STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Post Acute	115 Ingalls St Lakewood, CO 80226

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 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** 47350 Based on observations, record review and interviews, the facility failed to provide services for three (#39, #22 and #52) of five residents out of 32 sample residents according to professional standards of practice. Specifically, the facility failed to monitor vital signs prior to the administration of a blood pressure medication for Resident #39, Resident #22 and Resident #52. Findings include: I. Professional reference According to Khashayar, F., [NAME], J. (2023). Beta Blockers. Stat Pearls. National Library of Medicine, was retrieved on 12/9/24 from https://www.ncbi.nlm.nih.gov/books/NBK532906/. Beta receptors are found all over the body and induce a broad range of physiologic effects. The blockade of these receptors with beta blocker medications can lead to many adverse effects. Bradycardia (low heart rate) and hypertension (low blood pressure) are two adverse effects that may commonly occur. The patient's heart rate and blood pressure require monitoring while using beta blockers. According to Bulara, K. G., [NAME], P., [NAME], M. (2024). Amlodipine. Stat Pearls. National Library of Medicine, was retrieved on 12/9/24 from https://www.ncbi.nlm.nih.gov/books/NBK519508/. Since amlodipine is an antihypertensive medication, clinics and patients should regularly measure blood pressure to achieve target levels per the 2017 American College of Cardiology/American Heart Association hypertension guidelines. According to Kiziour, R. J., [NAME], K. J. (2023). Metoprolol. [NAME] Nursing Drug Handbook. Elsevier. p. 770. Assess blood pressure (B/P), heart rate immediately before drug administration. If pulse is 60 beats per minute (bpm) or less or systolic B/P is less than 90 mm Hg (millimeters of mercury) withhold medication and contact physician. (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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(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	According to Kiziour, R. J., [NAME], K. J. (2023). Amlodipine. [NAME] Nursing Drug Handbook. Elsevier. p. 60. Assess B/P. If systolic B/P is less than 90 mm Hg, withhold medication and contact physician. According to Kiziour, R. J., [NAME], K. J. (2023). Amiodarone. [NAME] Nursing Drug Handbook. Elsevier. p. 52. Assess B/P, apical pulse immediately before drug is administered. If the pulse is 60 bpm or less or systolic B/P is less than 90 mm Hg, contact physician. II. Resident #39 A. Resident status Resident #39, age 78, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), the diagnoses included hypertension (high blood pressure), diabetes mellitus (DM) and abdominal aortic aneurysm (a bulge in the aorta). The 10/21/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 13 out of 15. He was independent with eating, toileting, personal hygiene, bed mobility and transfers. B. Observation On 12/4/24 at 9:00 a.m. registered nurse (RN) #1 was dispensing and administering Metoprolol 25 milligrams (mg) to Resident #39. RN #1 did not check the order for blood pressure parameters or review the resident's record for the resident's most recent vital signs prior to administration of the Metoprolol medication to Resident #39. C. Record review The December 2024 CPO documented a physician's order of Metoprolol 25 mg twice a day for hypertension and tachycardia (high pulse rate), ordered on 1/20/24. -The CPO did not document any vital sign parameters for when to hold the Metoprolol medication or when to notify the physician of irregular vital sign results. The December 2024 medication administration record (MAR) and treatment administration record (TAR) documented to check vital signs on the day shift every Wednesday, ordered on 2/14/24. The October 2024, November 2024 and December 2024 vital signs summary revealed Resident #35's blood pressure and pulse were only assessed on 10/2/24, 10/9/24, 10/14/24, 10/23/24, 10/30/24, 11/6/24, 11/13/24, 11/20/24, 11/27/24, 11/30/24 and 12/4/24 and not daily at the time the resident was given the prescribed Metoprolol tablets. III. Resident #22 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Resident status Resident #22, age 74, was admitted on [DATE]. According to the December 2024 CPO, the diagnoses included congestive heart failure (CHF), atrial fibrillation (irregular heart rate) and right below the knee amputation. The 11/8/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. She was dependent on staff for toileting, required substantial/maximal assistance with transfer, partial/moderate assistance with bed mobility and was independent with eating and personal hygiene. B. Observation On 12/4/24 at 9:10 a.m. RN #1 was dispensing and administering Amiodarone (medication that treats irregular and fast heart rhythms) 100 mg tablets, 1.5 tablets for a total of 150 mg to Resident #22. RN #1 did not check the order for blood pressure or pulse parameters or review the resident's record for the resident's most recent vital signs prior to administration of the Amiadarone medication to Resident #22. C. Record review The December 2024 CPO documented a physician's order of Amiodarone (medication used dto treat blood pressure) 100 mg tablets five 1.5 tablets for a total of 150 mg by mouth in the morning for atrial fibrillation, ordered on 9/30/24. -The CPO did not document any vital sign parameters for when to hold the Amiodarone medication or when to notify the physician of irregular vital sign results. The December 2024 MAR and TAR documented to check vital signs on the day shift every Wednesday, ordered on 7/8/24. The October 2024, November 2024 and December 2024 vital signs summary revealed Resident #22's vital signs were only assessed on 10/2/24, 10/9/24, 10/13/24, 1016/24, 10/23/24, 10/27/24, 10/30/24, 11/6/24, 11/13/24, 11/15/24, 11/16/24, 11/17/24, 11/20/24, 11/27/24. 11/29/24, 12/1/24, 12/2/24, 12/3/24, 12/4/24 and not daily when the resident was given the prescribed Amiodarone tablets. IV. Resident #52 A. Resident status Resident #52, age less than 65, was admitted on [DATE]. According to the December 2024 CPO, the diagnoses included hypertension, DM and chronic kidney disease (CKD). The 10/17/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with eating, toileting, personal hygiene, bed mobility and transfers. B. Observation (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/24 at 9:15 a.m. RN #1 was observed dispensing and administering Amlodipine (medication used to treat blood pressure) 10 mg. RN #1 did not check the order for blood pressure or pulse parameters or review the resident's record for the resident's most recent vital signs prior to administration of the Amliodipine medication to Resident #52. C. Record review The December 2024 CPO documented a physician's order of Amliodipine 10 mg in the morning for hypertension, ordered on 4/10/24. -The CPO did not document any vital sign parameters for when to hold the Amliodipine medication or when to notify the physician of irregular vital sign results. The December 2024 MAR and TAR documented to check vital signs on the day shift every Wednesday, ordered on 5/3/24. The December 2024 documented an order to check vital signs every shift for hyperkalemia (high blood potassium), ordered 10/14/24. The November 2024 and December 2024 vital signs summary revealed Resident #52 blood pressure and pulse were only assessed on 11/4/24, 11/6/24, 11/7/24, 11/8/24. 11/13/24, 11/19/24, 11/20/24, 11/21/24, 11/23/24, 11/24/24, 11/25/24, 11/26/24, 11/27/24, 11/28/24, 11/29/24, 11/31/24. 12/3/24 and 12/4/24 and not daily at the time the resident was given the prescribed Amliodipine tablets. V. Staff interviews RN #1 was interviewed on 12/4/24 at 9:20 a.m. RN #1 said the residents who were admitted for rehabilitation had physician's orders to check vital signs every shift. She said the residents that were admitted for long term care had a physician's order to obtain their vitals taken once a week. She said not all blood pressure medications had parameters ordered. She said she checked vitals when there were parameters ordered. She said she did not routinely check vitals if there were not parameters ordered for blood pressure medications. The assistant director of nursing (ADON) was interviewed on 12/4/24 at 9:50 a.m. The ADON said residents had their vital signs checked once a week. She said the residents that had parameters ordered would have their vitals taken more frequently. She said the residents that did not have parameters did not have their vitals taken more frequently because the philosophy of the facility was to make it more homelike. She said part of the nursing assessment before giving a blood pressure medication was to assess making sure they were not dizzy or exhibiting any other signs of low blood pressure. She said part of the nursing assessment included taking vital signs and monitoring those vital signs before the administration of a blood pressure medication.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to develop and implement an effective discharge plan for two (#128 and #125) of three residents reviewed for discharge planning out of 32 sample residents. Specifically, the facility failed to provide an appropriate discharge planning process for Resident #128 and #125. Findings include: I. Facility policy and procedure The Discharge Planning policy and procedure, not dated, was provided by the nursing home administrator (NHA) on [DATE] at 11:08 a.m. It read in pertinent part, It is the policy of this facility that discharge planning and evaluation will be provided by the social services staff for each resident. The discharge planning process focuses on the resident's discharge goals, the preparation of the resident to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Discharge planning involves the resident, family, or responsible party, IDT (interdisciplinary team), and others involved in the resident's care plan. Monitoring of the discharge planning program is the responsibility of the Social Services staff. The social services staff will ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. The Social Services staff member assigned to the resident regularly evaluates and re-evaluates the resident to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. Referrals for discharge planning may be made by the physician, resident, family or responsible party, or staff member. It is essential to ensure that there is a planned program of continuing care to meet each resident's discharge needs Social Services or designee shall involve the interdisciplinary team (IDT) in the ongoing process of developing the discharge plan. Social Services or designee shall involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. Social Services or designee will document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation will be discussed with the resident or the residents representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. II. Resident #128 A. Resident status (continued on next page)

