

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give the resident's representative the ability to exercise the resident's rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on record review and interviews, the facility failed to ensure the resident's legal representative was provided an opportunity to exercise a right on behalf of the resident for one (#30) of five residents reviewed for resident rights out of 38 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #30's Medical Orders for Scope of Treatment (MOST) form was signed by the resident's medical durable power of attorney (MDPOA) instead of a family member who was not the resident's legal representative. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Advanced Directive and Health Care Directive policy, revised [DATE], was provided by the social services director (SSD) on [DATE] at 7:15 p.m. It read in pertinent part,</p> <p>It is the policy of the facility to honor their residents'advanced directives. The facility will provide orientation and training programs to educate staff on advance directives. A health care power of attorney or medical durable power of attorney delegating authority for an agent to make health care decisions in the case the individual delegating that authority subsequently becomes incapacitated. The legal representative, agent, attorney in face, proxy, substitute decision-maker, or surrogate decision-maker is a person designated and authorized by an advanced directive or by State law to make a treatment decision for another person in the event the other person becomes unable to make necessary health care decisions.</p> <p>II. Resident status</p> <p>Resident #30, age 87, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and dementia (impaired ability to remember, think and make decisions).</p> <p>The [DATE] minimum data set (MDS) assessment documented Resident #30 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15.</p> <p>(continued on next page)</p>

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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0551</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>III. Record review</p> <p>Resident #30's MDPOA document, signed and effective [DATE], was provided by the director of nursing (DON) on [DATE] at 3:25 p.m. It documented that the resident legally granted two of his family members the power to act in his place, for his benefit, to the same extent he could have acted for himself with regard to all medical matters.</p> <p>The document identified, by name, the two family members (first MDPOA and second MDPOA) the resident wished to have act on his behalf when he could not. The second MDPOA would act on his behalf if the first MDPOA was no longer able to fill that role.</p> <p>The document was signed by the resident and both MDPOAs on [DATE].</p> <p>Resident #30's MOST form was reviewed on [DATE]. The MOST form documented that Resident #30 wished for no cardiopulmonary resuscitation (CPR), he wanted selective treatment without burdensome measures and no artificial nutrition by tube.</p> <p>The MOST form documented the discussion and the form was completed by one of Resident #30's family members.</p> <p>-However, the facility failed to ensure the family member who signed the MOST form was Resident #30's first MDPOA or the second MDPOA, who were legally appointed as the resident's representatives.</p> <p>IV. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on [DATE] at 4:25 p.m. RN #1 said she completed MOST forms when residents were admitted to the short-term rehabilitation hall. She said she checked the electronic medical record (EMR) to find out who the MDPOA was for the resident. She said she was unsure how to confirm the MDPOA listed was actually the resident's MDPOA.</p> <p>The social services director (SSD) was interviewed on [DATE] at 7:10 p.m. The SSD said the nurse assigned to the hall the resident was admitted to was responsible for getting the resident's MOST form completed. She said she confirmed the MDPOA as she checked the paperwork received from the last placement of the resident. She said the rehabilitation residents MOST forms were reviewed during admission and at care conferences and the long-term care residents were reviewed quarterly. The SSD said if it was discovered a MOST form was signed by someone other than the resident or the MDPOA, the form was inaccurate and a new form needed to be completed. The SSD said the MOST forms were not reviewed by social services except during care conferences.</p> <p>The director of nursing (DON) was interviewed on [DATE] at 7:27 p.m. The DON said the floor nurses were responsible for completing the MOST forms during admission. She said she did not know how the nurses confirmed the MDPOA was accurate. She said there was not a process but the facility worked with the residents and their families to get a guardianship going if that was needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467</p> <p>Based on resident and staff interviews and record review, the facility failed to act promptly upon the grievances concerning issues of resident care and life in the facility that were important to the residents.</p> <p>Specifically, the facility failed to effectively address, resolve and maintain a systematic approach to ongoing resident concerns of staff treatment towards residents that were brought up during resident council.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The following policies were provided by the director of nursing (DON) on [DATE] at 6:06 p.m.</p> <p>The Resident Council policy, revised [DATE], identified the facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council. The policy directed to the facility to follow the grievance process.</p> <p>The Grievance/Concern policy, last revised [DATE], read in pertinent part, Grievances will be routed and tracked by the grievance officer/social service or designee.</p> <p>They (grievances) will be given to the appropriate department manager for follow-up, according to the nature of the grievance.</p> <p>Grievances will be responded to within 7 days for non-emergency concerns. The facility will notify the complainant to provide updates on resolution for the complaint. Additionally, complainants have the right to a written decision regarding the grievance.</p> <p>The manager responsible for investigating and resolving the grievance will complete the grievance/concern form including a plan for resolution.</p> <p>Grievance decisions will include: the date of the grievance was received, the summary of the resident's grievance, steps taken to investigate the grievance, summary of finding/conclusion regarding the grievance, statement is whether the grievance was confirmed or not confirmed, corrective action taken by the facility as a result of the grievance, and the date the written grievance was issued</p> <p>Tracking system will be used for quality assurance, identifying any trends, systematic problems, and Improvement efforts.</p> <p>II. Resident council minutes</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The resident council minutes and a sheet identified as resident council follow-up were provided by the DON on [DATE] at 5:05 p.m. The review of the resident council minutes identified residents indicated concerns with staff treatment during care. The minutes did not identify follow-up and/or a sustainable plan for resolution. The concerns were not resolved according to resident interviews (see below interviews).</p> <p>The [DATE] resident council minutes read a resident had problems with the certified nursing aides (CNAs) being rough with her and careless. Two other residents agreed and commented that the CNAs did a lot of jerking and pulling. According to the minutes, the concerns would be addressed by the DON and CNAs would be educated on bedside care.