STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065412	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green House Homes at Mirasol, The	490 Mirasol Dr Loveland, CO 80537

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 48112 Based on record review and interviews, the facility failed to ensure a response, action, and rationale to residents involved in group grievances. Specifically, the facility failed to provide a response, action, and rationale for resident concerns brought up in the resident council meetings, related to staff not making the residents' beds, the type of mattresses provided by the facility and the type of napkins provided during mealtime. Findings include: I. Facility policy and procedure The Complaints and Grievances policy and procedure, undated, was received from the nursing home administrator (NHA) on 3/12/25 at 5:15 p.m. It read in pertinent part, The administrator shall ensure all written grievances decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued. II. Resident group interview A resident group interview was conducted on 3/11/25 at 2:00 p.m. with five residents (#2, #21, #24, #27 and #81), who were identified as alert and oriented through the facility and assessment. All residents in the group interview said the certified nurse aides (CNA) were responsible for making their beds and the CNAs did not make their beds the way they liked. The residents said the CNAs would not fold the sheet at the head of the bed and the CNAs did not tuck in their sheets on the sides of their beds. The residents said they wished the CNAs knew how to make their bed the way they liked because the facility was their home and their bed was the only furniture they had to show visitors. The residents said they had visitors come to their rooms and the residents said if the bed was made right, they made a good impression to their visitors. The residents said staff knew their beds were not made to their preferences but nothing was done about correcting the problem. Resident #21 said the type of napkins the facility used at mealtimes were slick and not absorbent. (continued on next page)

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

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #24 said she agreed with Resident #21. Resident #24 said she was unable to leave her napkin on her lap because the napkin fell on the ground. The residents said staff knew the residents did not like the napkins. The residents said they had talked about the concern in resident council meetings. However, the residents said the staff members who attended the resident council meetings wrote down their concerns and their concerns were lost after the resident council meetings. The residents said staff did not follow up with a resolution to their concerns. Resident #81 said the type of mattress he had for his bed was too soft. He said he complained to the CNAs and the CNAs said there was nothing they could do to help him. III. Resident council meeting notes The November 2024 resident council meeting notes were reviewed. The notes revealed Resident #81 wanted to talk to someone about different mattress options. A notation under the dietary section read napkins!!!! -A request for records to reveal Resident #81's request for different mattress options was made on 3/12/25, however, the facility was unable to provide documentation to indicate Resident #81's concern had been addressed. -There was no additional documentation regarding the concerns about the napkins The December 2024 resident council meeting notes were reviewed. The notes revealed, in the old business section, that residents requested cotton napkins or paper napkins because the current napkins were not absorbent and slid off the residents' laps. -There was no documentation in the December 2024 resident council meeting notes that the concerns the residents brought up in the November 2024 resident council meeting about different mattresses were reviewed or approved by the residents. The January 2025 resident council meeting notes were reviewed. -There was no documentation in the January 2025 resident council meeting notes that the concerns the resident brought up in the December 2024 resident council meeting regarding the napkins were reviewed or approved by the residents. The February 2025 resident council meeting notes were reviewed. The notes revealed, in the old business section, that residents requested cotton napkins or paper napkins. The notes revealed the residents still needed new napkins. Additionally, the February 2025 resident council meeting notes revealed Resident #27 said her bed was not made properly. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a complaint and concern report, which was undated, revealed the residents wanted cotton or paper napkins. The response and action taken at the time of report section revealed the residents were told they could ask for paper towels. The follow-up action section revealed to ensure paper napkins and paper towels were available per preference. The complaint resolved to satisfaction box was checked as yes. -The recommendation from the resident council committee was left blank. There was no date when the report was initiated. There was no identification of which resident was satisfied with the follow-up action. -Additionally, the resident group interview revealed the concern regarding the napkins had not been resolved (see resident group interview above). Review of a second complaint and concern report, which was undated, revealed the residents said their beds were not getting made. The response and action taken at the time of the report section revealed the CNAs were asked to make beds. The follow-up action section revealed follow-up with the CNA peer mentor to ensure beds were made after the residents were up for the day. -The recommendation from the resident council committee was left blank. The complaint resolved to satisfaction was left blank. There was no date when the report was initiated. There was no identification of which resident was satisfied with the follow-up action. -Additionally, the resident group interview revealed the concern regarding the napkins had not been resolved (see resident group interview above). IV. Staff interviews The life enrichment director (LED) was interviewed on 3/12/25 