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F 0660

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Resident #128, over [AGE] years old, was admitted on [DATE] and discharged to the hospital on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included osteomyelitis left ankle and foot, type 2 diabetes mellitus, and trochanteric bursitis left hip.

The [DATE] discharge minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. He required substantial/maximal assistance with showers, and lower body dressing. He required partial/moderate assistance with sit to stand, and transfers.

The MDS assessment revealed active discharge planning was occurring for the resident to return to the community and no referrals had been made to the local contact agency because a referral was not wanted. Type of discharge: planned.

B. Resident's representative interview

Resident #128's representative was interviewed on [DATE] at 7:04 p.m. via email and phone. She said on [DATE] she took Resident #128 for a VA (Veterans Affairs) doctor's appointment to help facilitate him to go to a VA skilled nursing facility (SNF) however Resident #128 was unable to transfer to a car so they had to order an ambulance transport via stretcher. The representative said when they got to the VA doctor's appointment, regarding Resident #128's hip pain from bursitis, Resident #128 started talking gibberish so the VA doctor sent him to the hospital where he died the next day.

The representative said the facility's social workers had not helped her with finding a facility placement that was contracted with the VA and that was why she was taking the resident to the VA appointment on [DATE]. The representative said the social services director (SSD) had not offered to help her with getting Resident #128 transferred or discharged to a facility who would accept the resident's VA benefits. The representative said when Resident #128's skilled benefits insurance ran out, the facility offered to help get the resident on Medicaid, but when she asked about using Resident #128's VA benefits no assistance was offered. The representative said the SSD had made no effort to move Resident #128 anywhere. The representative said the facility just told her that the insurance decided to stop paying and Resident #128 would need to get on Medicaid benefits to continue his stay at the facility. The representative said the responsibility of finding a facility that would accept Resident #128's VA benefits were placed totally on her and her sister.

The representative said prior to Resident #128's discharge, she and her sister had considered caring for him at home but then realized that they were not prepared or able to care for him. The representative said she told the SSD she would not be able to care for him at home and had asked about getting the resident into a VA facility. She said the SSD did not offer her assistance with finding a VA facility.