</p> <p>A [DATE] follow-up notation was attached to the minutes regarding the CNAs were rough. The notation read the resident who identified the staff was rough was followed up with after the council meeting. She said did not feel abused but felt the CNA's were rushing her when she needed assistance with her care and were always in a hurry to go to the next resident. The resident felt the CNAs needed to take their time when providing more care.</p> <p>The [DATE] through [DATE] grievance/concern tracking resolution log was provided by the corporate consultant (CC) at approximately 6:15 p.m. The [DATE] log did not identify residents expressed rough or rushed care.</p> <p>The February 2024 resident council minutes identified three residents still felt the CNAs rushed too much and were not taking their time with provided care. The minutes did not identify a plan to address the continued and unresolved concern of CNAs rushing during care.</p> <p>The February 2024 grievance/concern tracking resolution log did not identify residents in resident council and continued to express feelings of rushed care by CNAs.</p> <p>The [DATE] resident council minutes indicated reeducation to nursing would be completed related to staff rushing during care. The minutes did not identify when staff would be reeducated as identified in the [DATE] and February 2024 minutes. The minutes did not identify the residents felt their concerns with rushing were resolved.</p> <p>The [DATE] resident council minutes read a resident was concerned about CNAs and nurses stating they would be back or the staff would not return to the resident. Other residents indicated they also had that as a concern and wanted an explanation on why the CNAs were not attending to them. Another resident said she was not happy that the staff left her on the toilet for a while. The minutes identified residents felt staff were giving the residents attitudes and reprimanding them for asking for help. According to the minutes, the former NHA told the residents that everyone needed to go to the bathroom after meals so receiving assistance may take longer at that time. The minutes did not identify how the facility was going to address the concerns of staff not returning to the resident; staff attitudes; feelings of being reprimanded; and a resident concerned she was left on the toilet for a while. The minutes did not identify whether the residents felt their concerns with staff rushing with care were resolved from the [DATE] and February 2024 resident council meetings.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The [DATE] grievance/concern resolution tracking log identified a resident not included in resident council meetings and not part of the below resident interviews, felt a CNA was rude. According to the log the identified CNA's contract expired as the resolution. The [DATE] log did not include residents from resident council who felt the staff had attitudes and felt they were reprimanded for asking for help.</p> <p>The [DATE] healthy workplace meeting minutes were provided by the CC on [DATE] at approximately 6:15 p.m. The workplace minutes identified the meeting was attended by seven members of the interdisciplinary team (IDT). The workplace minutes read the staff needed to be reminded at all staff meetings not to rush with residents and take their time as part of good customer service.</p> <p>A customer service sheet defining the traits of good customer service with a handwritten notation that read [DATE] all staff meeting was provided by the CC on [DATE] at approximately 6:15 p.m. The sheet did not identify who attended the all staff meeting and the sheet did not identify not rushing with care was addressed in the inservice as identified as a concern with residents in resident council. The sheet did not instruct staff to make sure the resident's needs were addressed before the staff left the room. According to the sheet, staff should maintain a positive attitude.</p> <p>The resident council follow up sheet, dated [DATE], read follow up items from resident council since [DATE]. The follow up form listed multiple concerns brought in resident council including water temperature, shower schedule, hearing aids, missing laundry, television on at night and staff rough/rushing. The follow-up sheet did not identify when the concerns were addressed other than on [DATE]. According to the follow up sheet, all the concerns were resolved or improved, other than Resident #24 still felt there was one CNA who still had issues with the rushing. However, this was contrary to resident interviews below, identifying other residents also identified concerns with rushing staff. The [DATE] follow up said the identified CNA would no longer provide care to the resident for the time being.</p> <p>The [DATE] resident council minutes did not identify if the residents felt their concerns of staff rushing, staff attitudes and staff reprimanding them when asking for help, left on the toilet, and staff telling residents they would be back and not return were resolved.</p> <p>The [DATE] grievance/concern resolution tracking log identified additional residents had concerns with staff treatment towards them. On [DATE] and again on [DATE], two different residents expressed concerns with rude staff. The [DATE] response was the nurse's contract expired. The [DATE] response was staff agreed to be careful. The residents were not part of the resident council meeting or resident interviews</p> <p>The [DATE] resident council follow up sheet did not identify the [DATE] resident council concern of staff attitudes and feelings of being reprimanded which was still identified as a concern during the [DATE] through [DATE] interviews (see below).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An undated quality assurance and performance improvement (QAPI) discussion form was provided by the CC on [DATE] at approximately 6:15 p.m. According to the form there had been a decrease in concerns and grievances which was unusual. The form identified between [DATE] and [DATE] there were grievances logged without follow up. The form identified resident council minutes were reviewed for the past three months and there were alot of concerns but most of the concerns were from one resident. The form identified action was to start generating concerns/grievances from resident council and log the concerns and leadership should plan to attend the meeting. The interdisciplinary (IDT) morning meeting would review all grievances and discuss until resolution.</p> <p>-QAPI discussion form read most of the resident council concerns were from one resident however a review of the council minutes identified multiple residents expressed concerns with staff care.</p> <p>III. Resident interviews</p> <p>A. Resident individual interviews</p> <p>Resident #4 was interviewed on [DATE] at 4:10 p.m. Resident #4 said the staff had an attitude in the way they spoke to her when she answered her call light or if she took a while in the bathroom.</p> <p>Resident #31 was interviewed on [DATE] at 4:31 p.m. Resident #31 said his main concern was staff would come in to help him but they would be very quick in the process with whatever he needed and then leave before he was able to get all the assistance he wanted such as help put on his jacket. He said he would like the staff not to rush so much and take the time to make sure he did not need more assistance. He said some things were very hard for him to do on his own.</p> <p>Resident #16 was interviewed on [DATE] at 4:36 p.m. Resident #16 said some of the staff were rude and had an attitude during care and they spoke to her. She said she had to ask one staff member not to come into her room because she was very rude.</p> <p>Resident #45 was interviewed on [DATE] at 10:20 a.m. Resident #45 said when the CNAs answered her call light, they did not stay long enough in her room to finish helping her. She said sometimes she just needed something small like getting her earrings for her but the CNAs leave too fast to help with the request.</p> <p>B. Resident group interview</p> <p>Five residents (#4, #22, #45, #51 and #53), who were identified as interviewable by the facility and assessment, were interviewed on [DATE] at 10:30 a.m.