at 12:36 p.m. The LED said she was new to the position and started in mid-November 2024. The LED said she was responsible for coordinating the resident council meetings. The LED said when a resident brought up a concern at the resident council, she went over the concern in the next day's morning meeting with the department heads. She said the department head was responsible for resolving the concerns. The LED said she did not go over the department's response in the next resident council meeting and she did not ask the resident council if they approved of the response from the facility to resolve the concern. The LED said the bed-making, napkins, and mattress concerns were not resolved. The NHA was interviewed on 3/12/25 at 2:51 p.m. The NHA said the LED was new to the position. The NHA said the LED was responsible for coordinating the resident council meetings. She said the resident council meeting concerns were reviewed in the morning meeting the day after the resident council meeting was held. The NHA said she was not aware of the mattress concern raised in the November 2024 meeting. She said she would follow up. The NHA said she was aware napkins were a resident council concern. She said the facility would find a better solution to satisfy the residents' concern with the facility's napkins.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on interviews and record review, the facility failed to ensure the activities program was directed by a qualified professional. Specifically, the facility failed to employ a qualified activities director in order to provide a program of activities for residents requiring activity and recreational support. Findings include: I. Professional reference According to the National Certification Council of Activity Professionals (NCCAP) (2023), retrieved on 3/17/25 from www.nccap.org, an activity director must meet specific qualifications in education, certification and/or experience. The qualifications read in pertinent part, The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist; or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and -Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or -Has two (2) years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or -Is a qualified occupational therapist or occupational therapy assistant; or -Has completed a training course approved by the State. An activity director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This includes completion of the activities component of the comprehensive assessment; contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident. II. Record review A copy of the life enrichment director's (LED) resume was provided by the nursing home administrator (NHA) on 3/12/25 at 4:12 p.m. The resume revealed the LED was the activities director at the facility from November 2024 to the present and was a certified nurse aide (CNA) at the facility from April 2023 to November 2024. From April 2020 to April 2023, the LED was a ward clerk (administrative help in a hospital). (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resume revealed the LED was not a qualified therapeutic recreation specialist or an activities professional, did not have two years of experience in a social or recreational program within the last five years, was not a qualified occupational therapist or occupational therapy assistant and had not completed a training course approved by the state. III. Staff interviews The LED was interviewed on 3/12/25 at 12:36 p.m. The LED said she was new to the position. She said she was a CNA at the facility for two to three years and became the LED in mid-November 2024. She said prior to working at the facility, she was a CNA at other skilled nursing facilities for over [AGE] years. She said she started to take an activities director course in November 2024 and had not completed the class. She said the NHA was her mentor. The NHA was interviewed on 3/12/25 at 2:51 p.m. The NHA said the LED did not complete an activities director course and she was not sure if the LED had two years of experience in a social or recreational program. The NHA said she needed to check the LED's prior experience at other nursing facilities. The NHA was interviewed again on 3/12/25 at 3:26 p.m. The NHA said she confirmed with the LED that she did not have the qualifications to be an activities director. The NHA said the LED was taking a break from working as a CNA and the last time she had social or recreational program experience was more than five years ago.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52045 Based on observations, record review and interviews, the facility failed to provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two (#10 and #40) of two residents out of 37 sample residents. Specifically, the facility failed to: -Ensure staff provided edema care per physician's order for Resident #10; and, -Ensure staff followed up with the physician regarding high blood levels of iron and the continued use of an iron supplement for Resident #40. Findings include: I. Failed to ensure staff provided edema care per physician's order for Resident #10 A. Resident status Resident #10, age 82, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses include edema, oxygen use and skin cancer. The 2/28/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required set up assistance with chair to chair transfers and toileting. B. Observations and resident interview On 3/9/25 at 3:08 p.m. Resident #10 was sitting in her recliner in her room. Both of the resident's feet and legs were very swollen and she was not wearing any compression devices on her legs or feet. Resident #10 said the staff was supposed to help put on her leg wraps every day in the morning, however, she said the staff was sometimes too busy to put them on and she felt bad for asking them to do it. On 3/10/25 at 2:00 p.m. Resident #10 was sitting in her recliner in her room. Both of the resident's feet and legs continued to be very swollen and she was not wearing any compression devices on her legs or feet. On 03/12/25 at 1:30 p.m. Resident #10 was sitting in her room. She had black stockings on her legs. -However, the physician's order was for the resident to have ace wraps applied to her legs, not black stockings (see physician's orders below). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review Review of Resident #10's comprehensive care plan revealed that the resident had a diagnosis of edema (a medical term for swelling caused by fluid building up in body tissues) in her legs and feet. -However, there was no intervention listed in her care plan to treat her edema. Review of the March 2025 CPO revealed that Resident #10 had a physician's order for ace wraps with kerlix gauze to be applied on both legs and feet for swelling in the morning and removed at night everyday. -However, observations of Resident #10 on 3/9/25 and 3/10/25 revealed the resident did not have compression wraps on her legs (see observations above). Review of the March 2025 treatment administration record (TAR) revealed nurses documented that the resident's ace wraps and kerlix gauze were applied on 3/9/25 and 3/10/25. -However, Resident #10 was observed without compression wraps on her legs on 3/9/25 and 3/10/25 and black stockings on her legs on 3/12/25 (see observations above). D. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 3/12/25 at 1:46 p.m. CNA #2 said staff put Resident #10's black stockings on in the morning and took them off at night. CNA #2 said if the resident refused to wear them, staff would document that. -However, review of Resident #10's electronic medical record (EMR) revealed no documentation to indicate the resident refused to wear her compression wraps. Registered nurse (RN) #1 was interviewed on 3/12/25 at 1:53 p.m. RN #1 said it was the responsibility of the nurses or CNAs to apply compression devices to Resident #10's legs if there was a physician's order. She said staff put Resident #10's black stockings on in the morning. RN #1 said she did not notice that the resident had an order for ace wraps with kerlix to be applied in the morning and removed at night everyday, instead of black stockings. She said it was her responsibility to check the physician's orders to make sure the correct treatments were being given to residents. The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 3/12/25 at 4:39 p.m. The DON said the nursing staff was to follow the physician's order for the use of compression stockings for Resident #10. The DON said the use of compression stockings should be updated on the resident's care plan. 51916 I. Failed to ensure staff followed up with the physician regarding high blood levels of iron and the continued use of an iron supplement for Resident #40 A. Professional reference (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Mayo Clinic's article on ferritin tests (12/29/23), retrieved from https://www.mayoclinic.org/tests-procedures/ferritin-test/about/pac-20384928 on 3/17/25, A ferritin test measures the amount of ferritin in the blood. This test can be used to find out how much iron the body stores. The typical range for blood ferritin in women is 11 to 307 micrograms per liter (mcg/L). If you have a high ferritin level, your health care professional might need to look at the results of other tests to figure out next steps. According to the Cleveland Clinic's article on ferritin tests (5/17/22), retrieved from https://my.clevelandclinic.org/health/diagnostics/17820-ferritin-test on 3/17/25, Symptoms of having too much ferritin or iron include painful joints, heart issues, unexplained weight loss, abdominal pain, and fatigue or loss of energy. B. Resident status Resident #40, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses included diverticulitis of the intestine, part unspecified, without perforation or abscess without bleeding, unspecified congestive (diastolic) heart failure, rheumatoid arthritis (RA) with rheumatoid factor, unspecified, and restless legs syndrome (RLS). The 1/14/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She was mostly independent in activities of daily living (ADL), transferring and mobility with her walker but required supervised assistance with showering. C. Resident observations and interviews Between 3/9/25 and 3/12/25 Resident #40 was observed during multiple different times of the morning and afternoons. She spent most of her time resting in her recliner with her legs elevated, either sleeping or watching television. Resident #40 was interviewed on 3/9/25 at 1:55 p.m. Resident #40 said she did not participate in activities or get around much in the day due to her cancer, arthritis, stomach pain and general fatigue. She said she had not left her room in weeks and was getting weaker and requiring increased assistance with care. Resident #40 said facility staff and physicians were not always good about informing her when her medications were discontinued, needed to be held or when doses changed so when she had problems she would notify management directly. D. Record review The medication regimen reviews (MRR) conducted by the pharmacist for September 2024 and October 2024 were provided by the nursing home administrator (NHA) on 3/11/25 at 1:10 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the September 2024 and October 2024 MMRs revealed the pharmacist had made recommendations to the facility to decrease Resident #40's iron supplement administration from every day to every other day, as this would allow for better absorption while potentially causing fewer troublesome side effects for the resident. -Review of Resident #40's medication administration records (MAR) for September 2024 and October 2024 revealed that she continued to receive an iron oral tablet 325 milligrams (mg) daily, despite the pharmacist's recommendation to change the dosage to every other day. Review of Resident #40's November 2024 and December 2024 MARs revealed that Resident #40's order for the iron supplement was changed to every other day on 11/19/24 (two months after the pharmacist made the initial recommendation). The iron supplement order resumed back to daily on 12/6/24 and was discontinued completely on 12/17/24. The order for iron supplements was resumed daily again on 12/29/24. Resident #40's care plan was updated on 12/9/24 to address her alteration in gastrointestinal (GI) status due to diverticulitis of the intestines. Interventions included discussing with the resident, family and caregivers any concerns, fears or issues related to GI distress, encouraging Resident #40 to avoid foods or beverages that