STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065382	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Skyline	2365 Patriot Hts Colorado Springs, CO 80904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 47150 Based on observations, record review and interviews, the facility failed to ensure residents who needed respiratory care was provided such care, consistent with professional standards of practice for one (#1) of two residents reviewed for the use of supplemental oxygen of 27 sample residents. Specifically, the facility failed to ensure Resident #1's oxygen was consistently administered according to physician's orders. Findings include: I. Facility policy and procedure The Oxygen Administration policy, revised April 2024, was provided by the nursing home administrator (NHA) on 4/17/2025 at 3:03 p.m. It read in pertinent part, The nurse should monitor oxygen administration and record the resident's response to oxygen therapy in the medical record. Verify that there is a physician's order for the procedure. Review the healthcare provider's orders or community protocol for oxygen administration. II. Resident #1 A. Resident status Resident #1, age 65, was admitted on [DATE]. According to the April 2025 computerized physicians orders (CPO), diagnoses included chronic respiratory failure with hypercapnia and hypoxia (a condition where there is an excess of carbon dioxide in the blood and low levels of oxygen in body tissue), chronic obstructive pulmonary disease (COPD), muscle weakness, cognitive communication deficit, phocomelia of the limbs (a rare congenital anomaly with the proximal aspect of an extremity is absent with the hand or foot) anxiety disorder, altered mental status and pneumonitis due to inhalation of food and vomit. The 1/14/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three out of 15. The assessment indicated the resident did not have any behaviors or rejections of care during the assessment period. She was dependent on staff due to upper and lower impairment on both sides and required extensive to maximum assistance with care. (continued on next page)

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 MDS assessment indicated the resident required continuous oxygen. B. Record review The oxygen care plan, initiated 1/14/25, revealed Resident #1 received oxygen therapy related to COPD, chronic respiratory failure. Pertinent interventions included providing oxygen via nasal canal between two to four liters per minute (LPM) during the day at a continuous flow per physician's orders. The April 2025 CPO included: -Oxygen at two to four LPM continuously via nasal cannula, ordered 4/7/25. C. Observations and interviews On 4/15/25 at 10:45 a.m. Resident #1 was in her room. There was an oxygen concentrator in her room, but the nasal canula was not in place via nasal canula. There was a portable oxygen tank on the back of the resident's wheelchair. However, the portable oxygen concentrator was empty. The personal care provider alerted the facility staff about the resident's oxygen tank being empty. Certified nursing assistant (CNA) #5 said the oxygen tank was empty. The resident was having difficulty understanding her personal care provider, who was visiting her. On 4/16/25 at 2:45 p.m., Resident #1 was in her room. She was talking on the phone. The resident repeatedly asked the individual she was speaking to on the phone if she was coming to get her. Resident #1 asked licensed practical nurse (LPN) #1 if her oxygen tank was working. The LPN checked the resident's portable oxygen tank and said she was replacing it for the resident. LPN #1 took the portable tank with her, leaving the resident with no oxygen for approximately two minutes. She returned with a full tank for the resident. D. Staff interviews Certified nursing aide (CNA) #5 was interviewed on 4/16/25 at 4:05 p.m. CNA #5 said Resident #1's portable oxygen tank was refilled by the night shift and the CNA's ensured that the resident had her oxygen on at all times. CNA #5 said the resident was receptive to having staff assist her with wearing her nasal cannula and would not resist or decline the oxygen use. CNA #5 said Resident #1 would get short of breath and display other medical complications if she was not receiving continuous oxygen. CNA #5 said she tried to keep an eye on all the portable oxygen tanks but sometimes they ran out without her noticing CNA #5 said Resident #1's portable oxygen tank was usually set between 2 to 4 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 4/16/25 at 4:25 p.m. LPN #1 said Resident #1 had a physician's order for 2 to 4 liters of continuous oxygen (LPM). She said all staff nursing members were responsible to check the portable tanks to ensure they were not empty. LPN #1 said oxygen was considered a medication and a physician's order for a resident to receive oxygen should be followed accordingly. She said the resident could suffer medical complications such as shortness of breath. The director of nursing (DON) was interviewed on 4/16/25 at 4:56 p.m. The DON said it was important for physician's orders to be followed. She said all of the CNA's and nurses were responsible for monitoring the portable oxygen tanks to ensure they were not empty. The DON said if Resident #1 was having difficulty and appeared agitated, the staff should have checked her oxygen tank. She said the nursing staff should have ensured that Resident #1 received continuous oxygen as prescribed by the physician. The DON said she had updated the medication administration record (MAR) for the nursing staff to check all portable tanks more frequently. She said she would immediately provide education to the nursing staff about the importance of oxygen administration and the proper monitoring of oxygen use.