</p> <p>Resident #45 said one problem that she and everyone had continued to have was that staff rushed in the room and did not take the time to listen to what the residents asked and needed from them. She said when the staff were rushed could cause miscommunication between staff and the residents. She said the staff leave and assume all the needs were met without asking the residents. Resident #4 agreed.</p> <p>Resident #4 said the staff dashed in and out of her room. Resident #4 said had reported her concerns repeatedly but staff continued to rush during care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #4 said when the staff helped her dress the CNAs took her shirt off so fast it hurt her ears.</p> <p>Resident #4 and Resident #51 said when staff helped transfer them, they moved so fast it made them feel dizzy. Resident #51 said he has asked staff not to assist him anymore and he does most things by himself.</p> <p>Resident #51 said that when he told staff he had a problem or need, the staff did not pay attention. Resident #22 said there was a nurse that would do that to her.</p> <p>Resident #53 said staff would complete the first thing he asked them to do but would then leave the room without making sure she did not need anything else. She said she would then have to push the call light on again to have them come back. She said the CNAs seemed so happy to leave the room before the resident could ask for items such as her water and her chapstick. She said the staff had too many people to take care of at one time and told her they were short staffed.</p> <p>Resident #4 said she had the same concerns and had told the nurses and the social service director (SSD).</p> <p>The group said staff treated them with dignity but the CNAs had an attitude and rushed care because they were so busy.</p> <p>Resident #22 said the staff was pushy when they gave her instructions.</p> <p>Resident #53 said CNA's tell her she was confused and talk to each other and not her when she asked for something.</p> <p>Resident #51 said he would tell the nurses his concerns but they would just raise their eyes up and talk over the top of him to other staff which made him feel frustrated.</p> <p>Resident #45 said she was worried and felt she was a burden to staff so she tried to do as much as she could by herself. Resident #22 and Resident #53 agreed.</p> <p>Resident #53 said she would try to give the CNAs all of her requests at one time because their time was short with her but still would do only one of the tasks.</p> <p>Resident #51 staff just needed to pay more attention.</p> <p>Resident #4 said she has bumped the bathroom wall because the CNAs rushed to put her on the toilet. She said the CNA would leave her on the toilet and tell her they needed to help another resident and would come back later. She said they would leave her there for a while. She said it was not comfortable to have to remain on the toilet for extended times. She said she did not have a clock in the bathroom so she could not say how long she was left there. She said it made her feel annoyed when she was left there. Resident #22 said she had been left on the toilet for over 15 minutes.</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The DON, the corporate consultant (CC) and the SSD was interviewed on [DATE] at 5:57 p.m. The SSD said the activity director used to be the one responsible for notifying staff of concerns addressed in resident council. The SSD said the resident council meetings were on Mondays every month but she did not work at the facility on Mondays. The SSD said she was present for the resident council in [DATE] and [DATE]. The DON said the SSD changed her schedule so she could help lead and be present for the meetings. The SSD said grievance cards also known as blue cards were created after resident council meetings if the residents expressed concerns. The SSD said every open/not resolved concern was reviewed in the morning meetings.</p> <p>The CC said during a [DATE] mock survey (survey preparation review) it was identified not all of the grievances were followed up on but there was a decrease in grievance cards generated. The CC said in [DATE] the facility started working on a process to address the grievances. She said the facility logged the grievances but the grievances cards for staff to follow-up on got lost in piles.</p> <p>The SSD said she was the one responsible for tracking unresolved or open concerns until the concern was addressed and resolved. She said on [DATE] she started writing down all the concerns in [DATE] and [DATE] because they needed to be addressed</p> <p>The SSD said she reviewed the recent resident concerns. She said Resident #4 had a concern with toileting in [DATE] regarding being left on a bed pan. She said no other resident had expressed concerns of being left too long on a toilet or a voiding device. The SSD said she checked in with Resident #4 and she did not say anything about being left too long on the toilet. The SSD reviewed the grievance tracking log and said nothing was reported in [DATE] and she was not aware of the concern. The SSD said she reviewed the [DATE] resident council minutes and said there was a concern regarding toileting care. She said she did not receive a grievance form and was not provided the [DATE] resident council minutes from the activity director.</p> <p>The CC said the resident council minutes should be reviewed in the quality assurance performance improvement (QAPI) meeting. The CC said starting next week the resident council minutes would be reviewed in QAPI.</p> <p>The SSD said regarding staff attitudes, a resident on [DATE] submitted a grievance that a nurse was rude to him. The SSD said the resident council said they would prefer to have a conversation with CNA's but the CNAs were too much in a hurry to talk to them. She said the staff sometimes were too fast in resident rooms and the residents felt the staff was rushing with the care and not communicating enough with the resident. The SSD said the follow-up of the concern should have been documented in council minutes and addressed on a grievance form. The SSD said the regarding staff rushing through resident care was not followed up using the grievance form process but she was made aware of the concern when the activity director told her about the concern after a meeting. The SSD said Resident #4 still felt there were concerns with an identified CNA and the CNA was removed for her care this week ([DATE]-[DATE]).</p> <p>The CC said the facility addressed customer service with staff during an [DATE] staff meeting.</p> <p>-However, the facility was unable to provide documentation which demonstrated that not rushing residents or asking residents if they needed anything else before the staff member left the room was included in the inservice.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The CC said it was important for the residents to feel important and heard. The CC said there needed to be more oversight in the grievance process. The CC said they identified the concerns with lack of grievance follow-up in February 2024 but plans to improve the process did not start till the week on [DATE] (during the survey process). The CC said the activity director who was originally responsible for the grievance cards after resident council was educated in [DATE] but there were still identified concerns but lack of follow through.</p> <p>The DON said the former NHA was responsible for overseeing the process but he was no longer at the facility.</p> <p>The SSD said in the QAPI meeting they had identified a slow down in grievance cards but there was not a follow-up plan.</p> <p>The DON the quality assurance nurse (QAN) led QAPI.</p> <p>The CC said the facility reminded staff not to rush with care but the facility could evidence that they addressed the concern with staff.</p> <p>-However, the CC could not provide dates when reminders were provided to staff.