

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER Sharmar Village Senior Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 W Abriendo Ave Pueblo, CO 81004	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350</p> <p>Based on observation, record review and interviews, the facility failed to ensure three (#13, #17 and #5) of four residents reviewed for accidents out of 24 sample residents remained free from accidents.</p> <p>Resident #13, who was identified with osteoporosis after a pathological (fracture caused by disease processes rather than trauma) right femur fracture (thigh bone above the knee) that required hospitalization and surgery on 6/22/24, sustained a non-displaced [NAME] fracture (an ankle injury that involves a fracture of the proximal fibula) on 1/12/25.</p> <p>The facility failed to ensure and document a root cause analysis and implement timely person-centered interventions after Resident #13 sustained a right femur fracture on 6/22/24.</p> <p>Additionally, the facility failed to schedule osteoporosis screening and treatment which was recommended after the resident had surgical repair to the fractured right femur.</p> <p>The facility failed to ensure and document a root cause analysis and implement timely person-centered interventions after Resident #13 sustained the right fibula fracture on 1/12/25.</p> <p>Additionally, Resident #17 was admitted to the facility on [DATE]. Upon admission the facility implemented fall interventions as the resident was determined to be a fall high risk.</p> <p>On 11/17/24 Resident #17 sustained an unwitnessed fall and sustained a concussion, a contusion (bruise) to the knee, a laceration of the forehead and cervical strain related to her fall. The facility updated the resident's fall care plan on 11/22/24 to include placing a floor mat at her bedside whenever she was in bed.</p> <p>However, observations revealed the facility did not consistently implement the fall mat while the resident was in bed (see observations below).</p> <p>On 1/11/25 Resident #17 sustained another unwitnessed fall when she attempted to self-transfer from her wheelchair to her bed. The fall care plan did not document any new interventions. The facility initiated 15-minute checks overnight for the resident on 1/16/25, however the facility did not update the resident's care plan to include the 15-minute checks.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/3/25 Resident #17 sustained another unwitnessed fall, the cause of which was not determined. Resident #17 sustained another unwitnessed fall on 2/4/25 when she attempted to self-transfer from her wheelchair to a sofa in the main living area. Upon evaluation, it was found Resident #17 sustained sacral insufficiency fractures (stress fracture). The facility failed to implement new person-centered fall interventions to prevent future falls.</p> <p>Also, the facility failed to complete a thorough root cause analysis to determine how Resident #5 obtained a skin tear.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Incidents/Accidents policy and procedure, revised September 2016, was provided by the nursing home administrator (NHA) on 2/27/25 at 3:11 p.m. It read in pertinent part,</p> <p>All incidents/accidents are to be documented.</p> <p>In the progress notes document the date time and location of the incident/accident; document any assistive devices in use; vital signs should be documented; document a full description of any injuries; any resident statement of the account of the incident; document only what was observed; indicate when the physician was notified and any orders; indicate when the legal representative was notified.</p> <p>II. Resident #13</p> <p>A. Resident status</p> <p>Resident #13, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), the diagnoses included Alzheimer's disease, type 2 diabetes mellitus (DM), displaced fracture of right lower femur and non-displaced [NAME] fracture of right fibula.</p> <p>The 1/2/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15. She was dependent on staff for toileting, personal hygiene, required substantial/maximal assistance with bed mobility, transfers and required set up assistance with eating.</p> <p>The assessment did not document the diagnoses of osteoporosis (disease that weakens the bones).</p> <p>-However, review of Resident #13's electronic medical record (EMR) revealed the resident had a diagnosis of osteoporosis.</p> <p>B. Observations</p> <p>On 2/24/25 at 1:00 p.m. Resident #13 was sitting in her room in a wheelchair with her feet down and resting on the foot rests on her wheelchair. Her right leg was in a splint. Resident #13's call light was lying on the floor next to the resident's wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 6/22/24 nursing progress note, documented at 12:30 p.m., revealed Resident #13's right knee was swollen and she was unable to bend her knee. The nurse practitioner was notified. Vital signs were taken. The resident was administered Tylenol for pain in her right knee. The resident was sent out to the hospital for evaluation and treatment.</p> <p>The 6/22/24 physical abuse investigation documented Resident #13 complained of pain in her right knee which was revealed to be a fracture above her knee. On 6/22/24, in the morning, Resident #13 was a stand pivot transfer by a CNA and had been up to the shower, up in her wheelchair for activities and laid down after lunch. Resident #13 denied anyone hurting her and there were no behavior changes. Staff were interviewed and did not witness any event that was a causative factor. Resident #13 was admitted to the hospital and required surgery to her right lower femur (thigh bone). The surgical report revealed specialized clips were used due to her brittle bones. The report of physical abuse was unsubstantiated.</p> <p>-However, there was no identification of a root cause analysis being completed after the resident sustained a right lower femur fracture and there were no person-centered interventions implemented after the resident sustained the fracture.</p> <p>The 6/22/24 hospital progress note documented Resident #13 had a displaced fracture of the right femur and was admitted for orthopedic consult and possible surgery.</p> <p>The 6/24/25 hospital physical therapy (PT) note documented Resident #13 was up with two person assistance using a stand-pivot transfer on the left. Right lower extremity precautions were weight-bearing as tolerated for transfers.</p> <p>The 6/25/24 hospital progress note documented Resident #13 had an open reduction internal fixation (ORIF) of the right femur (a surgical procedure to realign the bone and stabilize the fracture), done on 6/23/24. It recommended an outpatient osteoporosis screening and treatment.