tended to irritate her esophageal lining, such as alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods and to give medications as ordered, monitoring and documenting side effects and effectiveness. -Further review of the resident's electronic medical record (EMR) revealed there were no progress notes which documented why Resident #40's iron supplement was resumed on a daily basis on 12/29/24. -There was no documentation in Resident #40's EMR to indicate the facility had provided the resident with education related to the risks of taking her iron supplement. The MARs for January 2025, February 2025 and March of 2025 revealed that Resident #40 had been receiving her 325 mg iron oral supplement daily since 12/29/24. Laboratory (lab) results, reported to the facility on [DATE] from a blood draw performed on 12/30/24, revealed Resident #40 had a ferritin level of 497.7 mcg/L with a recommended range of 13 to 150 mcg/L. A nursing progress note, dated 1/15/25 at 11:40 p.m. documented the lab results were posted in the resident's EMR for review and the hospice nurse practitioner (HNP) was notified via message. A nursing note, dated 1/15/25 at 5:48 p.m., documented Resident #40 was lethargic, sleeping more than normal and eating less. Resident #40 told the nurse she felt the increase of her scheduled Morphine was causing her to feel this way. A nursing note, dated 1/15/25 at 6:04 p.m., documented that the hospice physician changed her Morphine dose back to BID (twice a day). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 1/16/25 hospice progress note documented that it was the hospice nurse's responsibility to assess Resident #40's medication responses and to instruct on scheduling, action, purpose, side effects, compliance and need to report side effects to the hospice staff. The hospice physician signed an attestment in the 1/16/25 progress note which read I attest that I have reviewed the medication profile for effectiveness of drug therapy, drug side effects, actual or potential drug interactions, duplicate drug therapy, and drug therapy currently associated with laboratory monitoring. -The hospice documentation failed to address Resident #40's elevated ferritin level. A nursing note, dated 1/16/25 at 10:45 p.m., documented Resident #40 was found to be alert but drowsy with difficulty keeping her eyes open and slurred speech. Her oxygen saturation was at 66%. The nurse obtained an order to administer oxygen 2L via nasal cannula from the hospice physician. The nurse indicated that this intervention was effective as her oxygen increased to 93% and was then placed on change of condition charting and frequent monitoring. A nursing note, dated 1/19/25 at 12:25 p.m., documented Resident #40 was verbalizing the wish to die because she felt very nauseated and sick and that she had been sleeping more often than normal and not eating or drinking. The note indicated that the hospice nurse was notified and said someone would come to evaluate her. An alert note, dated 1/20/25 at 12:01 p.m., documented Resident #40 was complaining of an upset stomach and requested pain medication. The writer of the note indicated Resident #40 was educated on the negative effects pain medication had on the GI system but she wanted the medication regardless, as well as Zofran for nausea. The resident was instructed to increase oral fluids as tolerated. Resident #40 reported feeling weaker than normal and requiring assistance with ambulation to the bathroom. A pain evaluation note, dated 1/21/25 at 11:02 p.m., documented Resident #40 said she felt like she was dying. A physician progress note dated 2/25/25 at 2:51 p.m. revealed Resident #40 was to begin taking folic acid oral tablet 1 mg while on Methotrexate for rheumatoid arthritis (RA) to decrease the side effects of this medication. (Pertinent side effects included loss of appetite, feeling or being sick, stomach pain or indigestion, and feeling tired or drowsy.) -However, review of Resident #40's progress notes from 1/15/25 through 3/12/25 failed to reveal that the resident's high ferritin level or her continued order for the daily iron supplement were addressed by the facility. A nursing note, dated 3/12/25 at 2:26 p.m. (during the survey), revealed that Resident's #40's high ferritin level from 12/30/24 was reported to the PCP's triage team at 2:02 p.m. and a physician's order to draw another ferritin level was requested. -Review of Resident #40's progress notes and care plan did not reveal documentation that the resident insisted upon taking her iron supplement despite the associated risks (see interviews below). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 3/12/25 at 1:30 p.m. LPN #1 said when the physician discontinued Resident #40's iron supplement in December 2024 due to frequent loose, tarry stools, the resident was very angry and demanded that it be resumed. She said the resident said she had been taking it all her life and was adamant that she needed it for her RLS and she was tired of people messing around with her medications. LPN #1 said the resident's supplement was resumed because Resident #40 insisted that her iron supplement not be removed from her medication regimen. -However, there was no documentation in the resident's EMR to indicate the resident was insistent about taking the medication or that she had been educated regarding the risks of continuing to take it (see record review above). LPN #1 said she always notified the physician immediately about abnormal lab results. She said if she had to leave a voice message, she would review the resident's EMR to ensure that abnormal lab results were reviewed by the physician. She said she was not certain as to whether or not Resident #40 had been educated on the risks and benefits of taking her iron supplement, however, she said after being alerted to the lack of notes indicating if the elevated ferritin levels had been addressed, she planned to notify the resident's PCP because she worried at this point that the resident's ferritin level could be at a critical level. The pharmacy consultant (PC) was interviewed on 3/12/25 at 3:10 p.m. The PC said if ferritin levels were high, she would recommend holding the iron and rechecking the serum ferritin level as well as iron. She said because Resident #40's ferritin level was not