

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Mount St Francis Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7550 Assisi Hts Colorado Springs, CO 80919	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46849</p> <p>Based on record review and interviews, the facility failed to ensure one (#16) of two residents reviewed for abuse out of 46 sample residents was free from abuse.</p> <p>Specially, the facility failed to protect Resident #16 from sexual abuse by Resident #58.</p> <p>Findings include:</p> <p>I. Incident of sexual abuse between Resident #16 and Resident #58 on 11/14/24</p> <p>A. Facility investigation</p> <p>The facility's investigation documented an incident occurred on 11/14/24 between Resident #16 and Resident #58 in Resident #16's room. Certified nurse aide (CNA) #2 witnessed Resident #58 in Resident #16's room prior to lunch. Resident #58 was patting Resident #16's buttocks with his hand and attempting to kiss her on the mouth. The residents were separated and taken to lunch. CNA #2 alerted registered nurse (RN) #1 of what was witnessed.</p> <p>Resident #16 was interviewed by the unit manager (UM) and stated Resident #58 had come into her room without knocking and uninvited. She said Resident #58 sat and talked with her and then attempted to kiss her while patting her buttocks. Resident #16 told the UM that Resident #58's behavior had made her uncomfortable and she was afraid to tell him no or to stop. Resident #16 told the UM she would like the staff to keep Resident #58 from going into her room.</p> <p>Resident #58 was interviewed by the UM and was asked if he had gone into Resident #16's room uninvited, patted her buttocks and attempted to kiss her. Resident #58 first wanted to know who had reported him for doing this.</p> <p>When he was asked a second time if he had entered the room uninvited, patted Resident #16's buttocks and attempted to kiss her, he said he had done those things. Resident #58 agreed with the UM that he should have obtained permission to engage in these behaviors and then went back to perseverating on who had reported him. The conversation ended with the UM providing education to Resident #58 on consent and he acknowledged understanding.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the investigation conducted by the facility to determine if other residents had been affected, the following events had been reported by staff:</p> <p>A progress note dated 11/13/23 by CNA #1 revealed the resident tried to touch and spank a CNA.</p> <p>A progress note dated 11/17/23 by RN #1 revealed the resident tried to grab a CNAs chest.</p> <p>A progress note dated 6/11/24 by RN #2 revealed Resident #58 was being cared for in pairs (two staff at all times during personal care).</p> <p>A statement written by CNA #2 and dated 11/14/24 documented Resident #16 told CNA #2 that Resident #58 made her uncomfortable.</p> <p>The UM statement, dated 11/14/24, revealed Resident #16 had told her she did not want Resident #58 in her room.</p> <p>The written statement documented Resident #16 told the UM she was fearful to tell Resident #58 to leave her room and he made her uncomfortable.</p> <p>The UM's second statement, also dated 11/14/24, revealed she had interviewed Resident #58 and he acknowledged he should have asked permission to go into Resident #16's room. The statement indicated Resident #58 admitted to the UM that he had attempted to kiss Resident #16 and touch her buttocks.</p> <p>On 12/3/24 CNA #3 wrote a statement which revealed Resident #58 had attempted to move the top of her shirt to reveal her undergarment strap. Resident #58 told CNA #3 he would become sexually aroused when he saw those straps and began to ask her personal questions about her intimate relationships.</p> <p>On 12/11/24 CNA #4 wrote a statement which revealed she saw Resident #58 confronting Resident #16 in the hallway asking if she was the reason why he was in trouble.</p> <p>A statement which was undated and written by CNA #6 documented was told by other care staff when she started working at the facility that Resident #58 was handsy. CNA #6 described one incident when she was transferring Resident #58 after toileting and he grabbed her arm and tried to pull her close to him. CNA #6 had to call out to another CNA before Resident #58 would release her. He made several sexually inappropriate remarks and requests to her during the interaction of care and other interactions. CNA #6 stated RN #1 had advised her to not go in his room without another CNA.</p> <p>An undated statement written by the hospice CNA (HCNA) revealed she had been told by staff to not go into Resident #58's room alone without other staff because of the resident's inappropriate sexual behaviors.</p> <p>An undated statement written by CNA #7 revealed a history of Resident #58 making sexually inappropriate comments to CNA #7 and requesting she clean his penis slowly and wife him.</p> <p>The facility substantiated the abuse of Resident #16 by Resident #58 based on staff and resident interviews and observations.