</p> <p>The SSD said moving forward she would regularly attend the resident council meeting, document staff education and concerns on a grievance form. She said the facility would provide timely follow-up of the concerns within a week of the concern and follow up with the resident to make sure the resident felt the concern was addressed and resolved.</p> <p>The QAN, DON and the SSD were interviewed together on [DATE] at 8:01 p.m. The QAN said during QAPI each department gave an update on what the facility needed to address, if there was anything reportable, and if there was anything we needed to discuss as a team. The QAN said if there were concerns in the resident council the activity director addressed the concerns in QAPI and the QAPI members would then review each concern.</p> <p>The SSD said starting this week she was ultimately responsible for the grievance follow-up in the resident council.</p> <p>The DON said the facility was to go over the concerns they knew they already had and there were more concerns they did not know about. She said she would review the concerns with the QAN and create a performance action plan to make sure all concerns are put on the grievance forms. The DON said there was a gap when not all of the concerns were addressed in QAPI.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on record review and interviews, the facility failed to ensure residents were kept free from abuse for two (#66 and #6) of five residents reviewed for abuse out of 38 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Prevent Resident #6 from physically abusing Resident #66; -Update Resident #66 and Resident #6's care plans with effective interventions to prevent abuse; and, -Identify patterns or causes of resident-to-resident abuse. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Resident or Client Protection Freedom from Abuse, Neglect and Misappropriation policy, revised 11/3/22, was provided by the director of nursing (DON) on 5/20/24 at 10:00 a.m. It read in pertinent part,</p> <p>It is the policy of this facility that all residents are free from abuse and neglect. Each individual has the right to be free from verbal, sexual, physical and mental abuse, including injuries of unknown source, misappropriation of resident property, corporal punishment, mistreatment, neglect and involuntary seclusion. Residents must not be subjected to abuse by anyone, including but not limited to, other residents. The objectives of this resident protection plan are to protect individuals cared for at our facility from maltreatment, to describe the policies and procedures adopted and implemented by our facility to protect the individuals, to comply with and exceed the protection required by law, facilitate the process of reporting suspected maltreatment and review the resident protection plan on an annual basis or more frequently if needed.</p> <p>II. Resident-to-resident incident between Resident #66 and Resident #6 on 5/6/24</p> <p>The incident notes for the 5/6/24 physical abuse incident were provided by the DON on 5/22/24 at 5:53 p.m.</p> <p>The victim, Resident #6, was documented as being severely impaired cognitively and had a history of behaviors that included agitation, outbursts, crying, restlessness, sadness, throwing items, yelling, hallucinations and paranoia. The alleged assailant, Resident #66, was documented as being severely impaired cognitively and had a history of behaviors that included hallucinations, restlessness, wandering into other residents'rooms, exit-seeking, yelling out at people who were not there and believing people were stealing her money.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/24 Resident #66 was trying to enter a room to use the bathroom as Resident #6 was leaving the room. Resident #66 asked Resident #6 to excuse her because she needed to use the bathroom. Resident #6 grabbed Resident #66 by the arm and slapped her across the face. Resident #66 was upset and yelled that she was going to bash her head in and referred to Resident #6. Resident #6 did not hear what Resident #66 said. Resident #6 yelled, They (Resident #66) do not want me in their room. The residents were separated.</p> <p>The incident was witnessed by a housekeeping staff member. The residents were assessed for injuries the following day 5/7/24. The investigation began on 5/7/24 because the incident was not reported timely by the staff. Resident #66 had a bruise on the back of her right hand and it was documented as a bruise that was healing from the resident hitting her hand on the bathroom door. Resident #6 had no new injuries documented.</p> <p>-However, the facility failed to assess the residents immediately after the incident to ensure temporary injuries were not present and to confirm the source of Resident #66's injury.</p> <p>III. Resident #66</p> <p>A. Resident status</p> <p>Resident #66, age 78, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dislocation of the right shoulder, dementia with other behavioral disturbances and adjustment disorder with depressed mood.</p> <p>The 4/3/24 minimum data set (MDS) assessment documented Resident #66 had severe cognitive impairment with a brief interview for mental status (BIMS) score of two out of 15.</p> <p>Resident #66 experienced hallucinations, physical behavioral symptoms, verbal behavioral symptoms and behavioral symptoms not directed toward other people, including wandering. Resident #66 put herself and other residents at significant risk for physical injury, her behaviors interfered with the resident's care, interfered with the resident's participation in activities or social interactions and potentially put Resident #66 at risk for wandering into a dangerous area or situation.</p> <p>B. Record review</p> <p>Resident #66's dementia care plan, initiated 3/7/24, documented the resident had dementia, unspecified severity of dementia with other behavioral disturbances. Interventions included keeping a daily routine consistent with the same repetition to promote memory cueing, keeping the resident's environment constant and items in reach, providing activities or recreation of the resident's choice and praising efforts when tasks were completed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #66's behavioral care plan, initiated 3/11/24, documented the resident's target behaviors included agitation, angry outbursts, crying, restlessness, sadness, throwing items, yelling, hallucinations and paranoia. Interventions included providing one-on-one activities such as crafts, keeping the resident separated from Resident #6 as much as possible with direct staff supervision if they were in the common area together, offering coffee and soda to the resident as well as sweet snacks, redirecting the resident and reapproaching the resident after a few moments, removing the resident from a high-stress area or common area, taking the resident outside to calm her down, turning on sports on the television (TV) as she enjoyed golf and softball, approaching the resident in a calm manner, not arguing with the resident, documenting behaviors and the resident's response to interventions and talking with the resident in a calm voice when behavior was disruptive.</p> <p>Resident #66's vulnerability care plan, revised 4/18/23, documented the resident was on an individual abuse prevention plan because she had behaviors and low cognition. Interventions included if the resident was displaying persistent or inappropriate behaviors, staff was to remove the resident to an area away from others, observing and implementing interventions to minimize and prevent reoccurrence and providing a safe environment for the individual and others and ensuring the safety of others.</p> <p>-However, the facility failed to revise Resident #66's care plans with personalized effective interventions to prevent resident-to-resident abuse following the physical altercation with Resident #6 on 5/6/24 (see physical altercation above).</p> <p>Cross-reference F744: failure to provide treatment/services for dementia care.</p> <p>IV. Resident #6</p> <p>A. Resident status</p> <p>Resident #6, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnosis included mild dementia.