STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065388	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at St Andrews Village, The	2670 S Abilene St Aurora, CO 80014

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure one (#25) of five residents out of 19 sample residents received treatment and care in accordance with professional standards of practice. Specifically, the facility failed to administer medications in a timely manner per the physician orders for Resident #25. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2022), E.[NAME], St. Louis Missouri, pp. 606-607. Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional Standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Facility policy and procedure (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administering Medications policy and procedure, revised in April 2019, was received from the executive director (ED) on 3/27/24 at 7:22 a.m. It revealed in pertinent part, Medications were administered in a safe and timely manner and as prescribed. Medication administration times were determined by resident need and benefit, not staff convenience. Factors to consider include: enhancing optimal therapeutic effect of the medication; honoring resident choices and preferences, consistent with his or her care plan. Medications were administered within one hour of their prescribed time. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: date and time the medication was administered. III. Resident #25 A. Resident status Resident #25, older than 65, admitted on [DATE]. According to the March 2024 computerized physician orders (CPO), diagnoses include congestive heart failure (excessive fluid), chronic kidney disease (decrease in kidney function), hypertension (increased blood pressure) and atrial fibrillation (abnormal heat function). The 2/16/24 minimum data set (MDS) assessment revealed the resident was moderately impaired with a brief interview for mental status (BIMS) score of 10 out of 15. He required one person's assistance with transfers and dressing. He required set up assistance for eating and personal hygiene. B. Resident interview Resident #25 was interviewed on 3/25/24 at 1:14 p.m. Resident #25 said his medications were late and he was afraid it would affect his health. C. Record review The March 2024 CPO documented the following medication orders: Metoprolol succinate (used for blood pressure control) 50 milligrams (mg) two times daily at 8:00 a.m. and 8:00 p.m. ordered on 10/26/23. Trazadone (used for insomnia) 50 mg once daily at bedtime at 8:00 p.m. ordered on 9/15/23. Genteal ophthalmic gel 0.25-0.3% instill one drop in both eyes for cataracts at bedtime 8:00 p.m. ordered on 5/17/23. Finasteride 5 mg (used to treat enlarged prostate) at bedtime 8:00 p.m. ordered on 6/12/23. Furosemide 10 mg (used to remove excess fluid in the body) every morning at 8:00 a.m. ordered on 8/19/23. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medication administration record (MAR) from 3/12/24 to 3/26/24 revealed the following: The Metoprolol succinate 8:00 a.m. dose was not administered timely on the following days: -3/12/24, the medication was administered at 10:21 a.m (one hour and 21 minutes after the allowed administration time); -3/15/24, the medication was administered at 11:22 a.m. (two hours and 22 minutes after the allowed administration time); -3/16/24, the medication was administered at 11:15 a.m. (two hours and 15 minutes after the allowed administration time); -3/17/24, the medication was administered at 10:11 a.m. (one hour and 11 minutes after the allowed administration time); -3/18/24, the medication was administered at 10:56 a.m. (one hour and 56 minutes after the allowed administration time); -3/24/24, the medication was administered at 10:11 a.m. (one hour and 11 minutes after the allowed administration time); and -3/25/24, the medication was administered at 10:34 a.m. (one hour and 34 minutes after the allowed administration time). The Metoprolol succinate 8:00 p.m. dose was not administered timely on the following days: -3/12/24, the medication was administered at 10:26 p.m. (one hour and 26 minutes after the allowed administration time); -3/14/24, the medication was administered at 9:36 p.m. (36 minutes after the allowed administration time); -3/16/24, the medication was administered at 11:56 p.m. (two hours and 56 minutes after the allowed administration time); -3/21/24, the medication was administered at 10:22 p.m. (one hour and 22 minutes after the allowed administration time); and -3/15/24, the medication was administered at 12:07 a.m. on 3/26/24 (three hours and seven minutes after the allowed administration time). The Trazadone 8:00 p.m. dose was not administered timely on the following days: -3/14/24, the medication was administered at 9:36 p.m. (36 minutes after the allowed administration time); and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-3/21/24, the medication was administered at 10:45 p.m. (one hour and 45 minutes after the allowed administration time). The Genteal ophthalmic gel 8:00 p.m. dose was not administered timely on the following days: -3/14/24, the medication was administered at 9:36 p.m. (36 minutes after the allowed administration time); -3/19/24, the medication was administered at 11:10 p.m. (two hours and 10 minutes after the allowed administration time); -3/21/24, the medication was administered at 10:49 p.m. (one hour and 49 minutes after the allowed administration time) The Finasteride 8:00 p.m. dose was not administered timely on the following days: -3/14/24, the medication was administered at 9:36 p.m. (36 minutes after the allowed administration time); and -3/21/24, the medication was administered at 10:43 p.m.