</p> <p>B. Resident #16 (victim)</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Resident status</p> <p>Resident #16, age 71, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included depression and encephalopathy.</p> <p>The 10/31/24 minimum data set (MDS) assessment documented the resident was moderately cognitively intact with a brief interview of mental status (BIMS) score of eight out of 15. She required staff supervision for bathing and transfers and was independent in ambulation, bed mobility, personal hygiene, dressing, and toileting.</p> <p>The assessment indicated the resident had no behaviors.</p> <p>2. Record review</p> <p>Resident #16's psychiatric care plan, revised 3/5/25 (during the survey), revealed the resident had a diagnosis of depression and received antidepressant medication. She displayed behaviors of low mood, agitation, hallucinations and delusions. Interventions included attempting non-pharmacological interventions.</p> <p>-However, the care plan failed to document what non-pharmacological interventions should be attempted.</p> <p>Resident #16's trauma care plan, initiated 8/2/24, revealed the resident had a trauma history of being emotionally abused by a religious leader she was providing child care for. The resident revealed the religious leader was discovered to be a pedophile and had attempted murdering his spouse. Interventions included allowing the resident time to express herself, offering reassurance, referring the resident to a psychologist for grief counseling and encouraging her family to visit.</p> <p>-The care plan failed to address the incident when the resident was touched inappropriately by Resident #58 on 11/14/24 or what interventions the facility put in place for her protection and psychosocial well-being following the incident.</p> <p>-Review of the March 2025 CPO failed to reveal a behavior monitoring order to monitor Resident #16's psychosocial well-being after the sexual abuse incident with Resident #58.</p> <p>Progress notes reviewed from 11/14/24 to 3/4/25 revealed the following:</p> <p>Resident #16 and Resident #58 were seen in the dining room talking to each other on 12/24/24, 12/28/24 and 1/5/25 (while on 15-minute checks).</p> <p>Resident #58 was seen on 1/1/25 (while on 15-minute checks) attempting to enter Resident #16's room and had to be redirected by staff as he was not permitted to go into the room.</p> <p>Further review of Resident #16's electronic medical record (EMR) revealed social worker (SW) #1 did not complete a psychosocial assessment with Resident #16 until 12/19/24 (thirty-five days after the sexual abuse incident with Resident #58).</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There were no additional social services assessments or visit notes located in Resident #16's EMR between the 11/14/24 to 3/4/25 timeframe.</p> <p>Review of 15-minute check staff documentation revealed Resident #16 was on 15-minute checks from 11/24/24 to 1/7/25.</p> <p>C. Resident #58 (assailant)</p> <p>1. Resident status</p> <p>Resident #58, age 73, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included unspecified dementia and hydrocephalus.</p> <p>The 1/14/25 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. He required maximum staff assistance with toileting and personal hygiene and required partial staff assistance with showering, dressing, bed mobility, and transfers. The resident was independent in propelling himself in his wheelchair.</p> <p>The assessment indicated the resident had no behaviors direct towards others, behaviors putting others at risk or sexually inappropriate behaviors.</p> <p>-However, Resident #58 had several occasions where he was documented as having inappropriate sexual behaviors, including the sexual abuse incident with Resident #16 on 11/14/24 (see facility investigation above).</p> <p>2. Resident interview</p> <p>Resident #58 was interviewed on 3/4/35 at 10:30 a.m. Resident #58 said the facility wanted to initiate an involuntary discharge for him based on a report of an interaction between himself and a female resident (Resident #16). He said staff had observed him embracing his friend with his hand on her buttocks. Resident #58 said the facility had given him several discharge notices and communications because his brother had been appealing the facility's decision. He said he felt the facility had made a big deal out of nothing. He said Resident #16 did not tell him to leave her room and when he asked her later if he had offended her, she said no. Resident #58 said he did not recall if he had increased supervision from staff after the incident. He denied any other inappropriate incidents with other residents or staff members.</p> <p>Cross-reference F622 for failure to follow appropriate discharge and transfer requirements.