</p> <p>The 3/6/24 MDS assessment documented Resident #6 had a severe cognitive impairment with a BIMS score of one out of 15.</p> <p>Resident #6 experienced hallucinations, delusions, physical behavioral symptoms and behavioral symptoms not directed at others, including wandering.</p> <p>B. Record review</p> <p>Resident #6's behavioral care plan, revised 8/22/23, documented the resident had a severe cognitive loss. Interventions included keeping the resident separated from Resident #66 as much as possible with direct staff supervision if they were in the common area together, offering crafts and one-on-one time, offering crafts and religious shows on TV, offering to go outside when she was agitated, offering her to read her bible and coloring, offering sweet treats, tea, juice, water and soda, approaching the resident in a calm manner and documenting behaviors and resident's response to interventions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #6's mood care plan, revised 6/26/23, documented the resident experienced an alteration in feelings of well-being and hallucinations that altered her mood. Interventions included approaching the resident warmly and positively, identifying the resident's interests and involving the resident in meaningful activities.</p> <p>Resident #6's dementia care plan, revised 4/4/23, documented she had mild dementia without behavioral disturbances. Interventions included approaching the resident in a calm, slow manner and reapproaching at a later time as needed, keeping daily routines consistent with the same repetition to promote memory cueing, keeping the environment constant and items in reach and providing activities or recreation of resident's choice and praising efforts when tasks were completed.</p> <p>-However, the facility failed to update Resident #6's care plans with effective personalized interventions to prevent resident-to-resident abuse following the physical altercation with Resident #66 on 5/6/24 (see physical altercation above)</p> <p>-Resident #6's care plan failed to document a vulnerability care plan and an individual abuse prevention plan.</p> <p>Cross-reference F744: failure to provide treatment/services for dementia care.</p> <p>V. Staff interviews</p> <p>Certified nurse aide (CNA) #5 was interviewed on 5/22/24 at 4:25 p.m. CNA #5 said the memory care unit had a lot of resident-to-resident abuse because most of the residents had dementia. She said sometimes the staff were fast enough to prevent contact from being made and sometimes the staff were not fast enough.</p> <p>CNA #9 was interviewed on 5/22/24 at 4:30 p.m. CNA #9 said the resident-to-resident incidents occurred but it depended on the day and which residents had behaviors. She said sometimes there were a lot of incidents on the unit.</p> <p>Activity aide (AA) #1 was interviewed on 5/22/24 at 4:35 p.m. AA #1 said the residents sometimes got into arguments or fights with each other but it was because of their dementia.</p> <p>Registered nurse (RN) #2 was interviewed on 5/22/24 at 4:38 p.m. RN #2 said if the staff kept the residents separated it helped prevent resident-to-resident incidents. She said it was a memory care unit so the residents had incidents but she was unsure if she would call the interactions abuse.</p> <p>The memory care coordinator (MCC) was interviewed on 5/23/24 at 11:05 a.m. The MCC said patterns of resident-to-resident incidents had not been identified but she noticed the incidents occurred in the evenings or when she was not there. The MCC said she thought the incidents were because of sundowning (behaviors that occurred in people with Alzheimer's or dementia in the afternoon or evening).</p> <p>Cross-reference F744: failure to provide treatment/services for dementia care.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MCC said she wondered if staff provided the residents with activities in the evening and was worried the lack of activities caused the residents to become more restless and agitated. The MCC said she planned to change her hours to provide the evening shift with more supervision. She said the memory care unit needed an activity aide who worked well on the unit and helped with activities. The MCC said if activities occurred like the residents needed, then the unit would have decreased behaviors and resident-to-resident altercations.</p> <p>The DON was interviewed on 5/23/24 at 2:11 p.m. The DON said a handful of residents were admitted ded to the memory care unit very quickly and overwhelmed the unit. The DON said she was unaware staff failed to provide activities on the evening shift. She said the MCC needed to have her own AA for the unit because the current AAs rotated each week as to who worked the memory care unit. She said the AA who covered the unit was supposed to work more of an 11:00 a.m. to 7:00 p.m. or 12:00 p.m. to 8:00 p.m. shift. She said she was not aware the AA worked from 2:00 p.m. to 10:00 p.m. and was not consistently providing activities like the residents needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>48412</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents were free from physical restraints for one (#50) of three residents out of 38 sample residents</p> <p>Specifically, the facility failed to ensure staff used a gait belt appropriately for assistance and not to restrain a resident from getting out of her wheelchair.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Physical Devices and Bedrails policy, revised 3/15/23, was provided by the director of nursing (DON) on 5/22/24 at 6:51 p.m. It read in pertinent part,</p> <p>In accordance with Federal and State laws, this company has a very stringent policy regarding the use of physical devices on residents, as a restraint. Our philosophy of providing residents with the highest possible quality of care and life, is reflective of our belief that it is essential for our residents to maintain their dignity and independence by being permitted to take the normal risks of everyday life. Devices used in an attempt to remove these normal risks of living, violate the rights of residents, greatly reduce their quality of life and present significant physical and psychological risks.</p> <p>For these reasons, and in accordance with Federal and State laws, devices used in our facility will only be considered to treat a medical symptom or condition that endangers the physical safety of the resident or other residents, and under the following conditions:</p> <ul style="list-style-type: none"> -To improve the resident's mobility and independent function; -To treat residents' medical symptoms; -To restrict movement to protect the resident during treatment and diagnostic procedures; -As a last resort measure, after less restrictive measures have been taken and proven unsuccessful; -To prevent the resident from injuring himself or others; -With a physician's order; -With the consent of the resident or responsible party; and, -When the benefits of the device outweigh the identified risks. <p>II. Observations</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continuous observation on 5/22/24, beginning at 3:00 p.m. and ending at 5:28 p.m., the following was observed:</p> <p>At 3:00 p.m. Resident #50 was observed continuously standing up and sitting down. She walked a couple of steps and pulled her wheelchair behind her. Resident #50 had a gait belt on and the staff with her used it to provide the resident with assistance because she was unsteady on her feet.</p> <p>At 3:44 p.m. registered nurse (RN) #2 switched out with certified nurse aide (CNA) #5 and took over providing oversight of Resident #50. Resident #50 continued to stand up and sit down. Resident #50 continued to walk a few steps as she pulled her wheelchair behind her.</p> <p>At 3:47 p.m. Resident #50 attempted to stand up and RN #2 used the resident's gait belt to pull her back into the seat of her wheelchair. Resident #50 stood up and walked a couple of steps. RN #2 pulled Resident #50's gait belt backward and pushed the resident's wheelchair forward and Resident #50 sat back down.