C. Record review

(continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discharge care plan, initiated [DATE], revealed Resident #128 was admitted to the facility for skilled services following a hospitalization . Prior to the hospitalization , the resident was living with family in the community and the resident and family felt that long-term care may be needed and were considering transition to long-term care. Interventions included reviewing the discharge plan quarterly and as needed, encouraging family/responsible parties to be involved in the facility events, plan of care and encouraging them to discuss feelings/concerns with impending discharge, monitoring for and addressing episodes of anxiety, fear, and distress, evaluating the resident's motivation to return to the community and inviting the resident and requested family to care plan and staff to provide any needed support. -The care plan was not updated to include the family's request for discharge to a VA facility. Review of the social services admission assessment/evaluation, dated [DATE], revealed the prior living arrangements were at home in the community with a family member. The discharge plan was long-term care placement in the current facility. -Review of Resident #128's progress notes revealed there was no documentation of any interdisciplinary team (IDT) meetings or care conference meetings or other discussions in regards to discharge planning. -Review of Resident #128's electronic medical record (EMR) did not reveal documentation which acknowledged the representative's wishes to find VA facility placement for the resident or documentation of referrals sent by the facility to VA facilities. The [DATE] physician note revealed, per social services, Resident #128's family member wanted Resident #128 sent non-emergently to the VA doctor appointment so they could assist with finding a facility placement that was contracted with the VA. The facility was working on coordinating transport. -The physician's note documented the reason for the transfer was so the VA physician could help find placement for the resident in a VA facility, however, there was no documentation in the resident's EMR that the SSD attempted to assist Resident #128's representative to find VA placement, despite the representative's request and reason for the resident's transport to the VA appointment. III. Resident #125 A. Resident status Resident #125, age 69, was discharged on [DATE], and readmitted on [DATE]. According to the [DATE] CPO, diagnoses included congestive heart failure (heart does not pump blood efficiently), acute respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood leading to low oxygen levels), atrial fibrillation (abnormal heart rhythm) and adult failure to thrive (a condition of physical and cognitive decline, decreased functional status, and poor nutritional intake). The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. He was independent with all functional abilities. The MDS assessment revealed no behaviors or rejection of care. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Resident interview Resident #125 was interviewed on [DATE] at 9:58 a.m. Resident #125 said his discharge plan was to go to a VA facility in a different state either a SNF or an assisted living facility (ALF) but he was not sure if social services was working on that for him. Resident #125 said he wanted to go to another state because it was warm there and he had spent many years as a bus driver in the cold. Resident #125 said he had tried to make the arrangements himself because the facility had not helped him and did not always follow his preferences. The social services assistant (SSA) walked past during the interview and said she thought Resident #125 wanted to discharge to a local ALF. Resident #125 responded that was not his preference and he wanted to go to a VA facility in a different state. C. Record review The [DATE] social services quarterly note revealed Resident #125 was currently in the facility for long-term care but was working with a transition's coordinator (who was not part of the facility) for potential ALF placement. Prior to admission, Resident #125 was living at a homeless shelter. Resident #125 was a veteran of the military forces and social services would continue to provide support as needed. -Review of Resident #125's EMR revealed there was no documentation of any IDT meetings, care conference meetings or other discussions with the resident in regards to discharge planning. The [DATE] physician note revealed Resident #125 wanted to discuss discharge planning with the physician. Resident #125 said he would like to move down to a different state as he had previously lived in the area and did better with the heat. Resident #125 said he had contacts at the VA and said he could easily get housing there. Resident #125 was competent and endorsed that he had bought a plane ticket. The facility had concerns about a potential safe discharge. Resident #125 was his own medical decision maker and was medically stable for discharge at that time. The physician's note documented the facility was to reach out to the resident's VA contacts to ensure a safe discharge for the resident. -However there was no facility or social services follow-up documentation that contact had been made with the VA community where the resident wanted to discharge to in order to ensure a safe discharge location. The [DATE] physician note revealed Resident #125 again asked to discuss with his physician his discharge plans. Resident #125 wanted to make sure that he had clearance for discharge but the resident had not yet been cleared by physical therapy for discharge. According to the physician's note, the facility confirmed that Resident #125 had a place to discharge to. -However, there was no facility or social services follow-up documentation that revealed the discharge location had been contacted. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] physician note revealed the facility had asked the physician to specifically follow up with the resident regarding discharge planning. Resident #125 was planning to discharge that weekend. He had a flight scheduled for Sunday. The physician was able to clarify Resident #125's discharge plan as there was concerns earlier in the week that Resident #125 was planning to fly to a different state and present to the emergency department. However, the physician's note documented the physician was able to clarify and confirm that Resident #125 had been in contact with the VA in the other state and would present to a VA facility there upon arrival. -However there was no social services discharge planning documentation in the progress notes that indicated the facility had been in contact with or arranged for Resident #125 to discharge to a VA facility in another state. The [DATE] discharge summary revealed Resident #125 had a planned discharge date of [DATE]. Discharge instructions were provided to the resident and he was able to make his needs known. The discharge location