</p> <p>-However, the facility failed to schedule the osteoporosis screening until March 2025, nine months after it was recommended (see facility follow up below).</p> <p>-A review of the EMR failed to reveal an interdisciplinary team (IDT) risk management review note of the 6/22/24 incident and root cause analysis with any interventions that needed to be implemented to prevent any further fractures.</p> <p>Review of the July 2024 CPO revealed the following physician's orders related to transferring the resident:</p> <p>-Use a Hoyer lift for transfers, ordered 7/8/24 and discontinued 7/15/24.</p> <p>-Weight bearing as tolerated for transfers only to the right lower extremity, ordered 7/15/24 and discontinued 7/17/24.</p> <p>The 8/8/24 PT discharge summary notes documented Resident #13 was substantial/maximal assistance for transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the August 2024 CPO revealed a physician's order for the resident to be weight-bearing as tolerated, ordered on 8/16/24 and discontinued 1/12/25.</p> <p>3. Incident on 1/12/25</p> <p>The 1/12/25 nursing progress note documented Resident #13 was calling out in pain and had swelling and heat in her right knee and ankle. The physician was notified and an x-ray was requested of the knee and ankle. The resident was given ibuprofen for pain per physician's order.</p> <p>The 1/12/25 nursing progress note documented the x-ray report identified a spiral fracture to the right lower extremity. Resident #13 was sent to the hospital emergency room for evaluation and treatment.</p> <p>The 1/12/25 nursing progress note documented the resident returned to the facility with a cast.</p> <p>The 1/12/25 physical abuse investigation documented Resident #13, before she got up in the morning, complained of pain to her right leg with swelling in her right knee and ankle. The right knee and ankle were warm to the touch. The physician was notified and an x-ray was obtained. The x-ray results indicated a spiral fracture to her right lower extremity. The resident was sent to the hospital for further evaluation and treatment. The resident had no recent history of falls or trauma. The activities director (AD) reported that on 1/11/25 the resident turned herself in her wheelchair which caused the affected leg to be twisted in front and outside the front of the wheel.</p> <p>CNA #4 reported on 1/11/25 she changed Resident #13 before getting her up for dinner and she grimaced and complained of leg pain. She asked the nurse to assess her and the nurse gave her medication for pain. CNA #4 said she was then able to transfer Resident #13 to the wheelchair with a gait belt. The report of physical abuse was unsubstantiated.</p> <p>-However, there was no summary of a root cause in the physical abuse investigation or identification and implementation of interventions to prevent future fractures.</p> <p>Review of the January 2025 CPO revealed a physician's order to use a Hoyer lift for transfers, ordered 1/12/25.</p> <p>The 1/15/25 quarterly care conference documented Resident #13's transfers were to be with a Hoyer lift with two people at all times.</p> <p>-A comprehensive review of the resident's EMR failed to reveal an IDT risk management review note of the 1/12/25 incident and root cause analysis with interventions that needed to be implemented to help prevent any further fractures.</p> <p>E. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 2/26/25 at 10:00 a.m. RN #1 said Resident #13 was totally dependent on staff for transfers and required two person assist with the use of a Hoyer lift. She said prior to the most recent fracture, she was a one person extensive assistance with pivot transfers.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 was interviewed on 2/26/25 at 11:10 a.m. CNA #2 said Resident #13 was full weight-bearing before she fractured her femur bone in June 2024. She said after Resident #13 returned from the hospital in June 2024, Resident #13 required the use of a Hoyer lift until PT cleared her to be a two person transfer assist. She said Resident #13 needed a Hoyer lift after she experienced a fracture in her right leg in January 2025 for safety reasons.</p> <p>The director of rehabilitation (DOR) was interviewed on 2/26/25 at 11:20 a.m. The DOR said that prior to her fracture in June 2024, Resident #13 was full weight-bearing. The DOR said after Resident #13 returned from the hospital, she was maximum assistance of two people for transfers. He said an order for a Hoyer lift was in place from 7/8/24 to 7/17/24 and then she was cleared to be weight-bearing as tolerated on her right lower extremity with one to two person assistance. He said after her second fracture, she was required to be a Hoyer lift. He said he did education with nursing staff at that time on transfers, Hoyer lift use and how to manage her splint/cast.</p> <p>The director of nursing (DON) and the NHA were interviewed together on 2/26/25 at 11:55 a.m. The DON said prior to Resident #13's fracture in June 2024, there were no precautions in place and she was a one person pivot transfer. She said prior to the fracture in June 2024, staff were assisting Resident #13 in the morning and she was complaining of right knee swelling and pain after they put her back to bed. She said the staff noticed at that point that her right knee was swollen. She said during the investigation and staff interviews, they were unable to identify any events that happened before that may have contributed to the fracture. The DON said it was not identified until after Resident #13 had surgery in June 2024 that she had a significant osteoporosis. The DON said after Resident #13 returned from the hospital she was a two person Hoyer lift for transfers and worked with therapy to build up her strength and endurance. She said in August 2024 PT felt she could stand and pivot with her lower extremities.</p> <p>The DON said during the physical abuse investigation for the fracture in January 2025, staff indicated that on 1/11/25 Resident #13 was observed by staff members to be moving her wheelchair herself and had caught her right leg in front of the wheel on her wheelchair and may have twisted it. She said they reviewed camera footage and Resident #13 moved herself around in her wheelchair with poor safety awareness and would catch her leg against the door. She said Resident #13 did complain of some increased pain in the evening of 1/11/25 that was medicated with Tylenol. She said when staff tried to get Resident #13 up in the morning for breakfast Resident #13 was complaining of extreme right knee pain. The DON said staff then noticed her knee was red and swollen. She said the physician was notified and an x-ray was ordered. She said when the results of the x-ray came back positive for a fracture, Resident #13 was sent to the hospital for further evaluation and treatment. She said after she returned from the hospital, the intervention that was implemented for Resident #13 was to make her a two person Hoyer lift for safety reasons.