were scored.-One white cutting board had a large circular burn resembling the bottom of a pot. On 7/23/25 at 11:20 p.m. a walk through of the walk-in refrigerator was conducted with the regional dietary resource. The following was observed:-There were two scored red and one scored white cutting board (with numerous gouges creating more than superficial indentations) ; and,-Three steam table pans that were stacked on top of each other were on a shelf were and were wet in between the pans. II. Failure to ensure perishable foods were discarded after the expiration date A. Professional reference The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15)A. ObservationsThe initial kitchen tour was conducted on 7/21/25 at 8:15 a.m. The following was observed:-A pan labeled egg salad with a discard date of 7/7/25;-A pan of undated blueberries that had a white film on the exterior of the blueberries; and,-A pan of undated lettuce that had a white film on the exterior of the lettuce. III. Staff interviewsThe regional dietary resource was interviewed on 7/23/25 at 11:20 p.m. He said when cutting boards became scored, damaged or pitted the boards were replaced. He said if a cutting board was burned it was immediately replaced. The regional dietary resources said the kitchen staff utilized a cleaning schedule. He said twice a week when they received the food deliveries, the staff went through the walk-in refrigerator and discarded expired foods. He said if the kitchen staff saw any foods in the walk-in refrigerator that were spoiled, the food was to be thrown out right away. The regional dietary resource said there were drying racks for the steam table pans and the pans were to be completely dry before being stacked together. He said if the pans were stacked when wet, the moisture could cause bacteria growth. He said if the residents were served expired food it had the potential to make the residents ill if eaten by them.

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Sunny Vista Living Center	2445 E Cache LA Poudre St Colorado Springs, CO 80909

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Specifically, the facility failed to:-Ensure housekeeping staff completed proper hand hygiene, cleaned high-touch surfaces and followed the appropriate guidelines for disinfectant solution when cleaning residents' rooms; and,-Ensure appropriate infection control procedures were followed urinary catheter care for Resident #68. Findings include: I. Failed to ensure housekeeping staff completed proper hand hygiene, cleaned high-touch surfaces and followed the appropriate guidelines for disinfectant solution when cleaning residents’ rooms A. Professional references According to The Centers for Disease Control And Prevention’s (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers (February 2024), retrieved on 7/28/25 from: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, “Recommendations to clean your hands include immediately before touching a patient, before performing an aseptic technique, before moving from work on a soiled body site to a clean body site, after touching a patient or patient’s surroundings, after contact with body fluids and immediately after glove removal.” According to the CDC’s When and How to Clean and Disinfect a Facility (April 2024), retrieved on 7/28/25 from https://www.cdc.gov/hygiene/about/when-and-how-to-clean-and-disinfect-a-facility.html#:~:text=At%20a%20glance,people%20have%20obviously%20been%20ill, “Regularly cleaning surfaces in your facility helps prevent the spread of germs that make people sick. Clean high-touch surfaces regularly (pens, counters, shopping carts, door handles, stair rails, elevator buttons and touchpads). Clean other surfaces that are visibly dirty.” According to the The Waxie Product Specification Sheet for 764 Lemon Quat Disinfectant Cleaner (2022), retrieved on 7/28/25 from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.waxie.com/pdf/spec-sheets/170700-WAXIE-spec-sheet.pdf on 7/28/25, “Every microorganism tested with the disinfectant aside from COVID-19, had a contact time of 10 minutes. Contact time for COVID-19 was one minute. B. Facility policy and procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Hand Hygiene policy and procedure, revised December 2024, was received from the nursing home administrator (NHA) on 7/24/25 at 11:00 a.m. It documented in pertinent part, “The facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene includes both handwashing and the use of alcohol-based hand sanitizer. In most situations, the preferred method of hand hygiene is with 70% (percent) alcohol-based hand sanitizer, as it is proven most effective. The following situations require the use of hand washing of 20 seconds using soap and water: when hands are visibly dirty or soiled, after contact with blood, bodily fluids, secretions, mucous membranes, or non-intact skin, after handling