(one hour and 43 minutes after the allowed administration time). The Furosemide 8:00 a.m. dose was not administered time on the following days: -3/12/24, the medication was administered at 10:21 a.m. (one hour and 21 minutes after the allowed administration time); -3/15/24, the medication was administered at 9:39 a.m. (39 minutes after the allowed administration time); -3/16/24, the medication was administered at 11:15 a.m. (two hours and 15 minutes after the allowed administration time); -3/17/24, the medication was administered at 10:12 a.m. (one hour and 12 minutes after the allowed administration time); -3/18/24, the medication was administered at 10:55 a.m. (one hour and 55 minutes after the allowed administration time); -3/24/24, the medication was administered at 10:11 a.m. (one hour and 11 minutes after the allowed administration time); and -3/25/24, the medication was administered at 10:34 a.m. (one hour and 34 minutes after the allowed administration time). -There were no progress notes documenting the reason the medications were administered late. IV. Staff interviews (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed practical nurse (LPN) #1 was interviewed on 3/27/24 at 8:10 a.m. LPN #1 said medications were to be administered in one hour before or after the medication scheduled time. LPN #1 said if a medication was not administered timely it could affect the resident's health, could be given too close to the next dose compromising the resident. LPN #1 said sometimes medications were given late due to an emergency with other residents. The director of nursing (DON) was interviewed on 3/27/24 at 8:21 a.m. The DON said resident medications should be administered timely to ensure the effectiveness of a medication purpose for the resident. The DON said the nurses should administer medications within the one hour window before and after the scheduled time. The DON said the administration of medications being timely was part of the seven rights of medication administration. The DON said it was up to the nurse to add a progress note to state why a medication was administered late. The DON said medication could be documented late if the nurse did not sign them out at time of administration but that was not best practice.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to conduct yearly certified nurse aide (CNA) performance reviews and provide training based on the outcome of the reviews for three out of five CNAs reviewed for annual reviews and training. Specifically, failed to provide performance reviews annually and training based on the outcome of the individual reviews for CNA #1, CNA #2 and CNA #3. Findings include: I. Facility policy and procedure The Performance Evaluations policy, revised September 2020, was provided by the executive director (ED) on 3/27/24 at 12:27 p.m. It documented in pertinent part, The job performance of each employee shall be reviewed and evaluated at least annually. Performance evaluations may be used in determining employee promotion, shift/position transfers, demotion, terminations, wage increases and to improve the quality of the employee's work performance. The written performance evaluations will contain the director's and/or supervisor's remarks and suggestions, any action that should be taken (further training) and goals. II. Record review The 2/8/24 facility assessment was provided by the social services director (SSD) on 3/26/24 at 12:07 p.m. It revealed the facility average census was 35 residents. The common diseases the facility provided care to were psychiatric/mood disorders, circulatory system, neurological system, vision and hearing, musculoskeletal system, metabolic disorders, respiratory systems, genitourinary system, diseases of blood, digestive system, integumentary system and infectious diseases. Performance evaluations for CNAs were reviewed. -However, the facility was unable to provide annual performance evaluations and reviews for CNA #1, CNA #2 and CNA #3 during the survey process. III. Staff interviews The human resources director (HRD) was interviewed on 3/27/24 at 9:18 a.m. She said the facility had a new administration team that came together in 2023. She said performance reviews were not a priority for the past administration team. She said the current administration team had made it a priority to complete the performance reviews timely. The director of nursing (DON) was interviewed on 3/27/24 at 11:06 a.m. She said performance evaluations should have been completed annually. She said she completed the performance evaluations for CNA #1, CNA #2 and CNA #3 on 3/26/24 during the survey. She said going forward the performance evaluations would be completed on the CNAs anniversary date.