STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065373	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Senior Living	1685 S 21st St Colorado Springs, CO 80904

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47818 Based on observations, record review and interviews, the facility failed to ensure a resident who received respiratory care and services that is in accordance with professional standards of practice for one (#17) of one resident reviewed for oxygen therapy out of 23 sample residents. Specifically, the facility failed to ensure the physician's order for oxygen use was clarified to include when Resident #17 was to use her supplemental oxygen. Findings include: I. Policy and procedure The Oxygen Administration policy, revised October 2010, was received by the director of nursing (DON) on 5/6/24 at 5:38 p.m. read in pertinent: The purpose of this procedure is to provide guidelines for [NAME] oxygen administration. Preperation: verify that there is a physician's order for this procedure. Review the physician's order's or facility protocol for oxygen administration; and, review the resident's care plan to assess for any special needs of the resident. Assessments:before administering oxygen, and while the resident is receiving oxygen therapy assess for the following:vital signs. Documentation:after completing the oxygen setup or adjustment, the following information should be recorded in the resident's chart:the frequency and duration of the treatment; and,the reason for the PRN administration. A. Resident status Resident #17, age 67, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), the diagnoses included chronic obstructive pulmonary disorder (COPD) (group of diseases causing airflow blockage and breathing-related problems). (continued on next page)

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

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/1/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of nine out of 15. She required extensive assistance of two staff members for transferring and toileting and partial assistance with personal hygiene. The 4/1/24 assessment indicated Resident #17 was utilizing oxygen therapy and did not specify if the resident was using the oxygen continuously or intermittently. B. Resident interview and observation Resident #17 was interviewed on 5/1/24 at 11:09 a.m. Resident #17 was lying in bed watching television. There was an oxygen concentrator in her room turned on and set at 2 liters per minute (LPM). Resident #17 said she only wore oxygen at night. Resident #17 was interviewed again on 5/6/24 at 1:30 p.m. Resident #17 was sitting up in her bed eating lunch and watching television. There was an oxygen concentrator in the room in the off position. Resident #17 said she only wore oxygen at night because she had COPD. C. Record review The May 2024 CPO revealed an order for oxygen, revised on 3/27/24, for oxygen at 2 LPM via nasal cannula. -However, the physician's order did not indicate if Resident #17 needed to wear the oxygen continuously or intermittently. An outside provider company packet with a date range of 3/26/24 to 4/4/24 indicated Resident #17 was dependent on oxygen for both continuous and nocturnal use. The oxygen care plan, initiated on 4/10/24, revealed Resident #17 utilized oxygen therapy for a diagnosis of COPD. It indicated Resident #17 would have no signs or symptoms of poor oxygen absorption through the review date. Pertinent interventions included giving medications as ordered by the physician, monitoring and documenting side effects and effectiveness or medication and the oxygen setting was 2 LPM continuously. C. Staff interviews Registered nurse (RN) #1 was interviewed on 5/6/24 at 1:35 p.m. RN #1 said Resident #17 had a physician's order for supplemental oxygen. She said the physician's order did not include documentation that the oxygen was being used. RN #1 said she was unaware if Resident #17 wore oxygen continuously and would need to clarify the order with the physician prior to updating it. The DON was interviewed on 5/6/24 at 2:00 p.m. The DON said the nurse who put the physician's order for oxygen in the medical record did not indicate if it was for continuous use or just at night. The DON said she was unsure if Resident #17 was using 2 LPM of oxygen continuously. The DON said RN #1 was in the process of clarifying the order with the physician. D. Facility follow up (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 5/6/24 progress note (during the survey) indicated the facility had contacted the physician for Resident #17 and the order was clarified for Resident #17 to supplemental oxygen during hours of sleep (HS) and as needed (PRN). The May 2024 CPO revealed the resident had a physician order to receive 2 LPM per nasal cannula at bedtime and as needed, ordered 5/6/24 (during the survey).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on interviews and record review, the facility failed to ensure residents were free from significant medication errors for three (#18, #6, #188) of 11 residents reviewed for medication errors out of 23 sample residents. Specifically, the facility failed to: -Ensure physician's hospital discharge orders for antibiotics to treat a urinary tract infection (UTI) from the hospital were initiated when Resident #18 admitted to the facility; -Ensure Resident #18's antibiotic medication and an inhaler were available timely for administration per physician's order; -Ensure Resident #6's nasal spray was available for administration per physician's orders; and, -Ensure Resident #188's pain medication was available for administration per physician's orders. Findings include: I. Facility policy The Medication Administration policy, revised April 2019, was provided by the director of nursing (DON) on 5/6/24 at 5:38 p.m. It read in pertinent part, Medications are administered in a safe and timely manner and as prescribed. Policy interpretation and implementation: the director of nursing (DON) supervises and directs all personnel who administer medications. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Factors considered include enhancing the optimal therapeutic effect of the medication and medications are administered within one hour of the prescribed time, unless otherwise specified. II. Resident #18 A. Resident status Resident #18, age greater than 65, was admitted on [DATE] and was discharged to the hospital on 4/21/24. According to the April 2024 computerized physician orders (CPO), diagnoses included UTI, acute kidney injury and COPD. The 4/3/24 minimum data set (MDS) assessment documented Resident #18 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required substantial/maximum assistance with bathing, toileting and transfers. He required partial/moderate assistance with dressing and hygiene. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment documented Resident #18 was admitted with an indwelling urinary catheter and he was prescribed antibiotics -However, the antibiotics were not administered as ordered (see record review below). B. Record review 1. Amoxicillin 500 milligrams (mg) twice daily for five days. A review of the 3/31/24 hospital discharge summary revealed the resident was prescribed Amoxicillin 500 mg twice daily for five days for treatment of a UTI. The April 2024 CPO included the following physician's order: Amoxicillin capsule 500 mg to treat a UTI, take one capsule by mouth two times a day for five days, ordered on 4/2/24. -The initial physician's order for Amoxicillin prescribed by the hospital physician upon the resident's discharge from the hospital on 3/31/24 was not in the April 2024 CPO. -Due to the antibiotics order not being entered into the physician's orders when Resident #18 admitted to the facility, the resident did not receive two doses of the Amoxicillin on 4/1/24. -There was no documentation in the electronic medical record (EMR) indicating the physician was notified the resident had missed two doses of the Amoxicillin on 4/1/24. -The facility's physician evaluated Resident #18 on 4/2/24, noted the Amoxicillin order was not in the resident's physician's orders and reordered the Amoxicillin as initially prescribed. -Despite the physician reordering the Amoxicillin on 4/2/24, a review of the resident's EMR revealed the resident was not administered the Amoxicillin 500 mg capsule two times a day on 4/2/24 or 4/3/24 and one dose of the medication on 4/4/24 because the medication was unavailable or on order. -There was no documentation in the EMR indicating the physician was notified that the resident had missed five doses of the Amoxicillin on 4/2/24, 4/3/24 and 4/4/24. -Between 4/1/24 and 4/4/24, Resident #18 missed seven doses of the Amoxicillin which had initially been ordered on 3/31/24 upon the resident's discharge from the hospital. 2. Umeclidinium/Vilanterol (inhaler used to treat COPD) 62.5 mcg (micrograms)-25 mcg/inh (inhalation). Take one puff orally once a day to prevent bronchospasm (sudden constriction of the lungs) caused by COPD. The April 2024 CPO included the following physician's order: Umeclidinium/Vilanterol 62.5 mcg-25 mcg/inh. Take one puff orally once a day to prevent bronchospasm (sudden constriction of the lungs) caused by COPD, ordered 4/1/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A review of the resident's EMR revealed the resident was not administered the Umeclidinium/Vilanterol medication on 4/1/24, 4/2/24, 4/3/24, 4/4/24, 4/5/24, 4/6/24, 4/7/24, 4/8/24 and 4/10/24 because it was not available. -There was no documentation indicating the physician was notified that the resident missed the doses on 4/1/24, 4/2/24, 4/3/24, 4/4/24, 4/5/24, 4/6/24, 4/7/24 and 4/8/24. The 4/6/24 nursing progress note documented the nurse followed-up with the pharmacist. The progress note documented the medication exceeded the facility's maximum price allowance for medication and the DON needed to approve the medication prior to filling the prescription. -A review of the resident's EMR did not indicate follow-up with the DON was completed to obtain approval for the medication. III. Resident #6 A. Resident status Resident #6, age 74, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included bipolar disorder, anxiety, muscle weakness, hypertension (high blood pressure) and malnutrition. The 4/18/24 MDS assessment documented Resident #6 was cognitively intact with a BIMS score of 15 out of 15. She required substantial/maximal assistance with bathing and partial/moderate assistance with toileting and dressing. She needed set-up assistance for eating and hygiene. B. Resident interview Resident #6 was interviewed on 5/6/24 at 12:15 p.m. Resident #6 said she used the nasal spray medication at night because it relieved her respiratory symptoms to help her sleep. She said when she did not have the medication, she felt miserable. Resident #6 said she had asked the staff about why the nasal spray was missing multiple times and never received a helpful response from the staff. She said she was told the medication had been ordered or had not arrived from the pharmacy. C. Record review The May 2024 medication orders included: -Fluticasone 50 mcg/act nasal suspension spray (medication used to control symptoms of nasal congestion, runny nose, sneezing and itching), two sprays in each nostril at bedtime for rhinitis (runny nose), ordered 4/12/24. -A review of the resident's EMR revealed the resident was not administered the Fluticasone 50 mcg/act nasal suspension spray on 4/12/24, 4/13/24, 4/14/24, 4/17/24, 4/18/24, 4/19/24, 4/21/24, 4/22/24, 4/24/22, 4/25/24, 4/26/24, and 5/2/24 because the medication was not available. The resident refused the medication on 5/1/24. The 4/16/24 nursing progress note documented the medication was unavailable because it was on order from the pharmacy. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 4/20/24 nursing progress note documented the medication was unavailable because it was on order from the pharmacy. -There was no documentation indicating the physician was notified the medication was not administered. -There was no documentation indicating the pharmacy had been contacted to determine when the medication would be delivered to the facility. IV. Resident #188 A. Resident status Resident #188, age greater than 65, was admitted on [DATE], discharged to the hospital on 4/24/24 and readmitted to the facility on [DATE]. According to the May 2024 CPO,diagnoses included Alzheimer's dementia, stroke, non-Hodgkin's lymphoma (cancer), aphasia (loss of ability to understand or express speech) and cognitive communication deficit. The 4/24/24 MDS assessment documented Resident #188 had severe cognitive impairment with a BIMS score of four out of 15. She required partial/moderate assistance with bathing, toileting, dressing and transfers. She needed assistance with bed mobility, eating, and hygiene. B. Record review The April 2024 CPO documented the following physician's order: Hydrocodone-Acetaminophen (Norco) 5-325 mg give one tablet by mouth three times a day, ordered 4/26/24. The 4/26/24 nursing progress note documented the resident did not receive the 8:00 p.m. dose of the Hydrocodone-Acetaminophen tablet because the medication was not available. -A review of the resident's EMR did not reveal the physician was notified that the resident had missed the 8:00 p.m. doses of the Hydrocodone-Acetaminophen tablet. The 4/27/24 nursing progress note documented that all three doses of pain relief medication were not administered that day because the medication was not available. The note documented the medication had been ordered. -A review of the resident's EMR did not reveal the physician was notified that the resident missed all three doses of the Hydrocodone-Acetaminophen tablet. The 4/28/24 nursing progress note documented that all three doses of the pain relief medication were not administered that day because the medication was not available. The note documented the medication had been ordered. -A review of the resident's EMR did not reveal the physician was notified that the resident missed the three doses of the Hydrocodone-Acetaminophen. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V. Staff interviews Registered nurse (RN) #2 was interviewed on 5/2/24 at 1:12 p.m. RN #2 said the admitting nurse was responsible for verifying and entering the physician's orders upon admission into the resident's EMR. RN #2 said after the orders were entered, the orders were automatically sent to the pharmacy electronically. She said medications were delivered to the facility the next time the pharmacy delivered medications to the facility. RN #2 said the pharmacy delivered medications twice a day to the facility. RN #2 said medications for a newly admitted resident were sometimes not included with the next medication delivery. She said sometimes it took the pharmacy more time to fill new prescriptions before the next delivery was sent out. RN #2 said the facility had an automated medication dispensing machine which stored several medications for emergency use. She said when the pharmacy did not deliver medications on time, a nurse could obtain in-stock medications from the dispensing machine while they waited for the pharmacy delivery. RN #2 said urgent medications, such as antibiotics, blood pressure, and pain medications, were usually in the dispensing machine. She said some medicines required pharmacy authorization for the nurse to access the medications. RN #2 said she had worked at the facility for approximately 18 months and received education on medication ordering from the MDS nurse and other coworkers. She said she did not recall other education on medication ordering and follow-up. She said several months ago, during a staff meeting, a co-worker nurse raised concerns about late/missing medication deliveries from the pharmacy. RN #2 said she understood when medications had not been received after the first or second pharmacy delivery, the nurse should call the pharmacy to follow-up on the order and delivery status. She said the nurse should notify the physician about medication delays and missing medication doses. RN #2 said it was important to notify the physician of a missing or late medication so the physician could consider a substitute medication or change treatments. RN #2 said if the physician was not informed about medication delays, the resident could experience adverse outcomes like declining health or delayed healing. RN #2 said if there was a delay in an antibiotic administration, a resident could experience worsening of an infection. RN #2 said there was a shift report twice daily and nurses discussed medication concerns that needed follow-up. RN #2 said when residents were administered antibiotics, nurses needed to monitor their responses to medication, especially when antibiotics had been administered. She said it was essential to assess allergic reactions, monitor vital signs, focus on the infectious process and consider if the resident tolerated the medication. RN #2 said the assessments were documented in the resident's EMR when they were completed. RN #2 said medication delays could contribute to negative outcomes such as withdrawal, prolonged discomfort and delayed healing. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON was interviewed on 5/2/24 at 1:43 p.m. The DON said when medications were unavailable, the nurse was prompted to enter a progress note to document the information. The DON said the nurses' progress notes populated to the 24-hour report and she and/or the assistant director of nursing (ADON) reviewed the report daily. The DON said when the ADON or herself reviewed the 24-hour report they were alerted when medications were unavailable for administration. The DON said the nurse progress notes were overlooked on the 24-hour report for Residents #18, #6 and #188. The DON said when she noted medications were missed she called the pharmacy to attempt to expedite medication delivery when necessary. The DON said each medication delay would have a different reason, so the delay's causes varied. The DON said if the first dose of a medication was unavailable, the nurses needed to utilize the dispensing machine. She said the machine included just about every medication, so missed or late doses should not happen. The DON said the facility had a maximum price watch budget which meant they needed to be careful when high cost medications were ordered. However, the DON said she was not notified of Resident #18's high cost inhaler and she was unaware of the medication delays and missed medication doses for Residents #18, #6 and #188. The DON said nurses received education on medication ordering and follow-up from co-workers when they were hired. The DON said the pharmacy had provided ordering information handouts and were available at the nurse's desk at all times. The DON said she had not provided education on medication ordering and follow-up when medications were unavailable. She said the nurses learned the medication ordering process during orientation and should ask a coworker or a nurse leader for assistance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases. Specifically, the facility failed to: -Ensure the facility monitored the water for the growth of Legionella; and, -Ensure Resident #12 was offered the COVID-19 vaccine. Findings include: I. Water management A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Toolkit: Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings,(3/25/21), retrieved on 5/4/24 from https://www.cdc.gov/legionella/wmp/toolkit/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flegionella%2Fmaintenance%2Fwmp-toolkit.html read in pertinent part, Many buildings need a water management program to reduce the risk for Legionella growing and spreading within their water system and devices. Legionella bacteria are typically found naturally in [NAME] environments but can become a health concern when they grow and spread in human-made water systems. Legionella can cause a serious type of pneumonia (lung infection) known as Legionnaires' disease. Some water systems in buildings have a higher risk for Legionella growth and spread than others. Legionella water management programs are now an industry standard for many buildings in the United States. Legionella bacteria can cause a serious type of pneumonia called Legionnaires' disease. Legionella bacteria can also cause a less serious illness called Pontiac fever. The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review. Seven key elements of a Legionella water management program are to: -Establish a water management program team; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Describe the building water systems using text and flow diagrams; -Identify areas where Legionella could grow and spread; -Decide where control measures should be applied and how to monitor them; -Establish ways to intervene when control limits are not met; -Make sure the program is running as designed (verification) and is effective (validation); and, -Document and communicate all the activities. Principles: In general, the principles of effective water management include: -Maintaining water temperatures outside the ideal range for Legionella growth; -Preventing water stagnation; -Ensuring adequate disinfection; and, -Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met. Monitoring Water Quality Parameters: The water management program team should regularly monitor water quality parameters, such as disinfectant residual and temperature levels. By monitoring these parameters, the team can ensure that building water systems are operating in a way to minimize hazardous conditions that could encourage Legionella and other waterborne pathogens to grow. If the team finds that a control limit temperature, disinfectant residual) is not being met, their next step will be to take corrective actions to get conditions back to within an acceptable range. Examples of chemical and physical control limits to reduce the risk of Legionella growth include: -Maintain hot water temperature at the highest temperature allowable by state regulations or codes and outside the favorable range for Legionella growth (77-113 degrees (fahrenheit) F). -Ensure disinfectant levels are detectable where water enters the building and at points of use. According to CDC' s Controlling Legionella in Potable Water Systems, (2/3/21) retrieved on 5/4/24 from, Store hot water at temperatures above 140 degrees F and ensure hot water in circulation does not fall below 120 degrees F. Recirculate hot water continuously, if possible. Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 degrees F); Legionella may grow at temperatures as low at 68 degrees F. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Facility policy The Water Management Program policy, undated, was received by the director of nursing (DON) on 5/2/23 at 10:32 a.m. and read in pertinent part, Monitoring and verification plan, cold water service monitoring task included: -Cold water temperature should be checked weekly. The limit is less than 77 degrees Fahrenheit (F). -Legionella culture test annually on a rotating basis. Hot water service, centralized, water storage systems monitoring. -Water storage or supply temperature should be checked weekly. -The temperature limit is 140 to145 degrees Fahrenheit with a thermostatic mixing valve (TMV) or 130 to 135 degrees Fahrenheit without a TMV. -Legionella culture test should be completed annually on a rotating basis. C. Record review The Legionella testing and watering monitoring results for March 2024 and April 2024 were requested from the DON on 5/2/24. A review of the March 2024, April 2024 and May 2024 work history report revealed the log marked the hot water was tested on [DATE], 3/9/24, 3/16/24, 3/23/24, 3/30/24, 4/6/24, 4/13/24, 4/20/24, 4/27/24 and 5/4/24. On 5/6/24 at 2:40 p.m. the maintenance director (MTD) provided the water temperature testing results for April 2024 and May 2024 from the direct supply electronic logbook. The logbook documented the following water temperature monitoring: On 4/3/24, the water temperature was tested in a resident room on the memory care unit. It was 113 degreesF. On 4/11/24, the water temperature was tested in resident room [ROOM NUMBER]. The temperature was 114 degrees F. On 4/19/24, the water temperature was tested in a non-specified resident room on the skilled unit. The temperature was 112 degrees F. 4/27/24 the water temperature was tested in a non-specified location on the memory care unit. The temperature was not recorded. On 5/2/24, the water temperature was tested in a non-specified location on the memory care unit. The temperature was 113 degrees F (continued on next page)

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	065373	A. Building B. Wing	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Senior Living	1685 S 21st St Colorado Springs, CO 80904

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	D. Interviews The DON was interviewed on 5/6/24 at 10:00 a.m. The DON said she shared the infection preventionist (IP) role with the assistant director of nursing (ADON). She said the IP was not a water management team member. She said she knew about the program but had not been responsible for the implementation or monitoring of the water testing for Legionella. The DON said if the water temperatures were out of range, an additional control measure was not used to monitor or test the water. The DON said the MTD tested water temperatures monthly and they sent a water sample on 5/1/24 for the annual analysis. She said the facility ordered the analysis to be completed because the water temperatures were not always in the range to prevent Legionella growth. She said waiting for a laboratory water analysis could delay follow-up monitoring when the follow-up to missed control measures is urgent. The DON said she would review testing and monitoring options for immediate results if water temperatures were not within control limits. The MTD was interviewed on 5/6/24 at 2:57 p.m. The MTD said he was unaware the hot water temperatures had not met the control measure temperature for hot water storage or supply of 130 to 135 degrees Fahrenheit (control without TMV). He said he entered the result into the log when he measured water temperatures. The MTD said when water temperatures were within the favorable range for Legionella growth which was 77 to 113 degrees F. He said there was no additional monitoring until the 5/1/24 water analysis was completed. The MTD said the facility tested the water one time a year. He said the water sample was collected by a third-party laboratory and was collected on 5/1/24. The MTD said the facility cooling tower/chiller included an oxidizing biocide, a chemical to kill microorganisms in the water. He said the chemical level was included in the water analysis and he was unaware of what level of the chemical was necessary to prevent the growth of Legionella. II. COVID-19 vaccine failure A. Professional reference The CDC' s Stay Up to Date with COVID-19 Vaccines (3/7/24) was retrieved on 5/7/24 from https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html and read in pertinent part, The CDC recommends the 2023-2024 updated COVID-19 vaccines. Everyone aged five years and older should get one dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19 . People aged [AGE] years and older who got the previous COVID-19 vaccine(s) before 9/12/23 should get one updated COVID-19 vaccine. People who are up to date have a lower risk of severe illness, hospitalization , and death from COVID-19 than people who are unvaccinated or who have not completed the doses recommended for them by CDC. B. Facility policy The COVID-19 Ongoing Vaccination Plan, dated 7/1/23, was provided by the NHA on 5/1/24 at 9:05 a.m. It read in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Immunization with a safe and effective COVID-19 vaccine is a critical component of the strategy to reduce COVID-19 related illnesses. Facility COVID-19 vaccination coordinator is responsible for organizing and overseeing any COVID-19 vaccination efforts at the facility. The vaccination coordinator is responsible for organizing the COVID-19 vaccination clinic. The registered nurse vaccination director is responsible for documenting and reporting vaccinations and received training from nursing school and the pharmacy that provided the vaccinations. The facility procedure to determine if residents have been fully vaccinated for COVID-19 is to ask the resident for their vaccination card and log the vaccine information into the facility vaccine tracking portion of the electronic medical record. The facility promotes the COVID-19 vaccine to residents by emailing residents and family members in a group email. C. Resident #12 1. Resident status Resident #12, over the age of 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included generalized arthritis and muscle weakness. The 2/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) with a score o f15 out of 15. 