</p> <p>The NHA said the facility had incident reports and physical abuse investigations which summarized their findings. She said the facility did not have a formal IDT root cause analysis which documented the findings with interventions in the resident's EMR. She said their process was informal and verbal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #4 was interviewed on 2/27/25 at 1:15 p.m. CNA #4 said Resident #13 was a one pivot transfer prior to her fracture in January 2025. She said on 1/11/25 Resident #13 was up for breakfast and went to activities. She said she laid Resident #13 back down after activities. She said she tried to get Resident #13 up and she was tearful and complaining of right knee pain. She said she contacted the nurse to assess and Resident #13 was medicated with Tylenol. She said she was contacted by the facility later that Resident #13 had experienced a leg fracture. She said the facility watched the cameras for the day and they saw Resident #13 had reached down after she had twisted her leg. She said she was not aware of any other additional interventions to help prevent fractures. She said Resident #13 had foot pedals but she would take her feet off the pedals to self propel herself in the wheelchair.</p> <p>E. Facility follow up</p> <p>The facility fractures root cause analysis and timeline was provided by the NHA on 2/28/25 at 5:10 p.m. (after the survey). It documented the undated root cause of the 6/22/24 femur fracture was due to Resident #13's bone demineralization that was identified during surgery. The exact cause of the fracture was unknown. Interventions included transfers with a Hoyer lift and working with PT. On 7/15/24 she had an order by orthopedics that she could be weight-bearing as tolerated for transfers only. She was discharged from PT on 8/19/24 with a substantial maximal assistance of one person for transfers and remained wheelchair bound for mobility.</p> <p>The 1/12/25 fracture root cause analysis, undated, identified Resident #13's osteoporosis as a contributing factor. The resident was participating in activities and the facility suspected the resident twisted her leg when independently moving her wheelchair. Resident #13 was identified to lock her wheelchair and then tried to move forward and dragged her leg. After returning from the hospital to the facility, she was a Hoyer lift transfer, a footboard was to be in place and two people assisted for care. PT services were involved for strengthening of the upper extremity, ADLs and wheelchair positioning.</p> <p>The medical director letter, undated, documented a nondisplaced spiral fracture of the right tibia and closed fracture of the proximal right fibula which were due to demineralization of the bone, severe peripheral vascular calcification and advancement of her comorbidities. A DEXA scan (a scan that measures bone density) was scheduled for March 2025.</p> <p>-However, osteoporosis screening and treatment was ordered nine months after osteoporosis was identified during an ORIF to the right femur and two months after Resident #13 sustained a second fracture to her right lower extremity.</p> <p>50219</p> <p>III. Resident #17</p> <p>A. Resident status</p> <p>Resident #17, age greater than 65, was admitted on [DATE]. According to the February 2025</p> <p>CPO, diagnoses included dementia, generalized muscle weakness, osteoarthritis, osteoporosis and a history of falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 2/13/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS assessment score of three out of 15. The resident was dependent on staff for most ADLs.</p> <p>B. Resident friend and representative interviews</p> <p>Resident #17's friend was interviewed on 2/26/25 at 1:30 p.m. The resident's friend said she felt Resident #17 was declining and wanted to sleep all the time. The resident's friend said Resident #17 had fallen several times at the facility, during which she had fractured her tailbone and had received seven stitches in her head. The resident's friend said the falls were serious. The resident's friend said there was someone sitting with Resident #17 for ten hours per day.</p> <p>The resident's representative was interviewed on 2/26/25 at 1:32 p.m. The resident's representative said Resident #17 had several falls within the months prior and sustained some injuries. The resident's representative said she thought some of Resident #17's falls had been the result of her trying to get out of bed without calling for help due to her dementia. She said she had asked the facility staff how they could prevent her falls, to which the facility said they were trying to monitor Resident #17 more closely.</p> <p>C. Resident observations</p> <p>On 2/25/25 at 1:11 p.m. Resident #17 was lying in her bed. The fall mat was folded up beside the one-on-one caregiver's chair.</p> <p>On 2/26/25 at 9:24 a.m. Resident #17 was lying in the fetal position in her bed. The fall mat was not in place and was folded up beside the one-on-one caregiver's chair.</p> <p>On 2/27/25 at 1:35 p.m. Resident #17 was lying in her bed. The fall mat was folded up beside the one-on-one caregiver's chair.</p> <p>D. Record review</p> <p>The fall care plan, initiated 10/7/24, revealed Resident #17 was at an increased risk of falls and/or serious injury related to falls due to a recent fall resulting in fractured vertebrae and antidepressant medication use. Pertinent interventions, initiated on 10/7/24, included encouraging Resident #17 to have the bed in lowest position, encouraging non-skid socks and footwear, keeping frequently used items within reach, assisting with transfers as needed and administering medications as ordered. An intervention for a floor mat at bedside while Resident #17 was in bed was initiated on 11/22/24.</p> <p>-However, Resident #17's care plan was not updated after her falls on 1/11/25, 2/3/25 and 2/4/25 (see below).</p> <p>A fall risk evaluation, dated 10/2/24, revealed Resident #17 was at a high risk for falling.</p> <p>A progress note, dated 11/8/24 at 2:33 p.m., revealed Resident #17 was discharged from skilled services with physical therapy. An order for an anti-rollback device for Resident #17's wheelchair was placed due to the resident transferring without asking for assistance because of her dementia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 11/11/24 at 10:46 a.m. revealed the facility received orders to place an anti-rollback device on Resident #17's wheelchair.