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure medications and biologicals were stored and labeled properly in two of three medication storage rooms and one of three medication carts. Specifically the facility failed to: -Ensure expired medications were not stored with current medications in the medication storage rooms; -Ensure medications were stored at correct temperatures in medication storage refrigerators; -Ensure medications were not stored in a dormitory style refrigerator/freezer combination; and, -Ensure used medication vials were not stored in the medication cart. Findings include: I. Professional reference According to the Vaccine Storage and Temperature Monitoring Equipment (January 2023), retrieved on 3/18/24 from https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf, It is important the facility has proper storage and monitoring equipment that was set up correctly, maintained appropriately and repaired as needed. The equipment protects patients from inadvertently receiving compromised vaccines. Do not store any vaccines in a dormitory-style or bar-style combined refrigerator/freezer unit under any circumstances. These units have a single exterior door and an evaporator plate/cooling coil, usually located in the freezer compartment. These units pose a significant risk of freezing vaccines, even when used for temporary storage. Temperature ranges for refrigerators should maintain temperatures between 36 and 46 degrees fahrenheit (F). II. Facility policy and procedure The Medication Labeling and Storage policy and procedure, revised February 2023, was received from the executive director (ED) on 3/27/24 at 7:22 a.m. It revealed in pertinent part The facility stores all medication and biologicals in locked compartments under proper temperature, humidity and light controls. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy was contacted for instructions regarding returning or destroying these items. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications requiring refrigeration were stored in the refrigerator located in the medication room at the nurses station. III. Observations and staff interviews On 3/26/24 at 1:40 p.m. the first floor east wing medication cart was observed with RN #1. The following item was found: -One open and used vial of ceftriaxone 1 gram injection (an antibiotic medication used for infections). -The vial had no resident name or date on it. Registered nurse (RN) #1 said it was the responsibility of each nurse working the medication cart to ensure the cart was clean. She said the empty vial should have been disposed of after the medication was drawn up from the vial. RN #1 said the vial did not have a resident name on it but it could have been removed from the facility's emergency medication supply. On 3/26/24 at 1:47 p.m., the east wing medication storage room was observed with RN #1. The following items were found: -One opened bottle of vitamin D3 5000 units that expired 11/2023; -One unopened bottle of Iron 325 milligrams (mg) expired 12/2023; and, -Two unopened bottles of Senokot (aids in relieving constipation) 8.6 mg that expired 11/2023. Additionally, the temperature in the medication storage refrigerator in the medication storage room was 33 degrees F which was confirmed by RN #1. The refrigerator had a single door and had a freezer compartment which had about six inches of ice build up in the freezer section. The ice build up would not allow for anything to be stored in the freezer section. The refrigerator had the following vaccines and medications stored in it: -Three Basaglar insulin pens (used for blood glucose management); -One bottle of liquid Lorazepam (anti-anxiety medication); -One Fluad quadrivalent flu vaccine for residents over [AGE] years old; -One quadrivalent flu vaccine for residents younger than [AGE] year olds; -One open vial of tuberculin (used to test for tuberculosis); -One unopened vial of tuberculin; and, -One box of Bisacodyl suppositories (used for constipation). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN #1 said the medication storage refrigerator was not within the correct temperature range per the facility's log and the medications or vaccines in the refrigerator could be compromised if they were not stored at the correct temperatures. RN #1 said the expired medication bottles should have been placed in the cabinet labeled expired medications which was at the other end of the medication storage room to ensure a nurse did not collect them to be used for a resident. On 3/26/24 at 2:02 p.m., the second floor medication room was observed with licensed practical nurse (LPN) #1. The medication storage refrigerator in the medication storage room was a dormitory style refrigerator where the freezer was in the same compartment as the refrigerator. The freezer had two inches of ice build up. The following medications were observed to be stored in the refrigerator: -One open vial of Tuberculin; and, -One novolog insulin vial. LPN #1 said she did not know medications could not be stored in a dormitory style fridge. LPN #1 said she did not think the medications in the refrigerator were compromised as the temperature log for the fridge did not have any temperatures out of the safe range. IV. Additional staff interviews The director of nursing (DON) was interviewed on 3/26/24 at 2:20 p.m. The DON said medications and vaccines should be stored per the recommendations of the medication manufacturers to ensure medications were effective at the time administered. The DON was not aware the facility could not use the dormitory style refrigerators because of increased risks of temperature fluctuations. The DON observed the ice build