2. Record review -A review of Resident #12' s EMR on 5/2/24 revealed the resident was not offered the COVID-19 vaccination since being admitted to the facility on [DATE]. The EMR did not indicate if the resident had received any COVID-19 vaccinations prior to admission to the facility. D. Staff interviews The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 5/6/24 at 10:00 a.m. They said they shared the responsibility of keeping track of resident vaccination status. The ADON said when residents were admitted to the facility, she or the DON reviewed the medical records to gather the resident' s vaccination history. The ADON said if the resident had not received the most recent COVID-19 vaccine, the facility offered the vaccine upon admission. The ADON said the information was documented in the electronic medical record (EMR) if the facility administered a vaccine. The ADON said if the resident had previously received vaccines, the vaccine documentation was scanned into the EMR and filed under the miscellaneous tab. The ADON said the facility did not otherwise track and document resident immunization information. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ADON said she was unable to find documentation which indicated Resident #12 was educated, offered, received or refused the COVID-19 vaccine since her admission on 11/3/23. The DON said the facility should follow state and CDC guidelines for offering vaccines and documenting the vaccination status of each resident in their EMR.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536 Based on record review and staff interviews, the facility failed to develop and implement policies and procedures related to pneumococcal vaccines for one (#12) of five residents reviewed for vaccinations of 23 sample residents. Specifically, the facility failed to ensure Resident #12 was offered the pneumococcal vaccine. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Pneumococcal Vaccine Recommendations website, revised 9/21/23, was retrieved on 5/7/24 from https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html. It read in pertinent part, CDC recommends routine administration of pneumococcal conjugate vaccine (PCV15 or PCV20) for all adults [AGE] years or older. II. Facility policy The Pneumococcal Vaccine policy, revised March 2022, was provided by the director of nursing (DON) on 5/6/24 at 1:21 p.m. It read in pertinent part, All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series unless medically contraindicated. Assessments of pneumococcal vaccination status are conducted within five working days of the resident's admission. Residents have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record. For each resident who received the vaccination, the appropriate information is documented in the resident's medical record. III. Resident #12 A. Resident status (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included generalized arthritis and muscle weakness. The 2/10/24 minimum data set (MDS) documented Resident #12 had no cognitive impairment, as evidenced by a brief interview for mental status (BIMS) score of 15 out of 15. The assessment indicated the pneumococcal vaccine status had not been assessed. B. Record review -A review of the resident's electronic medical record (EMR) on 5/2/24 revealed the resident had not been offered the pneumococcal vaccine since she was admitted to the facility on [DATE]. The EMR did not indicate if the resident had received any pneumococcal vaccinations prior to her admission to the facility. IV. Staff interviews The assistant director of nursing (ADON) and the DON were interviewed together on 5/6/24 at 10:00 a.m. They said they shared the responsibility of keeping track of resident vaccination status. The ADON said when residents were admitted to the facility, she or the DON reviewed the medical records to gather the resident's vaccination history.The ADON said if a resident had not received the pneumococcal vaccine, the facility offered the vaccine upon admission. The ADON said the information was documented in the EMR if the facility administered a vaccine. The ADON said if the resident had previously received vaccines, the vaccine documentation was scanned into the EMR and filed under the miscellaneous tab. The ADON said the facility did not otherwise track and document resident immunization information. The ADON said she was unable to find documentation which indicated Resident #12 was educated, offered, received or refused the pneumococcal vaccine upon her admission on 11/3/23. The ADON said the DON and herself missed reviewing Resident #12's immunization history upon admission to determine if she was due for a pneumococcal vaccination. The DON said the facility should follow state and CDC guidelines for offering vaccines and documenting the vaccination status of each resident in their EMR