</p> <p>-However, review of Resident #17's care plan did not reveal documentation regarding the implementation of anti-rollbacks for Resident #17.</p> <p>1. Fall incident on 11/17/24 - unwitnessed</p> <p>A fall risk evaluation, dated 11/17/24 at 12:34 p.m., revealed Resident #17 was at a high risk for falling.</p> <p>A progress note, dated 11/17/24 at 4:43 a.m., revealed Resident #17 was found on the floor at 3:45 a.m. by a CNA. Resident #17 had blood on her gown and was bleeding from her head. Resident #17's vital signs and neurological examination were within normal limits. The nurse performing the assessment alerted Resident #17's provider and received orders to send the resident out for evaluation. Resident #17 was transferred to the emergency room at 4:05 a.m.</p> <p>The facility fall report, dated 11/17/24 at 4:28 a.m., revealed Resident #17 was found on the floor with her head underneath her bed. The resident's bed was in the lowest position. The report documented it appeared Resident #17 had been trying to get up and had repeatedly hit her head against the bars underneath the bed as evidenced by blood on them. Resident #17's bed was moved away from her to avoid further injuries. An abrasion was noted to the top of Resident #17's scalp. The report documented the predisposing environmental factors included the furniture and poor lighting. The report documented predisposing physiological factors included incontinence, weakness, and gait imbalance.</p> <p>-The report did not identify a root cause of Resident #17's fall or include what interventions were put into place.</p> <p>Hospital notes, dated 11/17/24 at 9:46 a.m., revealed Resident #17 presented to the emergency room after a sudden fall at the facility. Resident #17 sustained a concussion, contusion of the knee, laceration of the forehead, requiring stitches, and cervical strain related to her fall.</p> <p>A progress note, dated 11/17/24 at 10:10 a.m., revealed Resident #17 had returned to the facility. Resident #17 had swelling and bruising to both eyebrows, both eyelids and both knees. Resident #17 had seven stitches in place over the left side of her forehead.</p> <p>An administrative note, dated 11/18/24, revealed Resident #17 was found on the floor next to her bed during the night. The facility staff determined Resident #17 had increased confusion. A floor mat was added for a fall intervention.</p> <p>-However, observations during the survey revealed the floor mat was not consistently utilized.</p> <p>2. Fall incident on 1/11/25 - unwitnessed</p> <p>A fall risk evaluation, dated 1/11/25 at 4:00 p.m., revealed Resident #17 was at a high risk for falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 1/11/25 at 4:00 p.m., revealed Resident #17 had an unwitnessed fall in her room after she self-transferred from her wheelchair to her bed. Resident #17 was assessed by the nurse and her vital signs and neurological assessment were within normal limits. Resident #17 denied any pain and her skin was intact without evidence of injury. Resident #17 was encouraged to use the call light to request assistance from the staff. The provider and Resident #17's representatives were contacted.</p> <p>The facility fall report, dated 1/11/25 at 4:00 p.m., revealed Resident #17 was found on the floor next to her bed. Resident #17 was sitting on top of a blanket which was on top of her floor mat. Resident #17 was sitting on her buttocks with her legs out in front of her. Resident #17 was wearing regular (not non-skid) socks and her shoes were across the room. Resident #17's wheelchair was within her reach. Resident #17 had attempted to self-transfer without calling for assistance. Resident #17 was encouraged to call for help if she wanted to get into bed. The report documented physiological factors included gait imbalance, impaired memory and weakness. The report documented predisposing situational factors included ambulating without assistance and improper footwear.</p> <p>An administrative note, dated 1/15/25, revealed Resident #17 was transferring herself without non-skid socks. Resident #17 was given non-skid socks and given education to wear the socks at all times to help with transferring herself. Resident #17 was educated on calling for assistance when attempting to transfer herself and having staff assist her with transfers.</p> <p>-However, review of the resident's care plan revealed non-skid socks were implemented on 10/7/24 and a new person-centered intervention was not implemented after the fall on 1/11/25.</p> <p>3. Fall incident on 2/3/25 - unwitnessed</p> <p>A fall risk evaluation, dated 2/3/25 at 3:44 a.m., revealed Resident #17 was at a high risk for falling.</p> <p>A progress note, dated 2/3/25 at 2:50 a.m., revealed Resident #17 was found lying on the floor next to her bed. Resident #17 said she did not know how she got on the floor, but said she hit everything on her body very hard on the floor and that her buttocks hurt. Resident #17 was assessed by the nurse and her vital signs and neurological assessment were within normal limits. Resident #17 did not have any obvious signs of injury. Resident #17 was assisted back into bed and repositioned for comfort with her call light within reach.</p> <p>The facility fall report, dated 2/3/25 at 2:50 a.m., revealed Resident #17 was found out of bed lying on the floor. Resident #17 said she did not know what she was doing. Resident #17 said she hit the floor hard and that her buttocks hurt. The report documented predisposing physiological factors included gait imbalance and impaired memory. The report documented predisposing situational factors included ambulating without assistance and improper footwear. Resident #17 was out of bed without assistance and was not wearing any footwear. Resident #17's call light was within reach.</p> <p>A progress note, dated 2/3/25 at 12:30 p.m., revealed the facility received new orders for x-rays of Resident #17's lumbar spine, sacrum and both hips. Resident #17's representative was notified of these new orders.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note, dated 2/3/25 at 5:47 p.m., revealed Resident #17 was being monitored for a witnessed fall (however, the fall was unwitnessed). Resident #17 said she had pain in her sacral area. Resident #17 was receiving acetaminophen every six hours as needed and had a new order for tramadol as needed, but the tramadol was not available at that time. Resident #17 did not have much of an appetite due to her pain.