</p> <p>3. Record review</p> <p>Review of Resident #58's mood and behavior care plan, revised 11/14/24, identified the resident had a diagnosis of major depression and anxiety. He had episodes of inappropriately touching staff sexually and making vulgar sexual comments to staff. He was involved in an incident on 11/14/24 where he made unwanted sexual contact with another resident, causing her to feel uncomfortable and unsafe. Interventions (revised on 10/16/24, prior to the incident) included attempting non-pharmological interventions as able, one-on-one visits, offering to toilet the resident, offering food and drink and administering medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The facility failed to update the care plan with new interventions following the incident with Resident #16 on 11/14/24.</p> <p>Review of Resident #58's March 2025 CPO revealed the following physician orders:</p> <p>Clinical staff to perform every 15-minute checks to determine the resident's location and to ensure the safety of the other residents due to this resident's history of sexually inappropriate behavior, ordered on 3/4/25 (during the survey).</p> <p>Behavior monitoring for exhibiting sexual behaviors such as inappropriate touching and inappropriate verbal language of a sexual manner, ordered on 3/4/25 (during the survey).</p> <p>Two CNAs at all times when providing care, ordered on 6/11/24.</p> <p>Review of Resident #58's progress notes from 11/14/24 to 3/4/25 revealed the following:</p> <p>SW #2 did not provide education to Resident #58 on his behavior towards Resident #16 until 12/9/24 (twenty-five days after the sexual abuse incident).</p> <p>A social services quarterly assessment, dated 1/17/25, documented Resident #58 had not had staff reported behaviors within the look back period (period of three months).</p> <p>Social services sent a referral for psychiatry services for Resident #58 on 1/24/25 (two months after the sexual abuse incident with Resident #16).</p> <p>-There were no additional social services assessments or visit notes located in Resident #58's EMR between the 11/14/24 to 3/4/25 timeframe.</p> <p>A psychoactive meeting note, dated 12/19/24, failed to reveal that Resident #58's sexual abuse incident towards Resident #16 had been reviewed or discussed by the facility's interdisciplinary team (IDT).</p> <p>A Risk Management worksheet, dated 12/2/24, documented The resident (Resident #58) has been deemed a danger to the other residents. He has been placed on every 15-minute checks until he is discharged as a means to ensure the safety of the other residents.</p> <p>Review of 15-minute check staff documentation revealed Resident #58 was on 15-minute checks 11/24/24 to 1/7/25.</p> <p>II. Staff interviews</p> <p>RN #3 was interviewed on 3/4/25 at 10:10 a.m. RN #3 said Resident #58 was a two-person assist for staff safety due to his sexually inappropriate behaviors. RN #3 said the change in status for staff assistance for the resident was passed on to her from other staff and not by the management team. RN #3 said the nurses documented the resident's behaviors in the progress notes because he did not have a physician's order to track sexually inappropriate behaviors on the treatment administration records (TAR). RN #3 said the management team did not do a training with the staff on interventions to use with Resident #58 when he displayed sexually inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The UM was interviewed on 3/4/25 at 11:00 a.m. The UM said Resident #58 had a history of sexually inappropriate language and touching towards staff when they were alone providing him care. She said the management team instructed the staff to set boundaries for the resident to stop and then tell the nurse or charge nurse what was happening. The UM said the CNAs did not document the resident's behaviors and that was something the nurses were responsible for documenting.</p> <p>CNA #6 was interviewed on 3/4/25 at 3:30 p.m. CNA #6 said the date she gave her written statement was on 11/21/24 (one week after the incident between Resident #16 and Resident #58). She said when she was hired on 9/5/23, she was warned by other staff that Resident #58 would touch staff inappropriately. She said there was an incident when Resident #58 would not let her go but when she called in another staff member and he let her go. She said she was adjusting his wheelchair and he kept trying to get hugs from her despite her telling him she did not give hugs. CNA #6 said during that same incident, he grabbed her breasts and she was told by the nurse to not go into his room without another CNA. CNA #6 said she was currently responsible for staff scheduling and tried to put male CNAs on Resident #58's unit.</p> <p>CNA #7 was interviewed on 3/4/25 at 3:56 p.m. CNA #7 said the CNAs and nurses had advised the prior nursing home administrator (NHA) about Resident #58's sexually inappropriate behaviors. CNA #7 said the prior NHA did not take action on the reports. CNA #7 said she knew Resident #58 was going to escalate and offend another resident but the administration did not handle his behaviors prior to the incident.