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 43950 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12-months and provide regular in-service education based on the outcome of these reviews for two of two certified nurse aides (CNA). Specifically, the facility failed to complete annual performance reviews and provide regular in-service education based on the outcome of the reviews for CNA #2 and CNA #3. Findings include: I. Facility policy and procedure The Annual Performance Planning Guide, undated, was provided by the nursing home administrator (NHA) on 4/17/25 at 4:47 p.m. It read in pertinent part, Performance planning is a critical part of the performance management process. While annual reviews are a look back, performance plans are a look forward. A collaborative process between associate and supervisor, they set the foundation for performance management by establishing clear and defined individual performance and development goals for the year. Revisit the performance plan throughout the year to measure progress, discuss obstacles, give feedback, and coach to success. At annual review time, measure performance against the goals set in the performance plan. Performance planning is a process conducted by a supervisor and their direct reports in which together they plan the performance goals for the upcoming year and discuss developmental goals. II. Record review Annual performance reviews were requested on 4/16/25 at 10:35 a.m. The facility was unable to provide annual performance evaluations for CNA #2 (hired 2/17/2020) and CNA #3 (hired 7/8/08). -CNA #2 and CNA #3 did not have an annual performance review completed and did not have an in-service education plan based on the outcome of the review. III. Staff interviews The director of nursing (DON) was interviewed on 4/17/25 at 3:21 p.m. The DON said the facility should complete a performance review of the CNAs at least once every 12 months and provide regular in-service education based on the outcome of the review. The DON said the facility had not completed it yet but their policy said it should be done. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON said she could not locate the reviews for CNA #2 and CNA #3. The DON said the purpose of completing the performance review was to see how the CNAs were doing, what they needed help with and to give feedback and set expectations. The DON said she would be doing a skills fair and regular in-service education based on the outcomes of the review. The DON said the plan now was to do the annual reviews and skills fair. She said she would start that within the next quarter to get everyone reviewed.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to attain or maintain his or her highest practical physical, mental, and psychosocial well-being for two (#29 and 42) of three residents reviewed for dementia care out of 27 sample residents. Specifically, the facility failed to effectively identify person-centered approaches for dementia care for Resident #29 and Resident #42 to provide the resident with their highest practicable quality of life and care. Findings include: I. Facility policy and procedure The Dementia Care policy and procedure, revised February 2022, was received from the nursing home administrator (NHA) on 4/16/25 at 10:39 a.m It read in pertinent part, Residents who have been diagnosed as having dementia should have a resident-centered care plan to maximize remaining abilities and quality of life. II. Resident #29 A. Resident status Resident #29, age 83, was admitted on [DATE]. According to the April 2025 computerized physician orders (CPO), diagnoses included dementia, type 2 diabetes mellitus with other diabetic neurological diabetic neurological complications, scrotal varices (enlarged veins in the scrotum that can cause pain), urinary tract infections and hearing loss. The 1/10/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of five out of 15. He required total assistance with toileting, showering, personal hygiene and dressing and moderate assistance with oral hygiene. The assessment revealed the resident did not reject care and did not exhibit physical or verbal behaviors or wander. B. Resident #29 interview and observations Resident #29 was interviewed on 4/15/25 at 10:45 a.m. The resident was in his wheelchair on the left side of his bed in his room. He said help me and said he wanted to go to bed. At 10:59 a.m. certified nurse aide (CNA) #7 went into the resident's room. The resident said he wanted to go to bed. The CNA said it was almost time for lunch and assisted the resident to the dining area. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:20 a.m. Resident #29 was in his room. He said help, help. CNA #6 went into his room. Resident #29 said he wanted to be in bed. CNA #6 said it was almost time for lunch and he could not go to bed. At 11:23 p.m. CNA #6 assisted Resident #29 out of the resident's room. At 11:26 a.m. Resident #29 went back in his room. He was on the left side of his bed, rolling back and forth in a repetitive motion. At 11:28 a.m. Resident #29 initiated his call light indicating he needed assistance. At 11:29 a.m. CNA #8 went into the resident's room. CNA #8 did not provide the resident with any care and left the room within the minute. At 11:30 a.m. Resident #29 initiated his call light. CNA #7 and CNA #8 went into Resident #29's room. Resident #29 said he wanted to go to bed. CNA #7 and CNA #8 said it was lunchtime and assisted the resident to the dining area. Between 11:30 a.m. and 11:35 a.m. Resident #29 assisted himself back to his room. At 11:35 a.m. Resident #29 was back in his room. An unidentified CNA was assisting another resident when they walked past Resident #29's room, Resident #29 was sitting in his doorway and attempted to reach for the unidentified CNA. -However, the staff did not offer any person-centered care when the resident requested to go to bed multiple times. During a continuous observation on 4/16/25, beginning at 11:12 a.m. and ending at 12:54 p.m., the following was observed: At 11:12 a.m. Resident #29 was in his wheelchair in his room on the left side of his bed with his head down. At 11:16 a.m.,Resident #29 left his room and looked at the newspaper that was on the counter in the common area. At 11:19 a.m. Resident #29 self-propelled back to his room and was on the left side of his bed. At 11:25 a.m. Resident #29 left his room, turned off his bedroom light and went back to the dining room. At 11:27 a.m. an unidentified CNA walked passed Resident #29, he said help and she said one second. The unidentified CNA left the common area. Resident #29 went to his room, turned on his bedroom light and went to the left side of his bed. From 11:30 a.m. to 11:32 a.m. Resident #29 left his room, turned his bedroom light off and went to the farthest dining table from his room. He was sitting in his wheelchair in front of the dining table with no activities in front of him. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 11:38 a.m. Resident #29 returned to his room. He turned his bedroom light on. He went to the left side of his bed. He turned around and he was at his doorway and said help nurse help. He turned off his bedroom light and went back to the dining table closest to his room. At 11:43 a.m. Resident #29 returned to his room, turned on his light, went to the left side of his bed and began rolling back and forth in a repetitive motion in his wheelchair. At 11:46 a.m. Resident #29 left his room, turned his bedroom light off and went to the dining table closest to his room. At 11:48 a.m. Resident #29 returned to his room, turned on his light, went to the left side of his bed and began rolling back and forth in a repetitive motion in his wheelchair. At 11:53 a.m. Resident #29 left his room, turned off his bedroom light, went to the dining table closest to his room and then self-propelled himself around the dining area. From 11:58 a.m. until 12:04 p.m. Resident #29 returned to his room, turned on his light, went to the left side of his bed and began rolling back and forth in a repetitive motion. At 12:05 p.m. Resident #29 was sitting in his doorway. He raised his hand when licensed practical nurse (LPN) #3 walked by. She told him he was first on the list for the scenic drive outing at 2:30 p.m. He looked at his watch and went to the dining table closest to his room. At 12:13 p.m. Resident #29 went to the dining table closest to his room. At 12:15 p.m. Resident #29 returned to his room, turned on his light, went to the left side of his bed and began rolling back and forth in a relative motion. At 12:26 p.m. Resident #29 left his room and went to the dining table farthest away from his room. At 12:33 p.m. an unidentified CNA walked by Resident #29. He told the CNA he had terrific pain in his scrotal area and needed a pain pill. The CNA said she would tell the nurse. At 12:35 p.m. Resident #29 went to his room and the CNA went to the nurse's station. At 12:37 p.m. LPN #3 went to Resident #29's room. At 12:42 p.m. Resident #29 left his room and went to the dining table farthest away from his room. At 12:46 p.m,. LPN #3 was with Resident #29 at the dining table farthest away from the resident's room. Resident #29 said his testicle hurt. LPN #3 offered incontinence care and Resident #29 declined. -During the observation, the staff failed to address the resident's request for help and provided person-centered interventions for the residents' behaviors. C. Record review (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #29's dementia care plan, initiated on 2/4/23 and revised on 3/15/23, revealed the resident had impaired cognitive function or impaired thought processes. Interventions included communicating with the resident, family and caregivers regarding the resident's capabilities and needs, encouraging the resident to take medications offered and asking yes or no questions to determine the resident's needs. -The care plan failed to include the resident's repetitive behavior of rolling back and forth, requests to go to bed before, asking for help or person-centered interventions to address the resident's behaviors. Review of Resident #29's activities care plan, revised on 9/22/24, revealed the resident benefited from associate support for resident programs. Interventions included establishing and recording the resident's prior level of activity involvement and interest with the resident, caregiver, and family on admission and as necessary, inviting the resident to programs of interest, preferred activities were reading the newspaper ,and family visiting. An additional intervention initiated on 4/17/25 (during the survey) included for the staff to assist the resident to bed per his preference when requested. -The care plan failed to include