</p> <p>-The report did not identify a root cause of Resident #17's fall or include what person-centered interventions were implemented.</p> <p>A progress note, dated 2/4/25 at 8:40 a.m., revealed Resident #17's x-ray results revealed she did not have any acute fractures.</p> <p>4. Fall incident on 2/4/25 - unwitnessed</p> <p>A progress note, dated 2/4/25 at 8:57 a.m., revealed Resident #17 was lying on the floor in the hallway after breakfast. Resident #17 said she fell out of her wheelchair. The nursing staff at were not able to determine if Resident #17 hit her head during the fall. Resident #17 was yelling out in pain when trying to move. Resident #17 was sent to the emergency room for evaluation.</p> <p>A hospital note, dated 2/4/25 at 1:33 p.m., revealed Resident #17 presented to the emergency room after a fall at the facility. Resident #17 had pain in her buttocks and left leg and hit her head. The hospital note documented the facility staff reviewed camera footage after the incident and saw Resident #17 fall forward onto the ground from her wheelchair. Resident #17 was found to have bilateral sacral insufficiency fractures.</p> <p>A progress note, dated 2/4/25 at 3:31 p.m., revealed Resident #17 returned to the facility. Resident #17 had a non-operable sacral insufficiency fracture and was ordered acetaminophen for her pain.</p> <p>A progress note, dated 2/4/25 at 6:02 p.m., revealed Resident #17 had been found in the common area after breakfast that morning and tried to lie down or transfer herself to the couch. Resident #17 was found on the floor on her side. Resident #17 was wearing shoes and the anti-rollback device was on her wheelchair. Resident #17 was assessed for injury but was unable to move her limbs related to her pain. Resident #17's practitioner and representative were contacted and the resident was sent to the emergency room for evaluation.</p> <p>An administrative note, dated 2/6/25, revealed Resident #17 was sitting in the common area waiting for breakfast. Resident #17 was uncomfortable and attempted to transfer herself to the couch. She was found on the floor in front of her wheelchair. Resident #17 had a fall the night prior. Resident #17 had fallen early in the morning for both falls. Resident #17 had a one-on-one companion at the time of the note while her pain management was addressed.</p> <p>-Review of the resident's care plan did not identify a new person-centered intervention that was implemented following the fall and did not include the one-to-one companion.</p> <p>A progress note, dated 2/12/25 at 1:40 p.m., revealed Resident #17 was moved to a new room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interdisciplinary team progress note, dated 2/14/25 at 8:58 a.m., revealed Resident #17 had a recent fall. The team would continue to focus on pain management and positioning for Resident #17. Resident #17 was added to a one-on-one activity program.</p> <p>E. Staff interviews</p> <p>CNA #1 was interviewed on 2/26/25 at 2:43 p.m. CNA #1 said fall interventions were found in the resident's Kardex (staff directive tool). CNA #1 said the Kardex detailed if the resident needed a floor mat, how they needed to be transferred, and if they were a high fall risk. CNA #1 said Resident #17 wanted to</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#30) of three residents reviewed for catheters out of 24 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Obtain physician's orders for the use of Resident #30's catheter; and, -Maintain documentation for Resident #30's catheter care and maintenance. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Care of an Indwelling Catheter policy and procedure, undated, was received from the nursing home administrator (NHA) on 2/27/25 at 3:04 p.m. It read in pertinent part, Routine catheter care helps prevent infections and other complications, and is usually performed daily and as needed.</p> <p>Record/report the care performed, the condition of the perineum and urinary meatus, the character of the urine and/or any sediment build-up, and intake and output as ordered.</p> <p>II. Resident # 30</p> <p>A. Resident status</p> <p>Resident #30, age 82, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included end-stage renal disease, dementia, retention of urine and obstructive and reflux uropathy (conditions that cause urine to go back up the ureters and potentially damage the kidneys).</p> <p>The 2/7/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. The resident was dependent on staff for most activities of daily living (ADL).</p> <p>The MDS assessment indicated the resident had an indwelling urinary catheter.</p> <p>B. Observations</p> <p>On 2/24/25 at 11:11 a.m. Resident #30 was lying in bed with his urinary catheter bag clipped to his bed.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital notes, dated 1/28/25 at 8:38 a.m., revealed Resident #30 had a urinary catheter placed during his stay at the hospital on 1/25/25 and was to continue to use the foley catheter.</p> <p>A review of Resident #30's February 2025 CPO revealed the following physician's orders:</p> <p>Indwelling foley catheter. May flush foley catheter with normal saline and may change foley catheter when there is evidence of obstruction or catheter malfunction, suspected infection, or compromise to the closed system, ordered 2/27/25 (during the survey).</p> <p>1.) With mild soap and water wash area by wiping away from, never toward, the urinary meatus. 2.) Clean catheter of feces to minimize bacterial migration into the urethra and bladder. 3.) Do not pull on the catheter while cleaning it. 4.) Gently pat dry. 5.) Place the collection bag below bladder level. 6.) Place a cover over the collection bag for resident dignity. 7.) Ensure foley stabilization device is in place to prevent dislodgement/pulls on the catheter line. Allow one inch of slack, ordered 2/26/25 (during the survey).</p> <p>-The facility failed to obtain physician's orders for the flushing and maintenance of Resident #30's indwelling urinary catheter prior to the survey).</p> <p>Review of Resident #30's indwelling catheter care plan, initiated 2/5/25, revealed Resident #30 had a foley catheter in place for his urinary retention. Pertinent interventions included providing care and changing the catheter per physician order and performing catheter care every shift.</p> <p>A document, dated 2/7/25, revealed Resident #30 had a chronic foley catheter. Resident #30's practitioner documented the resident had obstructive uropathy present on admission, urinary retention and benign prostatic hyperplasia.