</p> <p>The vice president of clinical services (VPCS), SW #1, SW #2, and the director of nursing (DON) were interviewed together on 3/4/25 at 5:07 p.m. SW #1 said the facility process regarding a resident with sexually inappropriate behaviors was to bring any incidents to the social services department to begin interviewing residents. SW #1 said the facility would offer to send the victim to the hospital for a rape kit, if applicable, and begin 15-minute checks on the victim and the perpetrator. SW #1 said the social services department acted as the abuse coordinators for the facility, but she said the corporate director of quality and safety (DQS) determined if incidents were reportable.</p> <p>SW #1 said after an investigation, she would update the care plans of the victim and the perpetrator. She said new behavioral interventions would be entered in the residents' care plans. She said care plans were reviewed by each department quarterly.</p> <p>SW #1 said behaviors would be indicated on the perpetrator's MDS assessment if they occurred during the assessment the look-back period. She said social services utilized progress notes, staff interviews, chart review and clinical meetings to collect information on residents in order to accurately complete assessments. She said the 1/14/25 MDS assessment should have reflected Resident #58's behaviors and the 11/14/24 incident. SW #1 said the care plan coinciding with the 1/14/25 MDS assessment should have been reviewed and updated for Resident #58 and Resident #16. SW #1 said she did not know why the MDS assessment, care plan and social services assessments had not been updated or kept accurate.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said she was not aware of Resident #58's past behavior towards staff until after the 11/14/24 incident with Resident #16, when staff started to come forward and she reviewed his records. She said 15-minute checks were started on both residents for safety after the incident. She said a behavior tracking physician's order would be obtained to monitor sexually inappropriate behaviors on the TARs, but she said she was only able to find a depression behavior tracking order on the TARs for Resident #58.</p> <p>The DON said 15-minute checks were stopped for both Resident #58 and Resident #16 on 1/7/25 because the facility had a meeting with Resident #16 and her family. The DON said Resident #16 did not want to remain on safety checks and asked for Resident #58 to also be removed from safety checks. She acknowledged she had no alternative safety measures put in place to prevent Resident #58 from inappropriately touching another female resident once the 15-minute safety checks were stopped.</p> <p>The VPCS said she believed Resident #58 had the potential to revert to repeating his behaviors if he believed he was no longer being watched. She said she was unaware the 15-minute safety checks had been stopped. She said the facility kept an eye on Resident #58 but staff were not formally documenting it. The VPCS acknowledged the facility needed to put more safeguards in place, including visual checks, to prevent incidents from occurring.</p> <p>The VPCS said the facility failed to keep residents safe by not tracking sexual behaviors, not having specific interventions in place, not moving Resident #58 off of Resident 16's hallway and by not training staff on what to report and how to redirect Resident #58.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>43950</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for three of three certified nurse aides (CNA).</p> <p>Specifically, the facility to complete regular in-service education based on the outcome of the annual performance reviews for CNA #8, CNA #9 and CNA #10.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Performance Management Procedure, reviewed 6/1/2020, was provided by the director of quality and safety (DQS) on 3/6/25 at 2:38 p.m. It read in pertinent part, The facility expects its managers and their direct reports to participate in the annual performance review process and discussions.</p> <p>Job performance is evaluated based on the following: established competencies, established responsibilities/job duties and established goals as determined by the organization, manager and employee.</p> <p>II. Record review</p> <p>The annual performance reviews and the regular in-service education based on the outcome of these reviews were requested on 3/5/25 at 9:58 a.m. for CNA #8, CNA #9 and CNA #10.</p> <p>-Review of the documentation provided revealed the three CNAs had their annual performance review completed, however, the facility was unable to provide documentation that the CNAs were provided with regular in-service education based on the outcome of the reviews.</p> <p>III. Staff interviews</p> <p>The DQS and the vice president of clinical services (VPCS) were interviewed together on 3/6/25 at 9:22 a.m. The DQS and the VPCS said there were no follow up in-services documented for CNA #8, CNA #9 or CNA #10 after their annual performance reviews. The DQS and the VPCS said the facility had just started to do systemic annual reviews on the new forms but they did not necessarily do specific in-services on what the CNAs said during their reviews. The DQS and the VPCS were unable to say what the importance was of doing follow up in-services based on the annual reviews. The DQS and the VPCS said the facility did not do in-service education based on the outcome of annual performance reviews, but they believed there may have been some follow-up completed, however they were unable to provide documentation.