the request for a bed before the start of the survey (see staff interview below). III. Resident #42 A. Resident status Resident #42, age 85, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included dementia, Parkinson's disease (disease that causes tremors), hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following cerebral infarction (stroke) affecting the right dominant side, insomnia (difficulty sleeping) and depression, The 3/4/25 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of 11 out of 15. He required moderate assistance with oral hygiene, showering and moderate assistance He required substantial assistance with toileting. The assessment revealed the resident did not reject care, did not exhibit physical or verbal behaviors or wander. B. Additional resident interviews Resident #153 was interviewed on 4/15/25 at 11:10 a.m. He said Resident #42 wandered into his room once since he was admitted to the facility. He said he did not know what the facility was doing to prevent him from coming into his room. Resident #38 was interviewed on 4/15/25 at 3:07 p.m. She said Resident #42 sometimes would wander into her room in the evening. She said did not know what the facility was doing to prevent him from coming into her room. She was frustrated he wandered into her room because it took time away from the staff to redirect the resident out of her room. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Observations During a continuous observation on 4/16/25, beginning at 11:12 a.m. and ending at 12:54 p.m., the following was observed: Resident #42 was observed in his bed lying on his right side with his eyes closed. D. Record review Review of Resident #42's wandering care plan, revised 3/23/25, revealed the resident was at risk for elopement and the resident wandered aimlessly. Interventions included discussing the risks, discussing safe discharge with the resident and responsible party, distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, identifying patterns of wandering and intervening as appropriate, monitoring location throughout the shift and documenting wandering behaviors and attempting diversional interventions. The care plan documented the resident prefers: (blank). -However, the care plan failed to identify the resident wandered into other resident's rooms, interventions to prevent wandering into other resident's rooms and did not specify the resident's preferences. The 3/5/25 nurse progress note revealed the resident made many attempts to wander into other resident's rooms. He was not easily redirected. The staff had to sit with the resident one-on-one at times to keep him from entering others' rooms. The 3/6/25 nurse progress note revealed the resident continued to wander around and sometimes in other resident's rooms. The 4/14/25 nurse progress note revealed the resident often exhibited increased wandering and agitation at this time of day due to disease process. The 4/16/25 nurse progress note revealed the resident was confused and wandered around the common area and attempted to go into another resident's room. He was not easily redirected. He was provided with snacks and games. -Review of the Resident #42's progress notes revealed there was not consistent documentation regarding what interventions were used and which interventions were effective when the resident's wandering was observed. The behavior monitoring and intervention task record was reviewed from 3/19/25 to 4/17/25. It revealed Resident #42 was known to have wandering on 3/22/25, 3/23/25, 3/28/25, 3/30/25, 4/4/25, 4/6/25, 4/7/25, 4/8/25, 4/11/25 and 4/16/25. -Review of the behavior monitoring and intervention task record revealed there was no documentation regarding what interventions were used and which interventions were effective when the resident's wandering was observed. IV. Staff interviews (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered nurse (RN) #1 was interviewed on 4/15/25 at 8:55 a.m. RN #1 said she was familiar with Resident #42. At the time of the interview, she said he was sitting at a dining table near the kitchenette near his room. She said he often wandered and he moved very quickly. She said she had to keep her eyes on him because he was quick to stand up. During the interview, RN #1 directed CNA #6 to assist the resident as he was trying to stand up. LPN #3 was interviewed on 4/17/25 at 3:44 p.m. LPN #3 said if a resident had dementia and they asked to go to bed, the nursing staff should help the resident go to bed. She said if a resident was consistently doing the same behavior, there should be interventions to redirect the resident. She said she needed to document behaviors she observed during her shift. She said she needed to do a better job of documenting the behaviors residents exhibited, what interventions she used and if the interventions were effective. LPN #3 said Resident #29 had dementia. LPN #3 said he asked to go to bed, he would go in and out of his room and roll back and forth on the left side of his bed daily. She said she did not know what interventions to redirect the resident to meaningful activities that were person-centered worked for him. She said she knew he liked participating in activities that were outside of the facility. She said Resident #39 went on an outing yesterday (4/16/25). LPN #3 said Resident #42 wandered and had dementia. LPN #3 said he wandered most recently on Friday and Saturday. She said he slept during the day because his sleep schedule was off. LPN #3 said he experienced