up in the first floor east wing medication room and said the facility did not use the freezer section to store medications. The DON said the medications stored in the refrigerator would be destroyed and new ones would be ordered from the pharmacy to ensure medications were not given to residents because they might have been compromised. The DON said expired medications were to be stored in the medication room in the cabinet labeled expired medications to ensure the nurses did not accidentally give a resident a medication that was expired. The DON said the expired medications should not have been in the cabinet labeled medication cart supplies. The DON said the empty vial of antibiotics should have been disposed of at the time the injection was given and should not have been stored in the medication cart. The DON said all nurses working the medication cart were to keep the carts clean. The DON said she completed random medication cart checks monthly and the pharmacy consultant also completed checks monthly.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection for one of two units. Specifically, the facility failed to: -Ensure resident rooms and bathrooms were cleaned in a sanitary manner; -Ensure surface disinfectants were used for the appropriate dwell time (amount of time surface must remain visibly wet); -Ensure appropriate hand hygiene was performed by housekeeping staff; and, -Ensure high touch surfaces were cleaned. Findings include: I. Professional reference According to the Environmental Cleaning procedures (reviewed 5/4/23) retrieved on 3/28/24 from: https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html, documented in part, Common high touch surfaces include: sink handles, bedside tables, call bells, door knobs, and light switches. High touch surfaces and floors should be cleaned at least once daily (24 hour period). At least once daily or every 24 hours high touch surfaces are to be cleaned. According to the List N tool: Covid 19 disinfectants retrieved on 4/1/24 from: https://cfpub.epa.gov/wizards/disinfectants/ Fabuloso requires a 10 minute contact time (surface must remain visibly wet for the duration of the contact time). II. Facility policy The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised August 2013, was received from the executive director (ED) on 3/27/24 at 12:14 p.m. It revealed in pertinent part The purpose of this procedure is to provide guidelines and disinfecting residents' rooms. Environmental surfaces will be disinfected (or cleaned) on a regular basis. Disinfecting solutions will be prepared as needed and replaced with fresh solutions frequently. Perform hand hygiene after removing gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The environmental service director and administrator, in conjunction with the infection preventionist will select appropriate facility disinfectants. Change cleaning clothes when they become soiled. Clean personal use items lights, phones, call bells with disinfectant solution. III. Observations On 3/26/24 at 9:36 a.m., housekeeper (HSK) #1 was cleaning room [ROOM NUMBER], a private resident room. HSK #1 grabbed a wet rag from a bucket on her cleaning cart, wrung it out and picked up a spray bottle with a purple solution in it. HSK #1 entered room [ROOM NUMBER], sprayed the purple solution from the bottle onto the bedside table and immediately wiped the table top and the legs of the bedside table with the rag. -HSK #1 did not allow the cleaning solution to remain wet on the surface of the bedside table for the manufacturer recommended dwell time of 10 minutes. HSK #1 proceeded to move into the bathroom, sprayed the purple solution on the sink and wiped it off immediately with the rag. -HSK #1 did not allow the cleaning solution to remain wet on the surface of the sink for the manufacturer recommended dwell time of 10 minutes. At 9:41 a.m., HSK #1 sprayed the toilet and brushed the toilet bowl with a toilet brush HSK#1 wiped the rim of the toilet, bottom of the toilet seat, then the top of toilet seat and lastly the toilet lid was wiped. HSK #1 used the same rag to wipe the toilet tank and the outside of the toilet down to the floor. -HSK #1 did not allow the cleaning solution to remain wet on the surfaces of the toilet for the manufacturer recommended dwell time of 10 minutes. -HSK #1 did not clean the toilet from cleaner areas to dirtier areas. At 9:42 a.m., HSK #1 sprayed and immediately wiped off the grab bars in the bathroom using the same rag she cleaned the toilet with. -HSK #1 did not allow the cleaning solution to remain wet on the surface of the grab bars for the manufacturer recommended dwell time of 10 minutes. HSK#1 returned to her cleaning cart and retrieved a broom to sweep the room. As she was sweeping, she touched the resident's recliner, pillow, bedside table, desk chair, shoes, toilet riser and the main door handle with the same gloves she had used to clean the bathroom with. -HSK #1 failed to change her gloves and perform hand hygiene after cleaning the bathroom and before she touched multiple items in the resident's room while sweeping the floor (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HSK #1 returned to her cart and grabbed a mop pad from a bucket with cleaning solution on her cleaning cart. -HSK #1 did not remove her gloves and perform hand hygiene before reaching into the bucket of solution for