was a VA facility in a different state. -However there was no documentation in Resident #125's EMR to indicate the facility had contacted the VA facility in the other state to confirm the resident had been approved for acceptance at the facility or to provide a continuity of care handoff to the facility. The [DATE] discharge note revealed Resident #125 left the facility via ride-share services around 6:10 p.m. Resident #125 had everything ready and said he was flying (name of airline) he had everything in order and the airline ticket was confirmed. Resident #125 made his own decisions. A copy of the discharge and medications list and instructions were handed to the resident, including his medication. Resident #125 took all his belongings with him. -However there was no documentation that the facility had assisted with discharge planning or contacted the VA location to confirm the resident was being accepted at the location. The [DATE] physician note revealed Resident #125 had been discharged from the facility on [DATE] and was supposed to fly to another state where he planned to be admitted to a VA facility. He purchased a plane ticket and went to the airport then fell asleep and missed his flight. He stayed in the airport for multiple days until he finally called 911 for chest and abdominal pain and was taken to a medical center on [DATE]. Resident #125 was discharged back to the facility for ongoing medical management. The [DATE] nurses note revealed Resident #125 was readmitted to the facility from the hospital via emergency medical services (EMS) accompanied by three paramedics via stretcher. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the discharge care plan, initiated [DATE] (upon the resident's readmission to the facility), revealed the resident readmitted for long-term care and was working with a transition's coordinator for potential ALF The goal was to find ALF placement in the near future. Interventions included for the discharge care plan to be reviewed quarterly and as needed, encouraging the resident to discuss feelings and concerns with impending discharge and to monitor for and address episodes of anxiety, fear, and distress, establishing a pre-discharge plan with the resident, family/caregivers and evaluating progress and revising the plan as needed, evaluating and discussing with resident/family/caregivers the prognosis for independent or assisted living, identifying, discussing and addressing limitations, risks, benefits and needs for maximum independence, evaluating motivation to return to the community and inviting the resident and the requested family to care plan quarterly and as needed and staff to provide any needed support. -However it was not documented in the care plan that Resident #125 wanted to go to a VA facility in another state. The [DATE] social services admission quarterly note revealed the resident had readmitted to the facility for long-term care and was working with a transition's coordinator for potential ALF placement. The goal was to find ALF placement for the resident in the near future. The resident had mild forgetfulness related to age and was able to make his own decisions. Social services would continue to provide support as needed. -There was no documentation of social services assistance or care conferences to discuss discharge planning since the resident returned to the facility and still desired to discharge to a VA facility in another state. IV. Staff interviews The SSD was interviewed on [DATE] at 1:44 p.m. The SSD said Resident #125 had gone to get on a plane to another state to go to a VA facility. The SSD said she had not contacted the facility or provided any assistance to Resident #125 with transferring there. The SSD said she had recommended an ALF to the resident but had not looked at any for him in the other state. The SSD was interviewed again on [DATE] at 2:00 p.m. The SSD said Resident #128's insurance for skilled benefits would not cover him anymore and the representative had wanted him to go to a VA facility. The SSD said the plan was for him to stay at the current facility but at the last minute the resident representative decided to take him to a VA clinic to facilitate a transfer to a VA facility. The SSD said she helped to coordinate the discharge planning for the representative to do that, but she did not write a care coordination conference note regarding the discharge. -However, there was no documentation in Resident #128's EMR regarding a discharge planning process (see record review above). (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The SSD was interviewed a third time on [DATE] at 9:59 a.m. The SSD said a referral could have been sent for Resident #128 to go from the current facility to a VA facility but she did not make any referrals. The SSD said it was a last minute decision that the resident's representative did not want him to stay at the facility and go onto Medicaid services. The SSD said, in the five years she had worked in the facility, she had never sent a referral to a VA facility before but she assumed it would be just like any other facility to facility transfer. The SSD said the resident;s representative had met with the business office about Resident #128's insurance ending but had opted to not transition to Medicaid because she wanted the resident to use his VA benefits. The SSD said the resident's representative decided to go to the VA for a medical appointment instead of staying at the facility and transitioning to Medicaid. The NHA was interviewed on [DATE] at 12:28 p.m. The NHA said when a resident was about to be discharged from therapy and the insurance would stop paying, the resident/representative would meet with the business office to discuss financial options, including discussions about Medicaid. The NHA said if the resident/representative did not want to transition to Medicaid, then private pay options would be discussed because the resident would need to have a payor source. The NHA said he was not sure how to work with VA resources and was still learning about that. The NHA said he would find out why, if a resident had VA resources, the social services department did not assist the resident/representative with transferring/exploring/researching the possibility of the resident transferring to a VA facility. The SSD was interviewed on [DATE] at 1:11 p.m. The SSD said she followed up with Resident #125 about his discharge goals (during the survey) and he still wanted to transfer to another state because it was warmer there. She said she researched and found out there were four VA facilities in the other state The SSD said she called all of them and was able to speak with two of the facilities.The SSD said she was working on getting a VA referral faxed over to the VA facilities she had spoken with in the other state.The SSD said she would notify Resident #125 that she had sent the referrals to the facilities in the other state.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Post Acute	115 Ingalls St Lakewood, CO 80226