</p> <p>-Review of Resident #30's catheter care task documentation, reviewed from 1/29/25 through 2/27/25, did not reveal any documented catheter care for the resident.</p> <p>Review of Resident #30's foley catheter output task documentation, reviewed from 1/29/25 through 2/27/25, revealed Resident #30 had urinary output recorded at least once per day from 2/13/25 through 2/26/25. Foley catheter output was recorded once per day on 2/16/25, 2/21/25, 2/23/25 and 2/26/25.</p> <p>-Urinary output was not recorded from 1/29/25 through 2/12/25, despite Resident #30 having a foley catheter in place.</p> <p>-Urinary output was recorded only once per day, rather than during each shift, on several days during the timeframe reviewed.</p> <p>-Review of Resident #30's January 2025 treatment administration record (TAR), from 1/29/25 through 1/31/25, did not reveal any documentation of urinary catheter care or maintenance.</p> <p>Review of Resident #30's February 2025 TAR revealed the following:</p> <p>Urinary catheter cleaning instructions (see February 2025 CPO above), initiated 2/26/25 (during the survey), was marked as completed on the evening of 2/26/25.</p> <p>(continued on next page)</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no documentation of urinary catheter care or maintenance on the February 2025 TAR prior to 2/26/25.</p> <p>-Review of progress notes, from 1/29/25 through 2/27/25, did not reveal any documentation of Resident #30's indwelling urinary catheter or catheter maintenance.</p> <p>D. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 2/26/25 at 2:43 p.m. CNA #1 said Resident #30 had a urinary catheter in place. CNA #1 said she did routine catheter care for Resident #30, which included draining the urinary catheter bag and recording his urinary output. CNA #1 said the CNAs at the facility wiped and cleaned Resident #30's catheter line and recorded they had done so on the catheter care task. CNA #1 said catheter care was performed every day and recorded in the electronic medical record (EMR).</p> <p>-However, there was no documentation of catheter care in the resident's catheter care documentation (see record review above).</p> <p>CNA #3 was interviewed on 2/27/25 at 8:18 a.m. CNA #3 said she performed catheter care two to three times per shift for Resident #30. CNA #3 said she cleaned the catheter using a washcloth to wipe down the catheter tubing starting from the meatus and working to the catheter bag. CNA #3 said she documented in the EMR at the end of her shift that she performed catheter care and emptied the catheter bag and recorded Resident #30's urinary output.</p> <p>-However, there was no documentation of catheter care in the resident's catheter care documentation (see record review above).</p> <p>Registered nurse (RN) #2 was interviewed on 2/27/25 at 11:35 a.m. RN #2 said there were two methods of documenting catheter care in the EMR which included the TAR or in the progress notes. RN #2 said catheter care needed to be documented each time so the appearance of the meatus and any discharge could be recorded and tracked.</p> <p>-RN #2 reviewed Resident #30's EMR but was unable to find any documentation regarding catheter care in the resident's progress notes or TARs.</p> <p>The infection preventionist (IP) was interviewed on 2/27/25 at 12:26 p.m. The IP said Resident #30 had had an indwelling urinary catheter since he returned from the hospital (on 1/29/25). The IP said catheter care should be performed at least once per shift. The IP said residents with urinary catheters usually had a physician's order in their EMR for the catheter itself. The IP said catheter care should be recorded in the TAR and the CNAs should document any catheter care they performed in the tasks section of the EMR. The IP said catheter care was performed to keep the catheter clean and prevent infection.</p> <p>The director of nursing (DON) and the IP were interviewed together on 2/27/25 at 1:00 p.m. The DON said catheter care should be performed during any peri-care and at least three to four times per shift. The DON said catheter care was recorded in the resident's EMR under the catheter care task. The DON said catheter care was performed to prevent infection.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said physician's orders for a urinary catheter were usually identified on the discharge instructions from the hospital and signed by the resident's practitioner on admission.</p> <p>-The DON and the IP both verified there was not an order for a urinary catheter in Resident #30's February 2025 CPO. The DON said the facility added a physician's order for a catheter (during the survey) for Resident #30, as it was missed during his readmission from the hospital. The DON said the physician's order for a urinary catheter did not get transferred to the facility's order system from Resident #30's hospital admission orders. The DON said the nursing staff should document catheter care each time it was performed.</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>50219</p> <p>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 possible development and transmission of infectious diseases.</p> <p>Specifically, the facility failed to ensure facility staff followed proper infection control procedures for a resident on enhanced barrier precautions (EBP).</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>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) (4/2/24), was retrieved on 3/4/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part,</p> <p>Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.</p> <p>EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>II. Facility policy and procedure</p> <p>The Enhanced Barrier Precautions policy and procedure, dated 3/1/24, was received from the nursing home administrator (NHA) on 2/27/25 at 1:53 p.m. It read in pertinent part, All staff receive training on high-risk activities and common organisms that require EBP.</p> <p>High-contact resident care activities include changing briefs or assisting with toileting and device care or use for urinary catheters.</p> <p>III. Observations</p> <p>On 2/24/25 at 11:11 a.m. Resident #30 was lying in bed with his urinary catheter bag clipped to his bed. A sign indicating that Resident #30 was on EBP was on his door and drawers containing PPE were positioned outside of his room.</p> <p>On 2/26/25 during a continuous observation of peri-care from 2:21 p.m. to 2:38 p.m. the following was observed:</p> <p>At 2:21 p.m. Resident #30 was lying in bed with his urinary catheter bag clipped to his bed. The director of rehabilitation (DOR) performed hand hygiene, donned gloves and pulled Resident #30 by his shoulders to reposition him in 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>At 2:24 p.m. the DOR repositioned Resident #30 and adjusted the resident's sheets on his bed.