critical, gastrointestinal (GI) upset would likely be the most distressing symptom for the resident. The PC said excess ferritin levels would be the result of excess iron being carried within the blood stream so if there was free iron in the blood or the iron was not being absorbed or excreted, it could indicate high levels. She said it would be recommended to hold the supplement and re-evaluate if ferritin levels were high. The PC said high iron levels could also indicate liver damage. She said high ferritin levels alone were not directly correlated with high iron levels. The PC said her colleague (who reviewed Resident #40's record) made the recommendations in September 2024 and October 2024 to change the iron supplement from daily to every other day. She said she was uncertain as to why no recommendations regarding the iron supplement were made in January 2025. The director of nursing (DON) was interviewed on 3/12/25 at 4:50 p.m. The DON said if the facility received an abnormal lab result for a resident, the facility would continue monitoring the labs and reassess with the provider. She said if a resident were receiving a supplement and levels came back high, the facility would discontinue or decrease the amount of supplement given. However, she said if the resident had a preference to continue the supplement as is, the facility would honor that preference and educate the resident on the risks involved with continuing the supplement and care plan the resident's preference appropriately. -However, Resident #40's care plan did not reflect that it was the resident's preference to continue the iron supplement and no documentation was found to indicate that the resident's physician was contacted to discuss the iron levels and resident's preferences (see record review above). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said the facility tried to discontinue Resident #40's iron supplement and have it given on alternate days, per the pharmacist's recommendations but the resident insisted that she needed it for her RLS. She said the hospice nurse practitioner (HNP) educated the resident on the risks some time in December 2024 and a note was documented around the same time the lab was drawn regarding the education. -However, the elevated ferritin result from the lab draw on 12/30/24 did not get reported to the facility until 1/15/25 and the follow-up hospice note on 1/16/25 failed to address education provided to Resident #4 regarding her iron supplement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51916 Based on observations, interviews and record review, the facility failed to ensure infection control practices were established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility failed to: -Ensure staff donned (put on) the appropriate personal protective equipment (PPE) while providing direct care for Resident #46 and Resident #57, who were on enhanced barrier precautions (EBP); and, -Implement an effective water management plan to monitor for Legionella. Findings include: I. Failed to ensure staff donned appropriate PPE while providing direct care to residents on EBP A. Professional reference According to the Centers for Disease Control and Prevention (CDC) Enhanced Barrier Precautions (EBP) in Nursing Homes, last reviewed on 4/2/24, was retrieved on 3/17/25 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html, EBP is an infection control intervention designed to reduce transmission of resistant organisms, such as multi-drug resistant organisms (MDRO), that employs targeted gown and glove use during high contact resident care activities. Effective implementation of EBP requires staff training on the proper use of PPE and the availability of PPE and hand hygiene supplies at the point of care. Examples of high-contact resident care activities requiring gown and glove use for EBP 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). B. Facility policy and procedure The Infection Prevention and Control policy, undated, was received from the nursing home administrator (NHA) on 3/10/25. It read in pertinent part, The nursing facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. All persons shall adhere to the infection prevention and control program by referencing said resources. This program is designed to help prevent development and transmission of disease and infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Infections are investigated, controlled and prevented through implementation of the infection control program. Specific isolation procedures are included in the infection control manual. The infection control program determines when a resident needs isolation to prevent the spread of infection. C. Resident and resident representative interviews Resident #57, who had a stage 3 pressure wound to his lower spine, and his representative were interviewed together on 3/9/25 at 2:14 p.m. Resident #57 said sometimes staff put on gowns whenever they did his wound care but they always wore gloves. Resident #57's representative, who spent most of her days visiting with the resident, said she could not recall a time when she saw any staff member come into the resident's room wearing a gown except maybe once or twice. Resident #46, who had an indwelling urinary catheter and a chronic wound with a MDRO of her left prosthetic knee, was interviewed on 3/9/25 at 2:53 p.m. Her representative was also present in the room. Resident #46 said some staff did not wear gowns when they were doing her catheter care or her wound care. She said one licensed practical nurse (LPN) always wore a gown and mask when doing direct care with her. D. Observations An initial observation of unit #7 was conducted on 3/9/25, between 10:40 a.m. to 11:15 a.m. A sign for EBP was posted on Resident #46's door and a PPE bin with gowns, gloves and masks was outside the resident's door. An initial observation of unit #8 was conducted on 3/9/25, between the hours of 11:18 a.m. to 11:40 a.m. A sign for EBP was posted on Resident #57's door and a PPE bin with gowns, gloves and masks was outside the resident's door. On 3/11/25, from 10:45 a.m. to 11:00 a.m., the assistant director of nursing (ADON) was observed doing wound care for Resident #57. The following was observed: The ADON knocked on Resident #57's door and entered after being told to