</p> <p>At 3:49 p.m. Resident #50 attempted to stand up and RN #2 pulled the resident's gait belt. RN #2 held the gait belt to the back of the wheelchair when the resident sat back down so the resident was unable to stand up.</p> <p>At 3:50 p.m. Resident #50 stood up and RN #2 pulled the gait belt as she used her right knee to push the wheelchair under the resident.</p> <p>At 3:52 p.m. Resident #50 was trying to stand up and walk with her wheelchair. The resident said please, please, please as RN #2 pulled the wheelchair backward and prevented the resident from moving forward.</p> <p>At 3:53 p.m. Resident #50 stood up and RN #2 used her right hand to grab the resident's right shoulder and pushed the resident back into her wheelchair. CNA #5 saw what happened and told RN #2 that Resident #50 was strong.</p> <p>At 3:55 p.m. Resident #50 stood up and RN #2 pulled the resident by her gait belt and made her sit back in her wheelchair.</p> <p>At 3:57 p.m. CNA #5 switched with RN #2 and began providing oversight of Resident #50. Resident #50 stood up and walked a few steps while she pulled her wheelchair behind her and then sat down in her wheelchair. CNA #5 walked with Resident #50 as she walked. CNA #5 assisted Resident #50 to her bedroom to use the bathroom.</p> <p>At 4:07 p.m. RN #2 switched out with CNA #5 again and began providing oversight of Resident #50. The activity director (AD) entered the memory care unit and RN #2 let Resident #50 walk without pulling the gait belt. When the AD left the unit RN #2 pulled Resident #50's gait belt and sat her back in her wheelchair.</p> <p>At 4:08 p.m. Resident #50 stood up and said give it to me. RN #2 said not right now and used both hands to pull the resident back into her wheelchair by her gait belt.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 4:09 p.m. Resident #50 stood up and pulled her wheelchair forward while RN #2 pulled the wheelchair backwards. The resident and the nurse pulled on the wheelchair so hard that the wheels stopped moving. RN #2 tried getting Resident #50 to sit in her wheelchair but the resident wanted to walk. Resident #50 made a sstt-sstt-sstt sound but when RN #2 prevented the resident from walking, the noise was more frequent.</p> <p>At 4:11 p.m. RN #2 let Resident #50 walk a little bit but she got too close to another resident and RN #2 pulled her gait belt and sat her back in her wheelchair.</p> <p>At 4:12 p.m. Resident #50 sat in her wheelchair and RN #2 pushed down on the gait belt so the resident was not able to stand. Resident #50 stood up and said hurry, come on, hurry, come on as she tried to walk. RN #2 pulled her gait belt backward and she sat back in her wheelchair.</p> <p>At 4:14 p.m. Resident #50 tried walking again and RN #2 pulled her back into her wheelchair with the resident's gait belt. Resident #50 said please, please, please and appeared upset.</p> <p>At 4:15 p.m. Resident #50 stood up and sat down numerous times. Each time Resident #50 stood up RN #2 pulled her back down with her gait belt. This occurred five times in a row.</p> <p>At 4:16 p.m. Resident #50 stood up and walked approximately five steps before RN #2 used her gait belt to pull her back into her wheelchair. When Resident #50 was sitting in the wheelchair, RN #2 pushed down on the gait belt which prevented the resident from standing.</p> <p>At 4:17 p.m. Resident #50 stood up and pulled her wheelchair for approximately 10 steps. RN #2 pulled the gait belt and the resident pulled her wheelchair. The wheelchair slid sideways and the nurse had to straighten the wheelchair out before she had the resident sit down.</p> <p>At 4:18 p.m. the AD entered the unit again and RN #2 let Resident #50 walk a few steps. When the AD looked at RN #2, the nurse pulled Resident #50's gait belt as she used her right knee to push the wheelchair under the resident and made her sit down. The AD saw the incident, however, the AD did not speak to RN #2 and left the unit.</p> <p>At 4:19 p.m. Resident #50 stood up and tried walking forward. As she pulled her wheelchair forward, RN #2 pulled the wheelchair backward which prevented the resident from walking.</p> <p>At 4:44 p.m. CNA #5 switched out with RN #2 and began providing oversight of Resident #50. Resident #50 walked around as she pulled her wheelchair behind her and stopped making the sstt-sstt-sstt noise as much as she was when she was prevented from walking by RN #2.</p> <p>III. Record review</p> <p>Resident #50's dementia care plan, initiated on 7/21/21, documented the resident had unspecified dementia without behavioral disturbances. Interventions included approaching the resident in a calm, slow manner and re-approaching at a later time as needed, keeping daily routines consistent with the same repetition to promote memory cueing and cueing and reorienting the resident as needed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #50's fall care plan, revised 10/11/23, documented the resident was at high risk for falls with a Morse fall risk score of 55. Interventions included keeping the bed in the lowest position while the resident was in bed, placing a fall mat at bedside while the resident was in bed, providing stand-by assistance when the resident was ambulating, hourly rounding for the 4P's (personal items, pain, personal needs and positioning), being sure the call light was in place in room and bathroom and reminding the resident to use the call light when assistance was needed and keeping needed items in reach of the resident.</p> <p>-However, the facility failed to include interventions to address what to do when the resident was constantly up and down and interventions to address what to do when the resident pulled her wheelchair behind her as she walked.</p> <p>IV. Staff interviews</p> <p>CNA #5 was interviewed on 5/22/24 at 4:25 p.m. CNA #5 said she covered any unit the facility assigned her. She said Resident #50 paced and was constantly standing and sitting. CNA #5 said when Resident #50 was walking, the staff pulled the wheelchair behind the resident in case she needed to sit down. CNA #5 said Resident #50 started pulling her wheelchair behind her while she walked on 5/22/24. CNA #5 said the resident probably pulled her wheelchair the way therapy pulled it behind residents to prevent falls.</p> <p>CNA #5 said Resident #50 was a fall risk but she was unaware of what fall interventions were in place for the resident. CNA #5 said staff were supposed to hold the gait belt in a supportive way and did not really touch the gait belt. She said staff just kept their hand under the gait belt in case the resident sat down unexpectedly.</p> <p>CNA #5 said she had Resident #50 walk because she was determined to get up and there was no reason to stop her. CNA #5 said she had seen other staff pull on the resident's gait belt and try to keep the resident in her wheelchair but CNA #5 was uncomfortable with that practice and did not tell anyone or speak to the staff who pulled the gait belt.</p> <p>CNA #9 was interviewed on 5/22/24 at 4:30 p.m. CNA #9 said she worked the memory care unit a lot and Resident #50 paced every day. CNA #9 said she felt Resident #50 had been standing and sitting constantly and walking with her wheelchair for quite some time. CNA #9 said she kept her hand by Resident #50's gait belt to support the resident as she walked.</p> <p>CNA #9 said she saw other staff pull on Resident #50's gait belt to make her sit down but the facility never allowed for the staff to pull on gait belts. CNA #9 said she let Resident #50 walk around and pace and hoped it would help with her behaviors. CNA #9 said she was taught if a resident wanted to walk the staff needed to let them walk safely. CNA #9 said staff were not supposed to restrain residents. CNA #9 said Resident #50 was a fall risk but she was unaware of any fall interventions in place. CNA #9 said she had not told anyone that some staff were pulling on the resident's gait belt in order to keep the resident from standing up.