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458</p> <p>Based on observations, record review and interviews, the facility failed to ensure proper storage of medications in one of three medication storage rooms and three of three medication storage carts.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure medications were labeled with the date they were opened; and, -Ensure expired or discontinued medications were removed and discarded from medication carts and storage refrigerators. <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the manufacturer GlaxoSmithKline, Highlights of Prescribing Information ([DATE]), retrieved on [DATE] from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Trelegy_Ellipta/pdf/TRELEGY-ELLIPTA-PI-PIL-IFU.PDF, Discard Trelegy Ellipta six weeks after opening the foil tray or when the counter reads zero (after all blisters have been used), whichever comes first.</p> <p>According to the manufacturer Astra Zeneca, Symbicort Medication Guide, Symbicort Prescribing Information ([DATE]), retrieved on [DATE] from https://den8dhaj6zs0e.cloudfront.net/50fd68b,d+[DATE]b-4550-b5d,d+[DATE]b045f8b184/a4b62ab[DATE]-91b,d+[DATE]ec239f790/a4b62ab[DATE]-91b,d+[DATE]ec239f790_viewable_rendition__v.pdf, Throw away Symbicort when the counter reaches zero, or three months after you take Symbicort out of its foil pouch, whichever comes first.</p> <p>II. Facility policy and procedure</p> <p>The Medication Storage policy, undated, was provided by the director of quality and safety (DQS) on [DATE] at 2:32 p.m. The policy read in pertinent part,</p> <p>When the medication cart is checked per schedule, the nurse will read the labels to ensure that all of the medications are being stored properly. If a medication is found to not be stored properly it will be discarded and the nurse will order a replacement.</p> <p>III. Observations and interviews</p> <p>On [DATE] at 10:15 a.m., the first floor back medication cart was observed with registered nurse (RN) #3. An opened Trelegy Ellipta 100 microgram (mcg)/62 mcg inhaler was found with a date opened of [DATE]. RN #3 said she was unsure how long the medication could be used once opened. RN #3 said the medication could be less effective if it was used past the date of the manufacturer's recommended storage instructions.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Mount St Francis Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 7550 Assisi Hts Colorado Springs, CO 80919	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 10:55 a.m., the second floor front medication cart was observed with licensed practical nurse (LPN) #1. An opened lidocaine 1% (percent) vial was not labeled with the date it was opened for use. LPN #1 said the medication should have been labeled with the date it was opened.</p> <p>On [DATE] at 11:55 a.m., the third floor front medication cart was observed with RN #4. The following was observed:</p> <p>-An opened Trelegy Ellipta 100 mcg/62.5 mg inhaler was not labeled with the date it was opened for use; and,</p> <p>-An opened Symbicort ,d+[DATE],5 mcg inhaler was not labeled with the date it was opened. RN #4 said the medications should have been labeled with the dates they were opened.</p> <p>On [DATE] at 12:14 p.m., the third floor back medication refrigerator was observed with RN #5. An opened tuberculin purified protein derivative (PPD), which was part of the floor stock, was labeled with an opened date of [DATE]. RN #5 said it should have been discarded 30 days after it was opened.</p> <p>IV. Staff interviews</p> <p>The registered pharmacist consultant (RPHC) was interviewed on [DATE] at 5:05 p.m. The RPHC said the Ellipta inhalers expired six weeks after they were opened. The RPHC said the Ellipta inhalers and lidocaine should have been labeled with the date they were opened. The RPHC said the lidocaine should have been discarded 30 days after it was opened. The RPHC said the tuberculin PPD should have been discarded 28 days after it was opened. The RPHC said the use of medications after the recommended discard dates could have reduced the efficacy (effectiveness) of the medications.</p> <p>The director of nursing (DON) was interviewed on [DATE] at 9:33 a.m. The DON said the Trelegy Ellipta inhalers were good for six weeks after they were opened. The DON said the previous pharmacist consultant had provided an incorrect reference sheet to the nursing staff for storage of inhalers which did not include an expiration date for use of the Trelegy inhalers. The DON said the undated medications should have been labeled with the date they were opened. She said the lidocaine order was discontinued on [DATE] and the medication should have been discarded from the medication cart at that time. The DON said the tuberculin PPD was no longer used at the facility as of [DATE] and the medication should have been discarded 30 days after it was opened.