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47350

Based on observations, record review and interviews, the facility failed to ensure each resident with limited range of motion received appropriate treatment and services to increase range of motion (ROM) and/or prevent further decrease in ROM for one (#42) of two residents reviewed for restorative services out of 32 sample residents.

Specifically, the facility failed to ensure Resident #42 was provided with a restorative nursing program to maintain and/or prevent deterioration of her current level of function and mobility.

I. Facility policy and procedure

The Restorative Nursing Program policy and procedure, reviewed January 2024, was received by the nursing home administrator (NHA) on 12/5/24 at 9:17 a.m. It read in pertinent part,

It is the policy of this facility to provide maintenance and restorative services designed to improve residents' abilities to the highest practicable level.

Nursing personnel are trained to basic or maintenance nursing care that does not require a qualified therapist or licensed nurse oversight.

This training may include, but is not limited to, maintaining proper positioning and body alignment, encouraging and assisting residents, as needed, in turning and position changes, encouraging residents to remain active and assisting with any exercises according to plan of care, promoting independence in activities of daily living (ADL), performing tasks for residents only as needed to ensure completion of tasks, assisting residents in adjustment to their disabilities and use of any assistive devices, assisting residents with range of motion exercises and performing passive range of motion for residents who lack active range of motion ability.

II. Resident #42

A. Resident status

Resident #42, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, chronic kidney disease (CKD) and osteoarthritis.

The 9/13/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15. She was dependent with toileting and bed mobility, she required partial/moderate assistance with personal hygiene and transfers and was independent with eating.

The assessment indicated Resident #42 was not involved in a restorative nursing program during the seven day look back period.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER Mapleton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Ingalls St Lakewood, CO 80226	

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Observation and resident representative interview On 12/2/24 during a continuous observation, beginning at 11:57 a.m. and ending at 12:15 p.m., the following was observed: At 11:57 a.m., during the lunch meal, the director of rehabilitation (DOR) approached Resident #42 and the resident's representative. Resident #42's representative told the DOR she understood the resident did not qualify for skilled rehabilitation services but she wanted Resident #42 to continue to receive some form of mobility services. The representative told the DOR she wanted Resident #42 to be transferred from her wheelchair and placed in a recliner after lunch so the resident would be in a different position than she had been all morning. Resident #42's representative told the DOR she could only imagine how the resident felt sitting in her wheelchair all morning. Resident #42's representative told the DOR she did not want the resident to become stiff. The DOR told the Resident #42's representative that a a ROM program provided through a restorative nursing program would address what the representative wanted the facility to provide for the resident. However, the DOR told Resident #42's representative that the facility did not currently have a restorative nursing program to provide the services to the resident. Resident #42's representative was interviewed on 12/2/24 at 4:01 p.m. The representative said she and her family had requested some kind of therapy to help her mother walk with a walker to help minimize her falling. She said the family was aware the resident was not going to get better, but they wanted to prevent the resident from getting worse and losing muscle mass. Resident #42's representative said the facility had changed ownership and the current ownership had discontinued the restorative nursing program. She said she and her family had had conversations with the facility regarding the resident being in a restorative nursing program. She said the family had a care conference scheduled in December 2024 and she was going to talk with the facility again about having Resident #42 participate in a restorative nursing program. C. Record review The ADL care plan, initiated 3/20/23 and revised on 5/15/24, documented Resident #42 was at risk for self care performance related to Alzheimer's disease, poor balance, weakness, incontinence, CKD, osteoarthritis and chronic pain. Interventions included therapy evaluation and treatment. The fall care plan, initiated 3/20/23, indicated Resident #42 was at risk for falls due to previous fall with injury, weakness, dementia, poor balance and unsteady gait. Interventions included checking the resident's ROM, continuing therapy services and physical therapy to evaluate and treat as indicated. -A comprehensive review of Resident #42's care plan failed to reveal documentation that the resident was offered a restorative nursing program to help the resident maintain and/or prevent a decline in her functional and mobility levels. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The 9/16/24 quarterly interdisciplinary team (IDT) care plan review failed to reveal documentation of Resident #42's previous involvement in a nursing restorative program or a current personalized restorative nursing program plan. A review of Resident #42's electronic medical record (EMR) revealed restorative nursing program notes from 1/1/24 through 6/30/24. The restorative nursing program notes revealed Resident #42 was provided restorative nursing services for active range of motion (AROM), which included knee extensions, seated marches, hip abduction, ankle pumps, hamstring curls and walking from 1/1/24 through 6/30/24. -There was no further documentation of restorative nursing program services being provided to Resident #42 after 6/30/24. III. Staff interviews. The director of nursing (DON) and the physical therapy assistant (PTA) were interviewed on 12/4/24 at 10:13 a.m. The DON and the PTA said the facility had not had a restorative nursing program since July 2024. The DON and the PTA said the facility discontinued the restorative nursing program due to not having financial support for the program. The DON and the PTA said the facility was looking at restoring the restorative nursing program. The DOR was interviewed on 12/4/24 at 12:00 p.m. The DOR said the facility had to discontinue the restorative nursing program in July 2024 due to certified nurse aide (CNA) staffing issues and the facility needed to use the CNAs who provided the restorative nursing services to help staff the floor. She said the facility was in the process of reorganizing and reinstituting the program. She said she did not have a date when the restorative nursing program might be reinstated. She said she would be overseeing the program once it was available again. She said Resident #42 had been on a restorative nursing program until the facility discontinued the program in July 2024. She said the facility had eight to 10 residents who would benefit from a restorative nursing program.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 47350 Based on observation and interviews, the facility failed to ensure all drugs and biological used in the facility were properly stored and labeled in two out of two units. Specifically, the facility failed to: -Ensure medications that were self administered were stored securely at the bedside for Resident #33; -Ensure a medication storage room was securely locked; -Ensure medications that were not administered were not left unsecured at Resident #28's bedside; and, -Ensure medications were not left unattended on medication and treatment carts. Findings include: I. Facility policy and procedure The Medication Access and Storage policy and procedure, reviewed November 2022, was provided by the nursing home administrator (NHA) on 12/5/24 at 11:08 a.m. It read in pertinent part, Only licensed nurses, the consultant pharmacist and those lawfully authorized to administer medications (medication aides) are allowed access to medications. Medication rooms, carts and medication supplies are locked or attended by persons with authorized access. II. Ensure medications that were self administered were stored securely at the bedside for Resident #33 A. Observations and resident interview On 12/3/24 at 9:34 a.m. Resident #33 was observed with one medication card of sevelamer (a medication used to control phosphorus levels in the blood) and two medication cards of calcium acetate (a medication used to treat high phosphorus levels in the blood) unsecured on his bedside table. Resident #33 was interviewed on 12/3/24 at 9:35 a.m. He said the staff evaluated him and he was allowed to self administer his own medications. On 12/3/24 at 1:47 p.m. Resident #33 was observed with sevelamer and calcium acetate (a medication used to treat high phosphorus levels in the blood) medication cards on the bedside table. III. Ensure the medication storage room was securely locked (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mapleton Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Ingalls St Lakewood, CO 80226	