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Activity aide (AA) #1 was interviewed on 5/22/24 at 4:35 p.m. AA #1 said she was assigned to the unit for activities. AA #1 said Resident #50 was always up and down. AA #1 said Resident #50 was a fall risk but she was unaware of any fall interventions in place because she was not allowed to provide resident care. AA #1 said she observed some staff pull the resident's gait belt to make her sit back in her wheelchair. AA #1 said she knew the staff were not allowed to pull on the gait belt but had not told anyone it was occurring.</p> <p>RN #2 was interviewed on 5/22/24 at 4:38 p.m. RN #2 said she was the nurse assigned to the memory care unit and she worked the unit all the time. She said Resident #50 started wandering within the past few weeks. RN #2 said Resident #50 was a fall risk and her fall interventions were that she needed one-to-one supervision. RN #2 said staff were not allowed to pull on the gait belt but the staff held the gait belt if they felt she was going to fall. RN #2 said she sometimes let Resident #50 walk but it depended on how her balance was at that moment. RN #2 said she pulled on Resident #50's gait belt if the resident was too far forward. RN #2 said she felt she was not pulling on the gait belt and she was concerned the resident was going to fall.</p> <p>The director of nursing (DON) and the corporate consultant (CC) were interviewed on 5/22/24 at 7:08 p.m. The DON said a gait belt was used to transfer residents and it was not okay to be used as a restraint or to put a resident in their wheelchair.</p> <p>The CC said some residents received restorative therapy and the staff needed to keep their hand under the bottom of the gait belt, not on top of the gait belt to be pulled.</p> <p>The DON said she was opening an investigation and was investigating abuse and restraints.</p> <p>The CC said the investigation started as abuse for the night. The CC said the facility was a restraint-free facility.</p> <p>The DON said she knew RN #2 and felt the nurse was probably more concerned about Resident #50's safety than trying to restrain her to her wheelchair. The DON said RN #2 probably did not realize she was hurting Resident #50 or potentially causing injuries and probably did not know she was using the gait belt as a restraint.</p> <p>The memory care coordinator (MCC) was interviewed on 5/23/24 at 10:30 a.m. The MCC said Resident #50 recently started walking. The MCC said the resident had a change in her condition a while back which prevented her from walking and staff used a lift for transfers. The MCC said RN #2 was not supposed to pull on the gait belt or prevent Resident #50 from getting out of her wheelchair. The MCC said she requested Resident #50's hospice team to complete an assessment because the MCC worried the resident was experiencing end-of-life agitation and restlessness.</p> <p>The MCC said she provided education to the staff who worked the unit on 5/23/24 and the DON was helping with the education to the rest of the facility. The MCC said all staff were required to complete a six-hour dementia computer course by 6/1/24 and felt it would help. The MCC said if activities occurred the way the residents needed, it prevented a lot of incidents which included potential staff burnout. The MCC said it was unacceptable for RN #2 to pull on Resident #50's gait belt, push the wheelchair into the resident, or prevent the resident from walking.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed again on 5/23/24 at 2:11 p.m. The DON said RN #2 was suspended and the investigation was ongoing. The DON said every shift was provided education in-person on the proper use of a gait belt. The DON said the facility assigned all staff online training for gait belts and restraints. The DON said all staff were required to complete a six-hour dementia training by 6/1/24 and she monitored everyone's progress to ensure it was being completed. The DON said dementia capable care training was going to be completed by all staff by the end of July 2024.</p> <p>The DON said the facility wanted the MCC to have an AA who was managed by the MCC so the AA was consistent for the unit and was able to provide the residents with the activities they needed. The DON said it was important not to pull on a gait belt to prevent injuries and pain. The DON said a lot of residents were admitted to the memory care unit at the same time which overwhelmed the unit and increased the tension.</p> <p>The DON said RN #2 was probably burnt out from Resident #50 and providing one-on-one supervision alone. The DON said she walked with Resident #50 and saw it was difficult to provide assistance to the resident with just one staff member. The DON said Resident #50's interventions were updated and if the resident wanted to walk she needed two staff members to provide assistance.</p> <p>The rehabilitation therapy director (RTD) was interviewed on 5/23/24 at 4:52 p.m. The RTD said gait belts should be used for assistance and not used to restrain residents.</p> <p>RN #1 was interviewed on 5/23/24 at 4:49 p.m. RN #1 said she was the rehabilitation nurse and said the gait belts were used to assist residents with transfers and ambulation. RN #1 said gait belts were not to be used as restraints.</p> <p>CNA #6 was interviewed on 5/23/24 at 6:21 p.m. CNA #6 said gait belts were used to walk with residents who were a fall risk. CNA #6 said gait belts kept the residents safe and prevented falls. CNA #6 said she had not seen staff restrain residents with a gait belt.</p> <p>CNA #4 was interviewed on 5/23/24 at 6:23 p.m. CNA #4 said gait belts were used to safely walk with residents. CNA #4 said she did not think staff were allowed to pull on the gait belt. CNA #4 said gait belts should not be used to restrain residents at any time.</p> <p>RN #3 was interviewed on 5/23/24 at 6:31 p.m. RN #3 said gait belts were used to safely transfer residents. RN #3 said staff were not allowed to pull on the gait unless staff were preventing a fall. RN #3 said gait belts were not used to restrain residents.</p> <p>V. Facility follow-up</p> <p>The DON provided a follow-up report on 5/29/24 at 3:08 p.m. The DON said RN #2 was no longer assigned to the memory care unit. She said RN #2 was required to complete gait belt and restraint training. The DON said RN #2 was assigned to work under the direct supervision of the evening nurse supervisor and was assigned the same schedule as the supervisor. The DON said RN #2's supervision level would be re-evaluated in six months.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314</p> <p>Based on record review and interviews, the facility failed to ensure two (#17 and #39) of five residents out of 38 sample residents received the care and services necessary to meet their nutrition and hydration needs and to maintain their highest level of physical well-being.</p> <p>Resident #17 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure and severe protein-calorie malnutrition.</p> <p>On [DATE], the resident weighed 137 pounds (lbs). On [DATE] the resident sustained a 5.8% (percent) (7.88 lbs) weight loss in 21 days, which was considered severe. After the resident sustained the weight loss the facility failed to implement additional nutritional interventions to address the resident's weight loss.</p> <p>The resident sustained an additional 8.5% (11.8 lbs) weight loss from [DATE] to [DATE], which was considered significant. The facility failed to implement additional nutritional interventions to address the resident's continued severe weight loss.</p> <p>On [DATE] a physician's order was entered into the resident's electronic medical record (EMR) which indicated to weigh the resident weekly on Wednesdays. The facility failed to consistently monitor the resident's weight.</p> <p>On [DATE], the resident weighed 111 lbs. The resident sustained 19% (26 lbs) weight loss from [DATE] to [DATE], which was considered severe.