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51710</p> <p>Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment for residents to help prevent the development and transmission of diseases and infection on one of three units.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure staff wore the appropriate personal protective equipment (PPE) for Resident #20, who was on enhanced barrier precautions (EBP); -Ensure proper infection control practices were followed during wound care; and, -Ensure hand hygiene was performed appropriately during wound care. <p>Findings include:</p> <p>I. Failed to ensure staff wore the appropriate PPE for Resident #20, who was on EBP</p> <p>A. Professional reference</p> <p>According to the Centers for Disease Control and Prevention (CDC): Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), Description of Precautions (4/2/24), retrieved from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html on 3/12/25,</p> <p>Enhanced barrier precautions:</p> <p>Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.</p> <p>Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:</p> <ul style="list-style-type: none"> -Dressing; -Bathing/showering; -Transferring; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Providing hygiene;</p> <p>-Changing linens;</p> <p>-Changing briefs or assisting with toileting;</p> <p>-Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; and,</p> <p>-Wound care: any skin opening requiring a dressing.</p> <p>In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because enhanced barrier precautions do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>B. Observations</p> <p>On 3/3/25 at 1:59 p.m., a sign on the wall next to Resident #20's door indicated the resident was on EBP. The sign indicated a gown and gloves must be worn for high-contact resident care activities, including dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies, and wound care. Resident #20 had an indwelling urinary catheter in place, as well as open wounds to her left ischium (lower back part of the hip bone), right ankle and left distal and proximal foot.</p> <p>There was a PPE storage container inside Resident #20's room.</p> <p>On 3/4/25, during a continuous observation, beginning at 9:50 a.m. and ending at 10:45 a.m., the following was observed:</p> <p>At approximately 9:50 a.m. an EBP sign was not observed on the wall outside of Resident #20's room and the PPE storage cart inside the resident's room was gone.</p> <p>At 9:54 a.m., licensed practical nurse (LPN) #2 and the unit's charge nurse (CN) entered Resident #20's room to perform the resident's wound care. They both performed hand hygiene and donned gloves, however, neither staff member put on a gown prior to beginning wound care.</p> <p>At 10:01 a.m., the CN held up Resident #20's right leg and LPN #2 prepared to remove the old wound dressing on the resident's ankle with scissors. LPN #2 was stopped and asked if staff should be wearing gowns. LPN #2 told the CN she felt more comfortable wearing a gown during wound care. LPN #2 removed her gloves and left Resident #20's room.</p> <p>At 10:04 p.m., the CN said she asked LPN #2 about gowns before entering the resident's room, and LPN #2 said the facility's infection preventionist (IP) had removed the PPE storage bin and the EBP sign from outside the resident's room that morning (3/4/25).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 10:06 a.m., LPN #2 returned to Resident #20's room with gowns, gloves and masks. Both the CN and LPN #2 donned gloves, gowns and masks and proceeded with the resident's wound care.</p> <p>At 10:44 a.m., after wound care was completed, a PPE cart containing gowns, gloves and masks was observed in the hallway outside of Resident #20's room. Additionally, a sign had been placed back on the wall near the resident's door indicating she was on EBP.</p> <p>On 3/5/25 at 3:16 p.m., certified nurse aide (CNA) #4, CNA #11 and LPN #2 entered Resident #20's room preparing to transfer the resident from her wheelchair to her bed and provide incontinence care. Upon entering the resident's room, CNA #4, CNA #11 and LPN #2 performed hand hygiene and donned gloves, however, they did not put on gowns.</p> <p>At 3:19 p.m., as CNA #4 and CNA #11 were connecting Resident #20's transfer sling to the Hoyer (mechanical) lift, LPN #2 told them if they were cleaning and changing the resident, they needed to put on gowns, which they did prior to continuing with the resident's care.</p> <p>-CNA #4 and CNA #11 did not put on gowns, or indicate they were going to, until LPN #2 advised them to put one on.