come in. As the ADON performed hand hygiene with an alcohol-based hand rub (ABHR), he explained to Resident #57 that he was going to clean and dress the wound on his lower back. The ADON donned gloves and placed a clean disposable cloth over Resident #57's table beside the recliner he was sitting in. He also placed a pack of sterile gauze and a 4-inch by 4-inch adhesive bordered dressing on top of the cloth. The ADON performed wound care on Resident #57 while he leaned forward in his recliner. The wound was intact with nonblanchable redness under a thin layer of skin with a small opening that was bleeding slightly. After finishing the wound care, the ADON signed and dated the dressing, removed his gloves, sanitized his hands and thanked the resident before leaving the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The ADON failed to don a gown when doing wound care for Resident #57. E. Staff interviews Certified nurse aide (CNA) #1 was interviewed on 3/9/25 at 11:32 a.m. He said he did not know why Resident #57 was on EBP because he did not have an active infection, but he knew he was recently treated for pneumonia. CNA #1 said he was never told he was required to wear any PPE besides gloves when doing direct care for Resident #57. He said he only knew sometimes it was utilized during wound care. The ADON was interviewed on 3/11/25, after finishing wound care on Resident #57. He said that the PPE bin was outside of the resident's room because he was on EBP. He said the PPE was to be utilized for direct patient care. -However, the ADON did not apply a gown when performing wound care on Resident #57 (see observation above). The ADON was interviewed a second time on 3/12/25 at 12:09 a.m. The ADON said he should have applied a gown and a mask when he did wound care on Resident #57. The director of nursing (DON) was interviewed on 3/12/25 at 12:02 p.m. The DON said it was the infection preventionist's (IP) job to ensure there was enough PPE available for all staff to utilize. She said EBP were initiated for all residents who had any MDROs, catheters, open wounds or peripherally inserted central catheters (PICCs - an intravenous line inserted into the upper arm and threaded into a larger vein near the heart). 52045 II. Failed to implement an effective water management plan to monitor for Legionella A. Professional reference According to Center for Disease Control (CDC), Controlling Legionella in Potable Water Systems, last reviewed 1/3/25, retrieved on 3/19/25 from https://www.cdc.gov/control-legionella/php/toolkit/potable-water-systems-module.html, Operation, maintenance, and control limits guidance: Monitor temperature, disinfectant residuals, and pH frequently based on Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values. For example, increase the measurement frequency if there's a high degree of measurement variability. Hot water: Store hot water at temperatures above 140 degrees F (fahrenheit) or 60 degrees C (celsius). Ensure hot water in circulation does not fall below 120 degrees F (49 degrees C). Recirculate hot water continuously, if possible. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cold water: Store and circulate cold water at temperatures below the favorable range for Legionella (77-113 degrees F, 25-45 degrees C). Legionella may grow at temperatures as low as 68 degrees F (20 degrees C). Flushing: Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Ensure disinfectant residual is detectable throughout the potable water system. Clean and maintain water system components, such as thermostatic mixing valves, aerators, showerheads, hoses, filters, and storage tanks, regularly. Consider testing for Legionella in accordance with the routine testing module of this toolkit. B. Facility policy and procedure The Legionella Water Management Program policy and procedure, dated 5/1/22, was provided by the maintenance director (MTD) on 3/12/25 at 2:03 p.m. It documented in pertinent part, Primary prevention strategies: -Cooling towers and potable water systems shall be routinely maintained; -At-risk medical equipment shall be cleaned and maintained in accordance with manufacturer recommendations; -Non-potable water systems shall be routinely cleaned and disinfected; -Cold water shall be stored and distributed below 68 degrees F; and, -Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F. C. Record review Review of the facility's water management plan revealed the following: -There was no documentation to indicate the facility had obtained water temperature readings in the building on a weekly basis. -There was no documentation to verify that dead legs and low flow piping runs had been flushed in the last calendar year. -However, the CDC recommended that all dead legs and low flow piping runs should be flushed at least weekly to prevent the growth and spread of legionella (see professional reference above). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The water management plan failed to document when empty resident rooms had low flow piping runs and lead legs flushed. -There was no documentation to indicate staff had been provided with training on the monitoring and prevention of Legionella. D. Staff interviews The MTD was interviewed on 3/12/25 at 12:27 p.m. The MTD said he did not have a plan for the facility to prevent Legionella. He said the water management plan binder that had been provided during survey was created by an outside company who had been responsible for the facility's water management plan, however, he said the company no longer contracted with the facility The MTD said he made sure there was no standing water in the residents' rooms by signing off on what the other staff members did when a resident discharged . The MTD said the facility had a check-list when a resident was admitted to the facility and discharged from the facility, and he signed off on what was done in the resident's room. The MTD said he was not sure what needed to be documented for the monitoring of Legionella or what education had been done for staff regarding Legionella. The nursing home administrator (NHA) was interviewed on 3/12/25 at 2:20 p.m. The NHA said her expectation was to test the water chlorine levels and do additional testing if she saw lower levels of chlorine. The NHA said the facility did not have documentation of any of the facility's testing for Legionella. The NHA said the MTD should be involved in the testing and water management planning for Legionella.