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 12/4/24 at 3:30 p.m. the director of nursing (DON) was observed opening the south side nurses station medication room door by pushing on the door without entering the code on the coded lock on the door. IV. Staff interviews The DON was interviewed on 12/3/24 at 2:00 p.m. The DON said Resident #33 had been evaluated and had a physician's order to be able to self administer his own sevelamer and calcium acetate medications. He said the resident had recently changed rooms and this was a reason why his medications were unsecured on top of his bedside table. He said the medications should not be left out unsecured because other residents could have access to them if they were unsecured. The DON was interviewed on 12/4/24 at 3:15 p.m. The DON said the outer door of the medication storage room should always be locked to prevent unlicensed and unauthorized personnel from being able to access medications in the medication storage room. 48112 IV. Failure to leave medications unattended with residents A. Observations and interview On 12/2/24 at 2:07 p.m. during an interview with Resident #28, a yellow tablet that was cut in half in a medication cup was on the bedside table. Resident #28 said the nurses left the medication at her bedside table. Registered nurse (RN) #2 was interviewed on 12/2/24 at 2:20 p.m. in Resident #28's room. RN #2 said the yellow tablet that was on the bedside table. RN #2 said she did not know what type of medication was left on the resident's bedside table. RN #2 did not remove the medication from the resident's bedside table. B.Record review A review of Resident #28's electronic medical record did not reveal a record that the resident was able to self-administer medications. C. Staff interviews LPN #1 was interviewed on 12/5/24 at 11:04 a.m. LPN #1 said medications should never be left at a resident's bedside. LPN #1 said the only time a medication could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medications. LPN #1 said she only worked on the North unit and there were no residents on the North unit who could self-administer medications. (continued on next page)

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	065097	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Post Acute	115 Ingalls St Lakewood, CO 80226