</p> <p>II. Failed to ensure proper infection control and hand hygiene practices were followed during wound care</p> <p>A. Professional reference</p> <p>According to the CDC: Clinical Safety: Hand Hygiene for Healthcare Workers (2/27/24), retrieved from https://www.cdc.gov/clean-hands/hcp/clinical-safety/ on 3/13/25,</p> <p>When to clean your hands:</p> <ul style="list-style-type: none"> -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. <p>When to wear (and change) gloves:</p> <p>Gloves are not a substitute for hand hygiene:</p> <ul style="list-style-type: none"> -If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings; and, -Always clean your hands after removing gloves. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When to wear gloves:</p> <ul style="list-style-type: none"> -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. <p>When to change gloves and clean hands:</p> <ul style="list-style-type: none"> -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. <p>B. Observations</p> <p>On 3/4/25 at 9:54 a.m. LPN #2 was observed providing wound care to Resident #20 with the assistance of the CN.</p> <p>LPN #2 performed hand hygiene and donned gloves.</p> <p>The CN did not perform hand hygiene before donning gloves.</p> <p>LPN #2 cleared Resident #20's bedside table of personal items and placed two pieces of paper towel on top of the table. LPN #2 began collecting packages of Kerlix (rolled gauze), abdominal pad (ABDs) dressings, a plastic cup with quarter (25%) strength Dakins solution (a specialized liquid wound treatment), wound cleanser and scissors from a medical supply storage container in the resident's room.</p> <p>-LPN #2 failed to cleanse or put a barrier pad onto the bedside table, failed to cleanse the scissors with cleansing wipes and failed to change her gloves and perform hand hygiene after touching the medical supply storage cart and the bedside table.</p> <p>LPN #2 opened two packages of Kerlix, two packages of ABD pads, and an uncounted amount of 4x4 gauze pads and laid them on top of their packing, on top of the paper towels on the bedside tables.</p> <p>While LPN #2 was collecting supplies and setting up, the CN was observed repeatedly touching the resident's bedside table, mattress, and sheets with her gloved hands.</p> <p>LPN #2 grabbed the trash can and moved it closer to her work area. LPN #2 used the bed controls to raise the bed and lower the head of the bed.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CN raised the resident's right leg. LPN #2 used the unsanitized scissors to remove the old dressing to the resident's right ankle and threw the dressing in the trash. LPN #2 used wound cleanser to moisten the dried gauze stuck to the wound bed, removed it by wiping with a gauze pad, and threw the gauze away. LPN #2 sprayed wound cleanser onto the wound, grabbed a new gauze pad, and patted the wound area approximately three to six times, using the same gauze pad, before throwing it away. LPN #2 soaked a gauze pad in quarter strength Dakins solution and placed the gauze on the wound bed. LPN #2 applied an ABD pad over the soaked gauze. The CN used one hand to support the resident's knee, and the other to support the right ankle by holding the ABD pad in place. LPN #2 wrapped Kerlix around the ABD pad and secured it with medical tape.</p> <p>-LPN #2 opened the supply cart and dressing packages, moved the trash can, and used the bed controls with the same gloves she used to remove the old dressing and apply the new one. LPN #2 failed to remove her gloves and perform hand hygiene after touching resident surfaces, removing the old dressing, and before applying the new dressing.</p> <p>-The CN touched the bedside table and the resident's mattress/sheets with the same gloves she used to hold the resident's right leg up and the ABD dressing in place. The CN failed to remove her gloves and perform hand hygiene after touching resident surfaces and while assisting with wound care.</p> <p>LPN #2 asked the surveyor if she needed to remove her gloves and perform hand hygiene in between wounds, which was confirmed. LPN #2 then removed her gloves and performed hand hygiene. LPN #2 applied new gloves and grabbed a permanent marker out of her pocket and dated the right ankle dressing. LPN #2 moved the bedside table, unlocked the resident's bed, and moved the bed away from the wall to access the resident's left side. The CN moved to the left side of the resident's bed and repeatedly touched the mattress and sheets.</p> <p>-The CN did not remove her gloves and perform hand hygiene before moving to the left side of the resident's bed.</p> <p>The CN raised the resident's left leg so LPN #2 could access her left foot. LPN #2 used the same scissors to remove the old dressing to the resident's left foot and threw the dressing in the trash. LPN #2 used wound cleanser to moisten the dried gauze stuck to the wound beds of both wounds, removed them by wiping each wound with a separate gauze pad, and then threw the gauze away. LPN #2 sprayed the wounds with wound cleanser and patted each dry with a separate gauze pad. LPN #2 soaked a gauze pad in quarter strength Dakins solution. LPN #2 applied soaked gauze to the resident's distal left foot wound and covered it with an ABD pad.