the mop pad. HSK #1 wrung out the mop pad with the same gloves she had been wearing throughout the entire cleaning process of the resident's room. She allowed the excess cleaning solution to drip back into the container and returned to the resident's room to mop the floor. HSK #1 mopped the resident's room from the window towards the bathroom. HSK #1 proceeded to mop the floor of the bathroom with the same mop pad before she finished mopping the resident's room to the main doorway. While HSK #1 was mopping the resident's room, she touched the call light, desk chair, shoes, bedside table, toilet riser and a package of adult briefs. -HSK #1 failed to change her mop pad after mopping the bathroom floor before she finished mopping the remainder of the resident's room. -HSK #1 continued to wear the same gloves she had worn throughout the cleaning process of the resident's room and again touched multiple items in the resident's room during the mopping process. On 3/26/24 at 9:54 a.m., HSK #1 began cleaning room [ROOM NUMBER], a private resident room. HSK #1 grabbed a rag from the bucket with the cleaning solution on her cart and the spray bottle containing the purple cleaning solution before entering the resident's room. With her gloved hands, which had cleaning solution on them from grabbing the rag, HSK #1 moved several personal items, including the resident's drinking cup which she grabbed by the rim of the cup, from the resident's bedside table and nightstand to the resident's recliner. HSK #1 proceeded to spray the bedside table and nightstand with the purple solution. After spraying the cleaning solution, she immediately wiped off the bedside table and nightstand. HSK #1 then wiped the bedside table and night stand immediately after spraying. -HSK #1 did not allow the cleaning solution to remain wet on the surfaces of the bedside table and nightstand for the manufacturer recommended dwell time of 10 minutes. At 9:57 a.m., HSK #1 sprayed and immediately wiped off the dresser. -HSK #1 did not allow the cleaning solution to remain wet on the surface of the dresser for the manufacturer recommended dwell time of 10 minutes. At 9:58 a.m., HSK #1 entered the bathroom where she proceeded to spray the sink with the purple solution and immediately wiped the faucet and sink bowl before wiping the faucet handles. -HSK #1 did not allow the cleaning solution to remain wet on the surfaces of the sink area for the manufacturer recommended dwell time of 10 minutes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065388	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs at St Andrews Village, The	2670 S Abilene St Aurora, CO 80014

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HSK #1 sprayed the bathroom cabinet, toilet bowl and toilet riser. HSK #1 moved the toilet riser out of the way and used the toilet bowl brush to scrub the visible brown residue in the toilet bowl. At 10:00 a.m., HSK #1 sprayed more purple solution on the toilet seat, tank and outside of the toilet. HSK #1 immediately wiped the toilet seat, tank, flushing handle, toilet seat (which had visible brown residue on top and underneath) and the rim of the toilet bowl. HSK #1 placed the dirty rag on the toilet riser and moved the toilet riser back over the toilet. -HSK #1 did not allow the cleaning solution to remain wet on the surfaces of the toilet for the manufacturer recommended dwell time of 10 minutes. -HSK #1 failed to clean the toilet from a cleaner area to a dirtier area. HSK #1 returned to her cart, changed her gloves without performing hand hygiene, grabbed a new rag from the bucket on the cleaning cart and returned to the bathroom to clean the toilet riser and the toilet again as there was still brown residue on them. -HSK #1 failed to perform hand hygiene between gloves changes. HSK #1 returned to her cart and retrieved the broom from the cleaning cart to sweep the room. -HSK #1 failed to change her gloves and perform hand hygiene after cleaning the bathroom and before using the broom to sweep the floor. After sweeping the room with the broom, HSK #1 retrieved a mop pad from the bucket on her cleaning cart wearing the same gloves she had worn to clean the bathroom. She wrung out the mop pad allowing the excess solution to drip back into the bucket. -HSK #1 did not remove her gloves and perform hand hygiene before reaching into the bucket of solution for the mop pad. HSK #1 returned to the room and mopped from the window to the bathroom and then to the main doorway of the room. While mopping the resident's room, HSK #1 touched the residents oxygen tubing, portable oxygen tank, wheelchair pedals, walker, shoes, bedside table, toilet riser and collected the trash from the trash can, all while wearing the same gloves she had been wearing to clean the bathroom. -HSK #1 failed to change her gloves and perform hand hygiene after cleaning the bathroom and before she touched multiple items in the resident's room while she was mopping the floor. -HSK #1 failed to use a separate mop pad after mopping the bathroom floor before she finished mopping the remainder of the resident's room. III. Staff interviews HSK #1 was interviewed on 3/26/24 at 10:15 a.m. HSK #1's primary language was French and a translating service was used during the interview. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HSK #1 said the purple solution in the bottle was used to make it smell good. HSK #1 did not know the name of the solution but showed a bottle with the name of Fabuloso on the label. HSK #1 said she mixed the solution with water but was unable to say how much water to solution was used. HSK #1 identified the cleaning solution, the rags and mop pads were in a heavy duty tub and tile cleaner from the housekeeping closet dispensing system. HSK #1 identified the following areas as high touch areas which should be cleaned daily: bathroom, tables and the floors. HSK #1 said the call light and light switches were only cleaned twice a week. HSK #1 said she only needed to change gloves if they looked dirty or in between rooms. HSK #1 did not know if the cleaning products she was using were disinfectants or if they had a dwell time. The human resource director (HRD), who was also the housekeeping manager, was interviewed on 3/27/24 at 9:25 a.m. The HRD said she was overseeing housekeeping for ordering the supplies they needed and advising housekeepers when there was a discharge or new admission. The HRD said she was not involved in the training process of housekeepers. The HRD did not know if HSK #1 was provided training in her preferred language. The HRD said HSK #2 was the lead housekeeper and was in charge of training new housekeepers. The HRD said Fabuloso was not one of the approved cleaning chemicals for the facility and she did not know where it came from as it was not a product she had ordered for the facility. HSK #2, who was in charge of training new housekeepers, was interviewed via telephone on 3/27/24 at 10:10 a.m. HSK #2 said high touch items in resident rooms were doors, tables and call lights and should be cleaned daily. HSK #2 said Fabuloso was used to sanitize the rooms. HSK #2 said she used the dispenser in the housekeeping closet for the mopping solution and the solution for the rags. -However HSK #2 was not able to say the name of the chemical as she indicated the writing was too small for her to read on the labels. HSK #2 said she had trained two other housekeepers for the facility. HSK #2 was not able to confirm that HSK #1 was trained in her preferred language. The director of nursing (DON), who was also the facility's infection preventionist (IP), was interviewed on 3/27/24 at 10:29 a.m. The DON said she did not know what chemicals were being used for cleaning of resident rooms. The DON identified the following as high touch areas in a room which should be cleaned daily: television remote, light switches, bedside tables and call lights. The DON said she did not complete any specialized training to housekeepers and it was HSK #2's responsibility to train new housekeepers as she had been working at the facility the longest. The DON said she did not know if the training/education was provided to HSK #1 in her preferred language of French. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said she did not know the facility was using Fabuloso for cleaning resident rooms nor did she know what the dwell time of the cleaner was. The ED was interviewed on 3/27/24 at 11:23 a.m. The ED said the facility initially had a dual HRD/housekeeper who would complete inservice and training with the housekeepers. The ED said the facility relied currently on HSK #2 to complete training with new housekeepers. The ED was not aware the housekeeping staff was using an unapproved chemical (Fabuloso) for cleaning. The ED said housekeeping staff were to change their gloves and perform hand hygiene between cleaning the bathroom and the resident rooms to prevent contamination. The ED said high touch areas like call lights, television remotes, bedside tables and light switches should be cleaned daily.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received the required 12 hours of annual in-service training to ensure continued competence. Specifically, the facility failed to ensure 23 of 24 CNAs received 12 hours of annual training. Findings include: I. Facility policy and procedure The In-Service Training policy, revised August 2022, was provided by the executive director (ED) on 3/27/24 at 12:25 p.m. It documented in pertinent part, The primary objective of the in-service training was to ensure that staff were able to interact in a manner that enhanced the resident's quality of life and quality of care and could demonstrate competence in the topic areas of the training. II. Training review CNAs were reviewed for the required annual 12 hours of continued education units (CEUs). -Training records revealed only one out of 24 CNAs had completed the required training. III. Staff interviews The human resources director (HRD) was interviewed on 3/27/24 at 10:45 a.m. The HRD said the facility did not employ a staff development coordinator. She said it was not communicated to her that the CNAs were required to have the 12 hours of annual in-service training. She said only one CNA had their 12 hour CEUs completed. The director of nursing (DON) was interviewed on 3/27/24 at 11:06 a.m. The DON said all CNAs should have completed their 12 hours of CEUs. She said the HRD should have a tracking system in place to track the amount of hours completed. The ED was interviewed on 3/27/24 at 11:22 a.m. The ED said all CNAs should have completed their 12 hours of CEUs. She said the HRD had initiated a tracking form (during the survey) to ensure CNAs were completing their required CEUs annually.