sundowners (confusion and agitation occurring in the late afternoon or early evening). She said the physician adjusted his medications to try to help with his sleep pattern but she said she has not seen a change in his sleep. She said she needed to be better at documenting when he wandered, what interventions she used and if the interventions were effective. The director of nursing (DON) was interviewed on 4/17/25 at 4:06 p.m. She said if a resident had dementia and they asked to go to bed, the nursing staff should not say it was almost time for lunch. The DON said the nursing staff could do better in offering personalized interventions for dementia residents. She said if the resident was asking for help or the same behavior, there should be personalized interventions in place to help redirect the resident. The DON said she knew Resident #29 asked to go to bed frequently. She said effective interventions to prevent the resident from going to bed before meal time were offering a newspaper or a banana.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, record review and interviews, the facility failed to ensure meals were served according to the resident's preferences for one (#103) of three residents out of 27 sample residents. Specifically, the facility failed to ensure Resident #103 received the meal items she ordered. Findings include: I. Resident #103 A. Resident status Resident #103, age greater than 65, was admitted on [DATE]. According to the April 2025 CPO, diagnoses included dementia, depression and Parkinson's disease (a disease that causes tremors). B. Resident interview and observations Resident #103 was interviewed on 4/17/25 at 12:20 p.m. The resident said she had problems with her lunch meal. The resident's meal ticket did not indicate the resident's choice for the lunch meal on 4/17/25 as it was blank. Resident #103 said this happened all the time since she was admitted to the facility. The resident said her son helped her fill out her meal tickets but the meal ticket that was delivered with her lunch tray was blank. She said she did not know what happened to her meal ticket that was completed a few days ago with the help of her son. The resident said she did not order the food on her tray so she did not eat it. C. Observations and resident representative interview During a continuous observation on 4/17/25, beginning at 12:25 p.m. and ending at 12:50 p.m. the following was observed: Resident #103's son arrived at the facility to visit his mother during lunch. The resident's son asked the registered dietitian (RD) the reason his mother's meal ticket was blank. He said he completed the meal ticket with a nurse on the phone and the meal his mother received was not what they had ordered. The (RD said she was not sure why the meal ticket was blank. The resident's son said it had been an issue since the resident was admitted to the facility and that's the reason he called to ensure that the ticket was completed. D. Record review The nutrition care plan, dated 4/10/25, revealed the resident was at nutritional risk as evidenced by her medical diagnosis. Interventions included providing the resident her diet as ordered and monitoring meal intake with each meal. II. Staff interviews (continued on next page)

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	065382	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookdale Skyline	2365 Patriot Hts Colorado Springs, CO 80904

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #4 was interviewed on 4/17/25 at 1:05 p.m. CNA #4 said the nursing staff assisted the residents who needed assistance to complete their meal tickets. CNA #4 said Resident #104's son assisted the resident in completing her meal ticket. She said she did not know why her ticket came back blank. The RD was interviewed on 4/17/25 at 12:40 p.m. The RD said Resident #103's son had called her and requested to assist his mother to complete the meal ticket. She said she gave the blank meal tickets to the nursing staff and it was completed on the phone with the resident's son. The RD said she does not know what happened to that meal ticket. The RD said the dietary staff should review and ensure all meal tickets were completed, submitted and notify the nursing staff of any incomplete meal ticket. The RD said she did not know this was happening and she would consult with the dietary department to come up with a plan to prevent this from happening again. The dining service supervisor (DSS) was interviewed on 4/17/25 at 12:55 p.m. The DSS said sometimes the dietary department received blank meal tickets. The DSS said when this happened the dietary staff would serve the main dish for the residents whose meal tickets were not completed. She said the nursing staff were supposed to assist the residents in completing their meal tickets. She said she was not sure if that was happening, as they received several blank meal tickets. She said the dietary staff should be reviewing the meal tickets to ensure they were completed and calling the nursing staff to verify every incomplete ticket. The DSS said if the meal tickets were not reviewed and verified for any inconsistencies, residents would receive meals that they did not order or preferred to eat. The executive chef (EC) was interviewed on 4/17/25 at 1:10 p.m. The EC said the dining service staff should be reviewing the meal tickets and informing the nursing staff of all inconsistencies to ensure residents receive their food preferences. The EC said he would consult with the dietary team to review their meal ticket process and immediately offer education to the staff to prevent the issue from happening again.