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The DON was interviewed on 12/5/24 at 3:30 p.m. The DON said the only time medications could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medications. The DON said Resident #28 could not self-administer medications because she did not have the agility to handle medications and because of her disease process. The DON said RN #2 told him on 12/2/24 a medication was left with Resident #38. V. Failure to leave medications unattended at medication carts A. Observations On 12/4/24 from 11:06 a.m., a medication cart on the North unit was observed with triple antibiotic cream on top of the medication cart. There was no nurse within the vicinity of the cart. At 11:23 a.m. LPN #1 and DON were at the medication cart on the North unit and they removed the triple antibiotic cream from the top of the medication cart. On 12/4/24 at 3:00 p.m., a tube of Aspercream (topical pain medication), a bottle of magnesium oxide tablet and a tube of triple antibiotic cream were left on top of a medication cart on the North unit. There was no nurse within the vicinity of the cart. B. Staff interviews LPN #1 was interviewed on 12/5/24 at 11:04 a.m. LPN #1 said medications including over-the-counter medications and creams should never be left unattended on the medication and treatment cart. LPN #1 said it was important not to leave medications unattended because the residents could take the medication and cause harm to themselves. The DON was interviewed on 12/4/24 at 3:30 p.m. The DON said he saw the antibiotic cream on top of the North unit's medication cart on 12/4/24 when he talked with LPN #1. The DON said he told LPN #1 not to leave any medication, creams, or over-the-counter medications on the cart when left unattended. The DON said it was important not to leave medications unattended because residents who can ambulate could easily take the medication and cause harm to themselves.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47350 Based on observations, interviews and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection on two out of two units. Specifically, the facility failed to: -Ensure glucometers were sanitized appropriately between uses; and, -Ensure the resident's rooms were cleaned in a sanitary manner. Findings include: I. Ensure glucometers were sanitized appropriately between uses A. Professional reference The Centers for Disease Control and Prevention (CDC). Considerations for Blood Glucose Monitoring and Insulin Administration (8/7/2024), was retrieved on 12/10/24 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Unsafe%20practices%20during%20assisted%20monitoring,for%20more%20than%20one%20person. It read in pertinent part, Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus, hepatitis C virus, human immunodeficiency virus (HIV) and other infections. Unsafe practices include: using fingerstick devices for more than one person, using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses. B. Facility policy and procedure The Glucometer Disinfection policy and procedure, reviewed on 1/1/24, was provided by the nursing home administrator (NHA) on 12/5/24 9:17 a.m. It read in pertinent part, Glucometers should be cleaned and disinfected before and after each use and according to manufacturer's instructions, regardless of whether they are intended for single resident or multiple resident use. Glucometers should be disinfected with a wipe presaturated with an environmental protection agency (EPA) registered healthcare disinfectant that is effective against human immunodeficiency virus (HIV), hepatitis C (HCV) and hepatitis B virus (HBV). The facility currently uses Medline Micro Kill Bleach Wipes, which have been validated by the glucometer manufacturer. C. Manufacturer recommendations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Medline Evencare G2 Blood Glucose Meter manufacturer cleaning and disinfecting guidelines. undated, were retrieved on 12/10/24 from https://www.medline.com/media/catalog/Docs/MKT/MAN_MPH1540_EvenCare%20G2%20Users%20Guide.pdf. It included the following recommendations in pertinent part, The following products are validated for disinfecting the Evencare G2 meter and lancing device: Dispatch Hospital Cleaner Disinfectant Towels with bleach, Medline Micro-Kill Disinfecting, Deodorizing Cleaning wipes with alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes, Medline Micro-Kill Bleach Germicidal Bleach Wipes. Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean. Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time listed on the wipe's directions for use. The Medline Micro Kill One disinfectant wipes manufacturer guidelines, undated, was retrieved on 12/10/24 from https://www.medline.com/media/catalog/Docs/MKT/LIT998_CAT_Healthcare%20Disinfectant%20W.pdf. It read in pertinent part, One minute disinfectant time for HIV, HBV and HCV. D. Observations On 12/4/24 at 7:37 a.m licensed practical nurse (LPN) #1 took a glucometer out of Resident #13's labeled bag. She went to Resident #13's room and obtained the resident's blood glucose. She returned to the medication cart and placed the glucometer on top of the medication cart. She returned the glucometer to Resident #13's bag. -LPN #1 did not clean or disinfect the glucometer before or after use. On 12/4/24 at 7:45 a.m. LPN #1 took a new glucometer out of the box. LPN #1 went in to Resident #224's room and obtained the resident's blood glucose. She then returned to the medication cart and placed the glucometer next to the computer. She obtained a new bag and labeled it with Resident #224's name and placed the glucometer into the bag. -LPN #1 did not clean or disinfect the glucometer before or after use. On 12/4/24 at 7:56 a.m. LPN #1 took a glucometer out of Resident #26's labeled bag. She then went into Resident #26's room and obtained the resident's blood glucose. She returned to the medication cart and returned the glucometer back into Resident #26's labeled bag. -LPN #1 did not clean or disinfect the glucometer before or after use. E. Staff interviews LPN #1 was interviewed 12/4/24 at 8:42 a.m. LPN #1 said each resident that needed blood glucose checks had their own designated glucometer. She said the glucometers should be cleaned after every use before they were returned to their labeled bag. She said they used the Medline Micro Kill germicidal wipes, which had a contact disinfection time of one minute. She said she was aware she did not do the appropriate cleaning after using each glucometer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered nurse (RN) #1 was interviewed on 12/4/24 at 9:20 a.m. RN #1 said all of the glucometers were cleaned before and after use with the Medline Micro Kill wipes with a disinfection time of one minute. The assistant director of nursing (ADON) was interviewed on 12/4/24 at 9:50 a.m. The ADON said the glucometers were cleaned with the designated Medline Micro Kill with the disinfection time of one minute. She said this needed to be done before and after every use with every resident to kill microorganisms, especially blood borne pathogens (microorganisms that cause disease). She said LPN #1 was a newly graduated nurse and would provide follow up education. II. Ensure the resident's rooms were cleaned appropriately A. Professional reference The Centers for Disease Control and Prevention (CDC), Environment Cleaning Procedures (3/19/24), was retrieved on 12/10/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Proceed from high to low to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas. Include identified high touch surfaces and items in checklists and other job aids to facilitate completing procedures. Common high touch surfaces include: bedrails, intravenous poles (IV) sink handles, bedside tables, call bells, doorknobs and light switches. B. Manufacturer's recommendations According to [NAME] Bay Lemon Disinfectant manufacturer guidelines, reviewed 2024, retrieved on 12/11/24 from https://s3.amazonaws.com/imperialdade.com/apps/catalog/digital-assets/55877/product-documentation/eb73269ecc51efb6993f5bef4a5e1a1aca22f589.pdf. It read in pertinent part, For use as a one step, general, hospital, medical disinfectant, fungicide, virucide, cleaner, deodorizer. Treated surfaces must remain visibly wet for two minutes to kill SARS CoV 2 or for 10 minutes to kill all organisms listed on the label. According to the [NAME] Bay Non Acid Disinfectant Bathroom Cleaner manufacturer guidelines retrieved on 12/11/24 from https://s3.amazonaws.com/imperialdade.com/apps/catalog/digital-assets/55879/product-documentation/fc5575bf4104f772b21e594fb2a632fdce4be18e.pdf. It read in pertinent part, For use as a one step, general, hospital, medical disinfectant, fungicide, virucide, cleaner, deodorizer. Treated surfaces must remain visibly wet for two minutes to kill SARS CoV 2 or for 10 minutes to kill all organisms listed on the label. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Observations On 12/5/24 at 9:20 a.m. the housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER] A and B. HSK #1 performed hand hygiene and put on gloves. She lightly sprayed the [NAME] Bay Lemon Disinfectant on the B side of the room, the top of the bedside tables and then sprayed the A side's top of the bedside table. She then sprayed the top of the bathroom vanity, the toilet hand rails, the top of the toilet seat, under the seat and top of the toilet bowl. She then placed the disinfectant bottle on the handrail next to the vanity. She obtained a clean towel and immediately started wiping down B side bedside tables. She disposed of the towel, removed her gloves and performed hand hygiene, obtained a new towel and wiped down the A side bedside tables. -HSK #1 failed to ensure surfaces remained visibly wet for the two minute virucidal and the ten minute total disinfection time specified by the manufacturer's guidelines. HSK #1 cleaned the inside of the toilet bowl with toilet brush, she then wiped down the hand rails on either side of the toilet, wiped the top of the toilet tank, top of the lid, under the lid and then the top of the toilet bowl. She then carried the used towel, picked up other used towels and cleaning supplies at the vanity and went to the housekeeping cart. She then disposed of used towels and placed cleaning supplies back into the housekeeping cart. -HSK #1 failed to change gloves, perform hand hygiene after cleaning the toilet and picking up used towels and before touching a clean disinfectant bottle and the housekeeping cart. -HSK #1 failed to clean high touch surface areas which included light switches, door knobs and call lights. On 12/5/24 at 9:35 a.m. HSK #1 was observed cleaning room [ROOM NUMBER]. HSK #1 performed hand hygiene and put on gloves. She lightly sprayed the book case that was next to the resident's bed, the top of the bedside table and the door knobs on the door into the room and the bathroom. She lightly sprayed the toilet tank, toilet lid, toilet bowl and toilet hand rails. She then immediately wiped down the bookcase and bedside table. She wiped down the door handles on the door from the hallway and to the bathroom. She disposed of used towel. She removed gloves and performed hand hygiene. -HSK #1 failed to ensure surfaces remained visibly wet for the two minute virucidal and the ten minute total disinfection time specified by the manufacturer's guidelines. HSK #1 wiped the toilet hand rails, wall around the hand rail, down the lid, down the top of the toilet bowl, down the sides of the toilet bowl and the toilet tank. She then left the bathroom, picked up the trash, disposed of a used towel on the housekeeping cart and returned cleaning supplies to the cleaning cart. She removed her gloves and performed hand hygiene. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065097	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Post Acute	115 Ingalls St Lakewood, CO 80226

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HSK #1 failed to clean the inside of the toilet bowl. She failed to change gloves and perform hand hygiene after cleaning down the toilet bowl and returning up to the toilet tank. She failed to remove her gloves and perform hand hygiene after disposing of used towel and before touching cleaning supplies and the housekeeping cart. E. Staff interviews HSK #1 was interviewed on 12/5/24 at 10:00 a.m. using a staff interpreter. HSK #1 said after cleaning a dirty area gloves must be changed and hand hygiene performed and a new towel before wiping a clean or high area. She said after cleaning the toilet, her gloves must be removed and hand hygiene be performed before touching clean supplies and the housekeeping cart. She said high touch areas including light switches, door knobs and call lights. She said the disinfection time for the cleaning supplies is two to three minutes. The housekeeping supervisor (HSKS) was interviewed on 12/5/24 at 10:05 a.m. The HSKS said gloves must be changed and hand hygiene performed after cleaning or touching a dirty area and before touching a clean area. He said the disinfection time of the cleaners is a three minute contact time.