items potentially contaminated with blood, bodily fluids, or secretion, and before eating and after using a restroom.” C. Observations During a continuous observation on 7/23/25, beginning at 10:56 a.m. and ending at 11:30 a.m., the following was observed: Housekeeper (HK) #1 was cleaning resident room [ROOM NUMBER]. HK #1 began by putting gloves on her hands. She took a spray bottle with 764 Lemon Quat Disinfectant Cleaner and a rag into the room. She sprayed the disinfectant on the rag and wiped the bedside table. She sprayed the window sills with the disinfectant and immediately wiped them down with the rag. She sprayed picture frames with the disinfectant and immediately wiped them down with the rag. She sprayed the closet and television stand (all one unit) and immediately wiped it down with the rag. She sprayed the headboard of the bed with the disinfectant and immediately wiped it down with a rag. HK #1 returned the disinfectant and rag to her cart, disposed of the rag, removed her gloves and donned clean gloves without performing hand hygiene. She set the disinfectant solution aside and went back into the room. She removed the trash bags in the room and replaced them with empty bags. She took the vacuum out of the cart and vacuumed the carpet in the resident’s bedroom. After vacuuming the carpet, HK #1 grabbed a new rag and the disinfectant solution and sprayed the bathroom counter and sink. She immediately wiped the surfaces with the rag. She sprayed the shower chair and immediately wiped it with the rag. She sprayed the grab bars in the shower and immediately wiped them with the rag. She sprayed the toilet and immediately wiped it with the rag. HK #1 returned to the cart and removed her gloves. She donned clean gloves without performing hand hygiene. She mopped the bathroom floor. She removed her gloves. She moved her cart to resident room [ROOM NUMBER]. She donned clean gloves without performing hand hygiene. HK #1 entered room [ROOM NUMBER] and sprayed the bedside table in the resident’s room with disinfectant and immediately wiped the surface with the rag. She sprayed the window sill and immediately wiped it with the rag. She sprayed the closet and television stand and immediately wiped them with the rag. She removed her gloves and donned clean gloves without performing hand hygiene. She removed the trash from the room and bathroom. She disposed of the trash in her cart and then began to clean the bathroom. -HK #1 did not perform hand hygiene in between glove changes or between cleaning different residents’ rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-HK #1 did not allow the disinfectant to remain on surfaces for the full 10-minute recommended dwell time before wiping off the surfaces (see disinfectant product specifications above). -HK #1 failed to disinfect high-touch surfaces such as the call light, the television remote, the door knobs and the light switches. D. Staff interviews The maintenance director (MTD) was interviewed on 7/24/25 at 9:00 a.m. The MTD said the disinfectant the housekeepers used to sanitize residents’ rooms was 764 lemon quat disinfectant solution. He said the dwell time for that solution was 10 minutes. He said the solution should sit on a surface for 10 minutes before it got wiped down with a rag. He said the housekeepers had a checklist they all followed to tell them the order in which to clean a resident’s room and what to clean. He said high-touch surfaces, such as phones, remotes, call lights, door knobs and light switches should be sanitized daily. He said hand hygiene should be performed after the use of gloves. The assistant director of nursing (ADON) and the regional director of clinical operations were interviewed together on 7/24/25 at 11:00 a.m., in place of the infection preventionist (IP). The regional director of clinical operations said housekeepers should be waiting for the appropriate dwell time for disinfectant solutions prior to wiping the solution away. The regional director of clinical operations said housekeepers should be disinfecting high touch surfaces as part of their daily cleaning of resident rooms. II. Failure to ensure appropriate infection control procedures were followed during urinary catheter care for Resident #68 A. Professional reference According to the CDC’s Clinical Safety: Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 7/31/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety: When to clean your hands: -Immediately before touching a patient; -Before moving from work on a soiled body site to a clean body site on the same patient; -After touching a patient or patient's surroundings; -After contact with blood, body fluids, or contaminated surfaces; and, -Immediately after glove removal. Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves. When to wear gloves: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When needed for standard precautions (when you anticipate that you will come in contact with blood or other infectious materials, mucous membranes, non-intact skin, potentially contaminated skin, or contaminated equipment); and, -When needed for transmission-based precautions. When to change gloves and clean hands: -If gloves become soiled with blood or body fluids after a task; -If moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs; and, -If they look dirty or have blood or body fluids on them after completing a task. B. Facility policy and procedure The Hand Hygiene policy, dated December 2024, was received by the nursing home administrator (NHA) on 7/24/25 at 11:00 a.m. It read in pertinent part, “The facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene includes both handwashing and the use of alcohol-based hand sanitizer. “The following situations require the use of hand washing of twenty (20) seconds using soap and water: -When hands are visibly dirty or soiled; -After contact with blood, body fluids, secretions, mucous membranes, or non- intact skin; -After handling items potentially contaminated with blood, body fluids, or secretions; -Before eating and after using a restroom; -Before inserting urinary catheters, peripheral vascular catheters or other invasive devices that do not require surgery; and, -When there is a likely exposure to C Diff (clostridium difficile) and Norovirus or GI (gastrointestinal) symptoms. “The use of gloves does not replace hand hygiene.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Foley catheter policy, dated December 2024, was received by the NHA on 7/24/25 at 11:00 a.m. It read in pertinent part, “A urinary catheter is any tube system placed in the body to drain and collect urine from the bladder. The facility is committed to serving the present and future needs of our residents/guests, utilizing a wide variety of resources. Urinary catheters are used to drain the bladder and the prescriber may recommend a catheter for short-term or long-term placement due to urinary incontinence associated with a specific diagnosis, urinary retention, surgery, or other medical condition. “Handwashing is to be performed by the nursing personnel prior to cleansing and after cleansing of the Foley catheter.” C. Observations On 7/23/25 at 11:40 a.m. the infection preventionist (IP) #2 was providing catheter care to Resident #68. The following observations were made: IP #2 applied gown and gloves before entering Resident #68’s room. IP #2 said she performed hand hygiene at the desk before going to Resident #68’s room. Resident #68 was sitting in a chair in his room. IP #2 assisted Resident #68 with ambulating to and lying down on his bed. IP #2 went into Resident #68’s bathroom and filled a basin with warm, soapy water. IP #2 brought the basin into the room and placed it next to Resident #68 on his bed. -IP #2 did not remove her gloves or perform hand hygiene after assisting Resident #68 to lie down in bed and touching the faucet in the bathroom while filling the basin with water . IP #2 lowered Resident #68’s pants to below his belly button. Resident #68 had a urinary catheter securely inserted into his belly button (suprapubic catheter). IP #2 grabbed a washcloth and submerged it in the water basin. IP #2 used the washcloth to wipe Resident #68’s catheter site from the inside out toward his left side. IP #2 wiped the site approximately three to five times, going from inside to out. IP #2 folded the washcloth and used a new spot with each wipe. IP #2 placed the washcloth in the dirty laundry bin, removed her gloves and donned a new pair of gloves. -IP #2 did not perform hand hygiene before donning the new pair of gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IP #2 took a new washcloth and submerged it in the water basin. IP #2 used the washcloth to wipe Resident #68’s catheter site from the inside out, towards his right side. IP #2 wiped the site approximately three to five times from the inside to out and refolded the washcloth to wipe the site with a new spot each time. IP #2 placed the washcloth in the dirty laundry bin, removed her gloves and donned a new pair of gloves. -IP #2 did not perform hand hygiene before donning a new pair of gloves. IP #2 emptied the water basin in Resident #68’s bathroom. Wearing the same gloves, IP #2 returned to Resident #68 and pulled up his pants over his catheter site. IP #2 then assisted Resident #68 into a sitting position at his bedside. D. Staff interviews The assistant director of nursing (ADON) and the regional director of clinical operations were interviewed together on 7/24/25 at 11:00 a.m., in place of the infection preventionist (IP). The regional director of clinical operations said hand hygiene should be performed before and after resident care. She said it should be performed after the removal of gloves. She said this was important for reducing the transmission of infections.