</p> <p>While LPN #2 was doing this, the CN moved her hand to support the resident's left foot by grabbing the middle of her foot in a way that the palm of the CN's hand was covering the proximal wound. After the ABD was applied, the CN moved her hand so she was holding the resident's foot and the Dakin's soaked gauze in place. LPN #2 applied a Dakin's soaked gauze pad to the distal left foot wound. LPN #2 covered both wounds with an ABD pad and the CN helped hold the ABD in place. LPN #2 wrapped the ABD pad with gauze.</p> <p>-LPN #2 touched a permanent marker, the bedside table, and the bed frame with the same gloves she used to remove the old dressing and apply the new one. LPN #2 failed to remove her gloves and perform hand hygiene after touching resident surfaces, removing the old dressing, and before applying the new dressing. LPN #2 failed to sanitize the wound scissors in between each wound dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The CN touched the mattress and sheets with the same gloves she used to hold the resident's left leg, grab her left foot, and hold the soaked gauze/ABD pad in place. The CN failed to remove her gloves and perform hand hygiene after touching resident surfaces and while assisting with wound care.</p> <p>LPN #2 and the CN removed their gloves and performed hand hygiene. They both applied new gloves. LPN #2 opened a foam dressing and laid it on the bedside table. She then opened a calcium alginate dressing (absorbent sponge dressing) and used the scissors to cut off an approximately 1 centimeter (cm) by 1 to 1.5 cm strip of the dressing. LPN #2 and the CN repositioned the resident onto her right side. LPN #2 removed the old foam dressing and threw it away. LPN #2 sprayed wound cleanser onto the wound, grabbed a gauze pad, and patted the area dry before throwing the gauze pad away. LPN #2 applied skin-prep (protective skin barrier) to the resident's skin and let it dry. LPN #2 used her gloved fingers to push the calcium alginate dressing into the wound. LPN #2 covered the wound with a foam dressing.</p> <p>-LPN #2 failed to cleanse the scissors with a cleansing wipe before using them to cut calcium alginate dressing. LPN #2 failed to remove her gloves and perform hand hygiene after cutting the calcium alginate dressing, removing the old dressing, and before applying the new dressing.</p> <p>III. Staff interviews</p> <p>LPN #2 was interviewed on 3/4/25 at 10:51 a.m. LPN #2 said gloves should be removed and hand hygiene performed between every task of wound care, and when moving from one wound to another. LPN #2 was unable to provide a reason for not doing this while she performed Resident #20's wound care.</p> <p>The wound care physician (WCP) was interviewed on 3/5/25 at 11:30 a.m. The WCP said the easiest way to establish a clean field for supplies was to place a Chux pad (absorbent bed pad) on top of the bedside table and open/set up supplies on top of the pad. The WCP said hand hygiene should be performed when first entering the resident's room and any time a staff member moved from a dirty-to-clean/clean-to-dirty area, including after removing an old wound dressing and before applying a new one. The WCP said the room should be fully set up and all wound care supplies should be gathered before the actual dressing change occurred.</p> <p>The WCP said it was not appropriate for staff to touch surfaces in the residents' room and then proceed with wound care, due to the risk of cross contamination. The WCP said cross contamination was a big concern and could occur from one area of a resident's body to another, or from one resident to another. The WCP said cross contamination could cause infection, and it also increased the risk of MDROs forming. The WCP said every resident with open wounds should be on EBP. The WCP said he would provide additional education to staff on EBP, proper PPE, wound care, and infection control practices related to wound care.</p> <p>The director of nursing (DON) was interviewed on 3/6/25 at approximately 3:30 p.m. The DON said residents with any medical tubes or drains, intravenous (IV) lines, open wounds and indwelling catheters should be on EBP. The DON said not following EBP could put residents and staff at risk of infection, and potentially create MDROs. The DON said hand hygiene should be performed every time staff changed their gloves. The DON said staff should change gloves and perform hand hygiene any time they went from a dirty-to-clean/clean-to-dirty area while performing wound care and as often as needed.</p> <p>IV. Facility follow-up</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/6/25 at 4:33 p.m. the DON provided a signed statement from the IP. The IP stated the EBP sign for Resident #20 was falling off of the wall, so she removed it and replaced it with a new one. The IP stated one of the drawers in the PPE cart was not working correctly, so the IP replaced it with a new cart.</p> <p>-However, the DON acknowledged that staff should have still followed EBP even if the signage and cart were not present.</p>		