</p> <p>At 2:29 p.m. certified nurse aide (CNA) #1 performed hand hygiene and donned a gown and gloves before entering Resident #30's room. The DOR told Resident #30 that CNA #1 was donning a gown so she could perform peri-care but the DOR was just going to help the resident turn.</p> <p>At 2:33 p.m. the DOR helped Resident #30 turn over in his bed while CNA #1 performed incontinence care. The DOR pulled the sheet resting under Resident #30 to roll him and reposition him. The DOR then placed a pillow between Resident #30's legs.</p> <p>At 2:38 p.m. the DOR adjusted the fitted sheet on Resident #30's mattress and helped CNA #1 place a new blanket over the resident. The DOR then adjusted Resident #30's pillow under his head.</p> <p>-The DOR failed to don a gown to provide direct care to Resident #30, who had a catheter.</p> <p>IV. Staff interviews</p> <p>CNA #1 was interviewed on 2/26/25 at 2:43 p.m. CNA #1 said Resident #30 had an indwelling urinary catheter. CNA #1 said she wore a gown and gloves when performing catheter care and emptying the catheter bag.</p> <p>CNA #3 was interviewed on 2/27/25 at 8:18 a.m. CNA #3 said she performed catheter care for Resident #30 two to three times per shift. CNA #3 said she wore two pairs of gloves while performing catheter care. CNA #3 said she did not wear a gown while performing catheter care.</p> <p>The infection preventionist (IP) was interviewed on 2/27/25 at 9:00 a.m. The IP said education on EBP was ongoing with the staff. The IP said she had given the CNAs pocket guides on what EBP was and when to use it, initiated EBP care plans for residents that required it and had a binder at the nurses' station detailing which residents needed what precautions.</p> <p>The IP was interviewed again on 2/27/25 at 12:26 p.m. The IP said Resident #30 had an indwelling catheter. The IP said the staff needed to wear a gown and gloves whenever they transferred Resident #30, provided catheter care, and changed his sheets or clothing. The IP said both staff members need to wear a gown and gloves during incontinence care if one staff member was helping Resident #30 turn and the other was providing incontinence care. The IP said when staff had any contact with Resident #30 the staff needed to wear a gown and gloves. The IP said it was important to use EBP because any of Resident #30's clothing or sheets could have his urine on it and the facility did not want to risk transferring his urine to other residents.</p> <p>The IP said she did reeducation with the staff about what EBP was and when to use it a few days prior to the interview.</p> <p>The DOR was interviewed on 2/27/25 at 10:59 a.m. The DOR said the nursing staff needed to wear a gown and gloves whenever they were doing catheter care or dealing with urine. The DOR said if a resident had contact precautions they needed to wear a gown and gloves during transfers or other high-contact care. The DOR said when he was assisting with Resident #30 (see observation above) he was providing basic care and only needed to wear gloves. The DOR said the staff needed to don a gown whenever they were dealing with Resident #30's catheter or urine.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sharmar Village Senior Care Community		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 W Abriendo Ave Pueblo, CO 81004	
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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>Certified nurse aide with medication aide authority (CNA-Med) #1 was interviewed on 2/27/25 at 11:09 a.m. CMA-Med #1 said Resident #30 had an indwelling urinary catheter and required EBP. CNA-Med #1 said EBP needed to be followed any time the staff were going to be in contact with any bodily fluids. CNA-Med #1 said the nursing staff needed to wear PPE any time they performed incontinence care, emptied catheter bags, or provided other care in which they would be in direct contact with bodily fluids. CNA-Med #1 said PPE for EBP included wearing a gown and gloves. CNA-Med #1 said EBP was to prevent cross-contamination of the staff or the resident with any pathogens.</p> <p>Registered nurse (RN) #2 was interviewed on 2/27/25 at 11:35 a.m. RN #2 said EBP meant the staff needed to wear a gown and gloves when providing catheter care, transfers or other high-contact activities. RN #2 said EBP was used to prevent the transfer or contamination of drug-resistant bacteria.</p> <p>The director of nursing (DON) was interviewed on 2/27/25 at 1:00 p.m. The DON said when a resident was on EBP, the staff needed to wear a gown and gloves when providing any personal care, repositioning, changing linens and other care activities. The DON said PPE needed to be worn when doing any personal care for Resident #30, not just when dealing directly with his urinary catheter. The DON said EBP was used to protect residents from the transmission of MDROs.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112</p> <p>Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for two (#22 and #37) of six residents reviewed for antibiotic use out of 24 sample residents.</p> <p>Specifically, the facility failed to effectively track and monitor the use of long-term antibiotics for Resident #22 and Resident #37.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to The Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes, (2024), retrieved on 3/4/25 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html.</p> <p>To track how and why antibiotics are prescribed, (providers perform reviews on resident medical records for new antibiotics started to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.</p> <p>II. Facility policy and procedure</p> <p>The Antibiotic Stewardship policy and procedure, undated, was received from the nursing home administrator (NHA) on 2/24/25 at 11:58. It read in pertinent part,</p> <p>The goal of antibiotic stewardship is to prevent unnecessary side effects and adverse symptoms or illness as a result of antibiotic use and to limit their use to only true infections as determined by the McGreer criteria. Antibiotics should be prescribed in the least harmful way by being organism-specific, ordered in the shortest amount of time, and in the lowest dose to treat the infection. The McGreer criteria is used to evaluate documented symptoms.