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52045 Based on observations, record review and interviews, the facility failed to develop an antibiotic stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance for three (#80, #46 and #2) of three residents out of 37 sample residents. Specifically, the facility failed to: -Ensure clinical signs and symptoms of an infection were identified and/or culture results were obtained prior to the administration of antibiotics for Resident #80; and, -Ensure staff effectively tracked and monitored the use of long-term antibiotics for Resident #46 and Resident #2. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, dated 2019, was retrieved on 3/19/25 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/hospital.html. It read in pertinent part, Implement policies that apply in all situations to support antibiotic prescribing to include specifying the dose, duration and indication for all courses of antibiotics so that they are readily identifiable. Implement facility specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimizes antibiotic selections, duration, and common indications for the usage of community acquired pneumonia, urinary tract infections, skin and soft tissue infections. II. Facility policy and procedure The Antibiotic Stewardship policy and procedure, undated, was provided by the nursing home administrator (NHA) on 3/11/25 at 3:00 p.m. It read in pertinent part, The purpose of this Antibiotic Stewardship Program (ASP) is to measure and promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration in order to improve resident outcomes, while minimizing toxicity and the emergence of antimicrobial resistance. Antimicrobial stewardship has been shown to be essential in the control of clostridium difficile (C-diff) infections and the emergence of multidrug resistant organisms. The goal of the ASP is to ensure that residents get optimal antibiotic therapy and it is a useful service in optimizing antibiotics in the facility. By instituting the ASP, utilization of antimicrobial agents will be optimized by improving the following aspects of antimicrobial management: (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility shall support and promote antibiotic use protocols which include: assessment of residents for infection using standardized tools and criteria, therapeutic decisions regarding antibiotic prescriptions based on evidence that is appropriate for the care of residents, specifying a dose, duration and indication on all antibiotic prescriptions, reassessment of empiric antibiotics after 2-3 (two to three) days for appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports and/or changes in the clinical status of the resident and, whenever possible, choosing narrow-spectrum antibiotics that are appropriate for the condition being treated. Develop and maintain a system to monitor antibiotic use, which includes: review antibiotics prescribed to residents upon their admission or transfer to the facility and those during the course of evaluation by a prescribing practitioner who is not part of the facility's staff, periodically (quarterly) review a subset of antibiotic prescriptions for inclusion of dose, duration and indication (or for length of therapy, documentation of an antibiotic time-out, appropriateness based on antibiotic use protocols and written documentation of clinical justification for antibiotic use that does not comply with the facility antibiotic use protocols), periodically review rates of prescriptions for any antibiotics or conditions identified by the committee as being of special interest and, at least annually, review antibiotic use data by the facility and by individual providers to determine if there is excessive use of specific antimicrobial agents. The assessment will measure antibiotic starts (antibiotic days of therapy, defined). Ensure the clinical and microbiologic efficacy of antimicrobials, including: choice of antimicrobial agent is supported by guidelines, laboratory results, or empiricism, potency of the antimicrobial agent is enhanced by dose or combination therapy, as appropriate, promote pharmacist involvement in antibiotic selection, dosing, and monitoring for antimicrobial agents, implement protocols, guidelines, or clinical pathways for infectious diseases or antimicrobials based on best practice (sepsis, pneumonia, urinary tract infections, and skin and soft tissue infection guidelines) and educate staff involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. Decrease the emergence of resistance. Study antibiotic susceptibility trends through the use of an anti-program, select most narrow spectrum antibiotic regimens based upon culture and susceptibility results, select most narrow spectrum antibiotics for empiric therapy against epidemiologically-proven common etiologic agents (community- and nosocomial-acquired), promote the use of antibiotics according to guidelines in order to avoid the emergence of resistance and promote the use of specific drug-drug combinations to delay or prevent the emergence of resistant strains based on data, guide appropriate duration of therapy. Decrease the potential for adverse drug reactions and predisposition to secondary infections. Adjust dosages according to renal and hepatic function, prevent thrombophlebitis, prevent superinfection and colonization (C. diff infection), prevent facility-acquired infections and promote safe transition from intravenous to oral antibiotics. Improve overall resident well-being by shortening length of stay and ensuring positive resident outcomes. Improve resident outcomes and shorten length of stay through utilization of optimal antibiotic therapy, identify and convert intravenous to oral antibiotics, educate prescribers on the advantage of sequential oral therapy and educate residents and family members as needed regarding appropriate use of antimicrobial medications. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	III. Resident #80 A. Resident status Resident #80, age 69, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses include retention of urine, chronic kidney disease and benign prostate hyperplasia. The 10/18/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident required set up assistance with chair to chair transfers and toileting. B. Record review The March 2025 CPO documented the following physician's order: Ciprofloxacin HCl (antibiotic) oral tablet 500 mg (milligrams), one tablet by mouth two times a day for a urinary tract infection (UTI) for seven days, ordered 3/8/25. The 3/1/25 nursing progress notes documented Resident #80 was having symptoms of a UTI, including abnormal urine color and strong smell and a urinalysis was ordered. -However, there was no documentation in the resident's electronic medical record (EMR) to indicate a culture and sensitivity (C&S - a laboratory test which identifies bacteria type and what antibiotics are best used to effectively treat the infection) was completed. IV. Resident #46 A. Resident status Resident #46, age greater than 65, was admitted on [DATE]. According to the March 2025 CPO, diagnoses include chronic congestive heart failure, presence of left artificial knee joint and infection and inflammatory reaction to internal left knee prosthesis. The 12/6/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required supervision or touching assistance with chair to chair transfers and toileting. B. Record review The March 2025 CPO documented the following physician's order: Cefadroxil (antibiotic) oral tablet 500 mg, one tablet by mouth two times a day as a prophylactic (action taken to prevent infection) for infected hardware, ordered 12/3/24. The 12/3/24 nursing progress notes documented Resident #46 had a new physician's order to start antibiotics for prophylactic infection of her knee hardware. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, there was no documentation in the resident's EMR to indicate a risk benefit assessment was completed by the facility's physician to determine the risks versus the benefits of taking the antibiotic on a prophylactic basis . -Review of Resident #46's comprehensive care plan revealed the facility failed to document a care plan focus to address the need for long-term use of an antibiotic. V. Resident #2 A. Resident status Resident #2, age 95, was admitted on [DATE]. According to the March 2025 CPO, diagnoses include chronic obstructive pulmonary disease (COPD), chronic respiratory failure and dependence on supplemental oxygen. The 1/14/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required supervision or touching assistance with chair to chair transfers and toileting. B. Record review The March 2025 CPO documented the following physician's order: Azithromycin (antibiotic) oral tablet 250 mg, one tablet by mouth two times a day prophylactic for chronic COPD, ordered 10/8/24. Review of Resident #2's comprehensive care plan revealed the facility failed to document a care plan focus area with an intervention for continuous antibiotic use for the resident's COPD diagnosis. VI. Staff interviews Registered nurse (RN) #1 was interviewed on 3/9/25 at 1:20 p.m. RN #1 said there was no type of specific monitoring that was needed for residents who were on antibiotics unless there was a physician's order to do so. The assistant director of nursing (ADON), who was also one of the facility's infection preventionists (IP), and the nursing home administrator NHA were interviewed together on 3/12/25 at 11:00 a.m. The ADON said the facility used the McGeer's criteria, which included assessing vital signs, obtaining a urinalysis and a culture and sensitivity (C & S) test, if indicated, when determining if a resident required antibiotics. The ADON said the benefits of using the McGeer's criteria was to optimize antibiotic use, reduce the risk of antibiotic resistance, improve resident outcomes and lower healthcare costs. The ADON said, according to the criteria that was used in the facility, Resident #80 did not meet the criteria to be placed on the antibiotic. The ADON said he should have consulted with the physician to get an order for a C & S test before starting Resident #80 on an antibiotic treatment. -However, there was no documentation in Resident #80's EMR to indicate a urine C & S test was done. (continued on next page)

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The ADON said part of his role as the IP was to do a time-out assessment 48 hours after the start of an antibiotic to monitor for adverse reactions. He said the nurses were responsible for the change of condition documentation, including progress notes and vital signs. The ADON said there should have been a monthly assessment for residents who were on long-term antibiotics to determine the appropriateness of the continued use of the antibiotic, with a focus on the risks versus benefits of continuous use of the medication. -However, there was no documentation in Resident #46 or Resident #2's EMRs to indicate the residents had received monthly assessments of the prophylactic antibiotic or a 48 hour time-out assessment while on the antibiotics. -Additionally, there was no documentation from a physician to justify the long-term use of the antibiotics for Resident #46 and Resident #2. The pharmacy consultant (PC) was interviewed on 3/12/25 at 4:06 p.m. The PC said Resident #46 required no antibiotic monitoring from the pharmacy and monitoring was referred back to the physician because of the resident's history of MSSA (methicillin-sensitive staphylococcus aureus, a type of bacteria that is susceptible to treatment with antibiotics). The PC said the facility should use the antibiotic as per the recommendations of the physician with a focus on the risks versus benefits of using the antibiotic. -However, there was no documentation from the physician to determine risks versus benefits in order to justify the use of a long-term antibiotic for Resident #46. The PC said Resident #2 required no antibiotic monitoring from the pharmacy but it was standard practice for that particular antibiotic to be monitored by the physician. The PC said the facility should use the antibiotic as per the recommendations of the physician with a focus on the risks versus benefits of using the antibiotic. -However, there was no documentation from the physician to determine risks versus benefits in order to justify the use of a long-term antibiotic for Resident #2.