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 52045 Based on observations and interviews, the facility failed to ensure an infection prevention and control programs (IPCP) was maintained and followed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on one of three units. Specifically, the facility failed to ensure staff wore the appropriate PPE when providing wound care for Resident #50 who was on enhanced barrier precautions (EBP) related to an abdominal wound. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of MDROs, retrieved on 4/22/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, It read in pertinent parts, EBP are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization, as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for enhanced barrier precautions include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator) and wound care, any skin opening requiring a dressing. II. Facility policy and procedure The Isolation Precautions policy, revised September 2022, and the Enhanced Barrier Precautions Policy, revised February 2025, was received from the director of nursing (DON) on 4/17/25 at 1:45 p.m. The policy read in pertinent part, EBP should be used as an infection prevention and control intervention to reduce the spread of MDROs to residents. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to associate hands and clothing. Gloves and gown may be applied prior to performing high-contact resident care activity. PPE is changed before caring for another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EBPs are indicated with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage (Band-Aid) or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. III. Observations On 4/15/25 at 11:25 a.m. there was a sign on Resident #50's door that indicated the resident was on EBP. The sign on the resident's door indicated gloves and a gown must be worn for resident care activities, including dressing, bathing/showering, transferring, linen changes, providing hygiene, changing briefs or assisting with toileting and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies and wound care. On 4/16/25 10:43 a.m. registered nurse (RN) #2 was completing wound care for Resident #50, who had a. abdominal wound. RN #2 had gloves on. RN #2 failed to put on a gown. IV. Resident interview Resident #50 was interviewed on 4/16/25 at 2:36 p.m. Resident #50 said the nurses never put on gowns when changing his abdominal wound dressing or when changing his abdominal wound vacuum machine. Resident #50 said they only wore gloves. V. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 4/16/25 at 2:44 p.m. CNA #1 said when she was providing care for Resident #50, she put on gloves and a gown. She said if she was going to assist the resident transfers, using the bathroom or helping the nurse with wound care, she would put on a gown and gloves to ensure the resident would not get an infection. RN #2 was interviewed on 4/16/25 at 3:00 p.m. RN #2 said Resident #50 was on EBP. She said the staff should wear gloves and a gown when providing wound care or when providing any close contact activities to protect the resident from getting an infection. RN #2 said she forgot to put on a gown today when she was changing his abdominal wound dressing. RN #2 said staff should put on gloves and gowns before going into Resident #104's room because he had an infectious bacteria in his wound. She said wearing a gown and gloves helped prevent the resident's infection from transferring to staff or residents. The director of nursing (DON) was interviewed on 4/16/25 at 4:33 p.m. The DON said if a resident was on precautions, the facility's procedure was to ensure there was a sign on the door to inform the staff the precautions that needed to be followed. She said if the resident was on precautions, a cart with PPE was stored outside of the resident's room. She said the nursing staff was provided education so they knew how to correctly care for the residents and prevent the transmission of bacteria or cause an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON said it was the responsibility of the nursing staff to update the care plan so all of the staff knew how to address the care needs for the individual residents. The DON said the staff should put on gloves and a gown before entering Resident #104 room and remove the gloves and gown before exiting the room. The DON said staff should put on gloves and gown with any high contact care for Resident #50 such as wound care, bathing, dressing, transfers and assisting the resident to the bathroom. The infection preventionist (IP) was interviewed on 4/16/25 at 4:55 p.m. The IP said staff should put on gloves and a gown when providing wound care for Resident #50 to ensure the wound does not get infected. The IP said she did not think the staff had to wear a gown when transferring a resident that was on EBP. The IP said Resident #50 had physician's orders that indicated he was on EBP. The IP said she was responsible for training the nursing, dietary and rehabilitation staff regarding EBP and contact precautions procedure. She said she would conduct surveillance and audits in addition to giving all staff re-education on the different precaution procedures. The IP said if the nurses and the CNA's did not read the care plan, that could have been the reason precaution procedures were not followed.