</p> <p>III. Resident #22</p> <p>A. Resident status</p> <p>Resident #22, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 computerized physician order (CPO), diagnoses included transient ischemic attack (a stroke that lasts only a few minutes), cerebral infarction (stroke), traumatic brain injury, overactive bladder, elevated white blood cell count, psychotic disorder with delusions, depression and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 1/29/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview (BIMS) score of seven out of 15.</p> <p>The assessment revealed the resident was not on an antibiotic.</p> <p>-However, review of Resident #22's electronic medical record (EMR) revealed the resident was currently receiving an antibiotic (see record review below).</p> <p>B. Resident #22's representative interview</p> <p>The resident's representative was interviewed on 2/24/25 at 2:06 p.m. She said Resident #33 was prone to urinary tract infections (UTI) and she did not think the facility was monitoring for signs and symptoms of UTIs.</p> <p>C. Record review</p> <p>Review of Resident #22's February 2025 CPO revealed the following physician's order:</p> <p>Nitrofurantoin 50 milligrams (mg), give one capsule by mouth one time a day prophylaxis (prevention), ordered 11/13/24.</p> <p>-The physician's order for the Nitrofurantin failed to indicate the duration for the use of the antibiotic and the diagnosis.</p> <p>The antibiotic therapy care plan, revised 10/31/24, revealed the resident was on antibiotic therapy related to UTI prevention. Interventions included administering the antibiotic medication as ordered, encouraging fluids, observing for side effects of medication use and reporting any changes to the physician.</p> <p>-Review of the resident's EMR did not reveal a risk versus benefit statement or a physician's justification for the long-term use of an antibiotic.</p> <p>-Review of Resident #60's EMR revealed no documentation to indicate the facility's infection preventionist (IP) completed an antibiotic use assessment or documented the McGeer's criteria met to justify the physician's order for Nitrofurantin.</p> <p>-Review of the IP infection surveillance documents from December 2024 to 2/26/25 revealed the facility identified residents with active infections.</p> <p>-However, the IP infection surveillance documents failed to include Resident #22's long-term use of Nitrofurantin.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 2/27/25 at 1:53 p.m. The IP said the facility's process for monitoring and tracking infections and antibiotic use included making sure the McGeer's criteria were met when there was a new antibiotic started or a resident admitted to the facility on an antibiotic. The IP said she discussed antibiotic usage with the medical director when an antibiotic was first ordered, when labs were needed and as needed. The IP said the medical director reviewed antibiotic use as needed if the resident was not improving, to monitor for efficacy and if sensitivity was obtained. The IP said the process for prophylactic antibiotic use was to monitor for side effects indefinitely.</p> <p>The IP said Resident #22 admitted to the facility on nitrofurantoin to prevent UTIs because she had frequent UTIs. The IP said the resident came from the hospital and the resident was on nitrofurantoin before the hospitalization . The IP said there was not a process for a physician to review the risk versus benefit when a resident was on an antibiotic for a prophylactic reason. The IP said she did not know what physician prescribed the antibiotic and followed the resident for prophylactic usage. The IP said there should be a duration and a reason Resident #22 was on nitrofurantoin.</p> <p>47350</p> <p>III. Resident #37</p> <p>A. Resident status</p> <p>Resident #37, age 70, was admitted on [DATE] and readmitted on [DATE]. According to the February 2025 CPO, the diagnoses included cirrhosis of the liver and non infective gastroenteritis and colitis (inflammation of the stomach and colon).</p> <p>The 1/24/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. She required partial/moderate assistance with eating, toileting personal hygiene, transfers and was independent with bed mobility.</p> <p>The assessment did not indicate Resident #37 was on antibiotics.</p> <p>-However, review of Resident #37's EMR revealed the resident was currently receiving an antibiotic (see record review below).</p> <p>B. Record review</p> <p>The February 2025 CPO documented the following physician's order:</p> <p>Cipro (an antibiotic) tablet 500 mg) once a day for abdominal infection, ordered 10/19/24 to be discontinued 10/19/25, one year after the initial order date.</p> <p>The 10/13/24 hospital progress noted documented spontaneous bacterial peritonitis (inflammation of the lining of the abdomen) and a left lower abdomen cellulitis (bacterial infection of the skin) with recommendations that Resident #37 would likely need long term prophylactic antibiotics after discharge.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no documentation in Resident #37's EMR to indicate side effects were being monitored while the resident was on the antibiotic.</p> <p>-There was no documentation in Resident #37's EMR to indicate an antibiotic checklist for Cipro had been completed (see IP interview below).</p> <p>-There was no infection surveillance line listing report provided for February 2025 for the Resident #37's prophylactic use of Cipro, signs/symptoms of infection, laboratory work and if McGeer's criteria were met.</p> <p>C. Staff interview</p> <p>The IP was interviewed on 2/27/25 at 9:00 a.m. The IP said the facility followed the McGeer's criteria for antibiotic stewardship. She said when an antibiotic was ordered or when the resident was admitted to the facility with an antibiotic, an antibiotic checklist was filled out and turned in the IP. She said she checked the dashboard every morning to see if any new antibiotics were ordered, the staff would fill out the antibiotic checklist and she would review the antibiotic stewardship to see if it met criteria. She said she would also review the supporting documentation and laboratory results. She said she would then map those infections and place them on her line list. She said she was not aware that Resident #37 was on an antibiotic when she was readmitted to the facility. She said Resident #37 had been hospitalized in October 2024 for liver disease. She said she reviewed Resident #37's medical record, during the survey, and it appeared she was being treated for an infection that was visible on her hospital CT (computed tomography) scan results. She said this should have been captured when she was readmitted, tracked and monitored for side effects and symptoms. She said she was not sure why this was not captured but would add Resident #3 so that the antibiotic was monitored and tracked.</p>