</p> <p>The only nutrition intervention that was implemented was a nutritional supplement in [DATE], prior to the resident sustaining severe weight loss. The facility failed to provide the supplement as ordered and consistently document the amount the resident consumed when the oral nutritional supplement was offered.</p> <p>Additionally, the facility failed to monitor and track Resident #39's weight loss and implement person-centered nutritional interventions to address the resident's weight loss.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Comprehensive Medical Nutrition Therapy Assessment policy, revised 2021, was provided by the nursing home administrator (NHA) on [DATE] at 1:18 p.m. It read in pertinent part, The registered dietician gathers information for the comprehensive assessment from the medical records, individual observations, and nutrition-focused physical assessment. Nursing staff provides details about the individual's nutrition intake, daily routines, food preferences, and vital signs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The registered dietician will develop the specification of the nutritional concern or nutritional diagnosis which is a clear statement that provides the basis for individual-specific interventions. For example, inadequate oral food and fluid intake related to oral intake less than 50% as evidenced by greater than or equal to 5% unintended weight loss in the past 30 days.</p> <p>The Dehydration policy, revised 2021, was provided by the NHA on [DATE] at 1:18 p.m. It documented in pertinent part, Each individual will receive sufficient amounts of fluid based on individual need and personal preference to prevent dehydration and maintain health.</p> <p>The High Calorie/High Protein Supplements policy, revised 2021, was provided by the NHA on [DATE] at 1:18 p.m. It documented in pertinent part, Individuals needing supplemental nutrition will be served a suitable high calorie/high protein supplement between meals or as part of a medication pass-supplement program.</p> <p>The food and nutrition services department will prepare supplements and deliver them to nursing staff at the appropriate time.</p> <p>Nursing staff will supervise the delivery and consumption of all supplements and record appropriately in the medical record, meal intake reporting records, and/or the medication administration record.</p> <p>II. Resident #17</p> <p>A. Resident status</p> <p>Resident #17, over the age of 65, was admitted to the facility on [DATE]. According to the [DATE] computerized physician's orders (CPO), diagnoses included COPD, chronic respiratory failure and severe protein-calorie malnutrition.</p> <p>The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The resident was independent with eating, required moderate assistance with oral hygiene. He was dependent on staff for bathing, toileting transfers and dressing.</p> <p>The assessment documented the resident was 70 inches (5 foot, 10 inches) tall and weighed 107 pounds. It indicated the resident had a weight loss of 5% or more and the resident was not on a prescribed weight loss regimen.</p> <p>B. Resident interview</p> <p>Resident #17 was interviewed on [DATE] at 9:26 a.m. Resident #17 said he did not eat any breakfast today. The resident said that he usually did not eat a large breakfast. He said he was actually a little hungry this morning ([DATE]). The resident said he had not been offered breakfast by nursing staff today and his nutritional supplement had not been given to him. The resident said a staff member came into his room and took his lunch order for the day. The resident said the nursing staff did not monitor how much he drank of the nutritional shakes. The resident said he did not get the nutritional shake every day like he was supposed to.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>C. Record review</p> <p>The nutrition care plan, revised on [DATE], revealed the resident had a diagnosis of malnutrition. The care plan documented interventions including educating the resident on food groups, monitoring laboratory values for nutritional well-being, observing signs and symptoms of depression and offering the resident foods high in protein and calories that will promote weight gain.</p> <p>-A review of the comprehensive care plan revealed the care plan was not updated with person-centered nutrition interventions after the resident sustained weight loss on [DATE], [DATE] or [DATE].</p> <p>Resident #17's weights were documented in the resident's electronic medical record (EMR) as follows:</p> <p>-On [DATE], the resident weighed 137 lbs;</p> <p>-On [DATE], the resident weighed 136 lbs;</p> <p>-On [DATE], the resident weighed 135 lbs;-On [DATE], the resident weighed 137 lbs;</p> <p>-On [DATE], the resident weighed 137 lbs;</p> <p>-On [DATE], the resident weighed 129.12 lbs;</p> <p>-On [DATE], the resident weighed 118.04 lbs;</p> <p>-On [DATE], the resident weighed 116 lbs;</p> <p>-On [DATE], the resident weighed 119 lbs</p> <p>-On [DATE], the resident weighed 111 lbs; and,</p> <p>-On [DATE], the resident weighed 108.4 lbs.</p> <p>-The resident lost 7.88 lbs (5.8%) from [DATE] to [DATE] in 21 days, which was considered severe.</p> <p>-The resident lost 11.08 lbs (8.5%) from [DATE] to [DATE] in one month, which was considered severe.</p> <p>-The resident lost 26 lbs (19%) from [DATE] to [DATE] in four months, which was considered severe.</p> <p>The [DATE] CPO revealed Resident #17 was to be weighed weekly on Wednesdays, initiated on [DATE].</p> <p>-Reident #17 was not weighed on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] as ordered.</p> <p>The [DATE] dietary nutrition data collection assessment documented Resident #17 had lost approximately 40 lbs in the last six months related to poor oral intake. The progress note documented the goal was for the resident to lose weight.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-However, there was no documentation from a physician indicating the weight loss was desired.</p> <p>The [DATE] dietary nutrition data collection assessment documented Resident #17 required 1500 milliliters (mL) of fluid per day.</p> <p>A dietary progress note, dated [DATE], documented that the resident had lost ten percent of his body weight in the last six months. The progress note documented that the resident had requested meat sandwiches in the past but these were often not eaten and instead were being thrown away by the kitchen when they expired. The progress note documented the resident had advanced COPD which was the reason he had poor oral intake. The progress note documented that the dietary staff expected the resident to continue to lose weight.</p> <p>-However, a review of the electronic medical record (EMR) did not reveal the facility had implemented person-centered nutritional interventions after the resident sustained weight loss or had documentation for a physician regarding unavoidable weight loss.</p> <p>A review of the resident's EMR revealed the resident had a physician's order to receive a house shake supplement one time a day for nutritional supplementation, ordered [DATE].</p> <p>The snack shake list (from [DATE] to [DATE]) was provided by the RD on [DATE] at 11:28 a.m. It documented Resident #17 was offered a nutritional supplement on 13 out of 29 days.</p> <p>-The facility failed to offer a nutritional supplement to Resident #17 for 16 of the 29 days between [DATE] and [DATE].</p> <p>A review of the certified nurse aide (CNA) task response history (from [DATE] to [DATE]) revealed Resident #17 had a task that specified to offer the resident snacks or supplements.</p> <p>-The task sheet did not differentiate between offering the resident a nutritional supplement or a snack. The task sheet only had documentation that he was provided a snack or supplement on 19 of the 30 days.</p> <p>A review of the CNA task response history (from [DATE] to [DATE]) revealed staff had documented the amount the resident had eaten for 85 out of 90 meals during the review period. It was documented the resident ate less than 50% of his meals for 32 of 85 documented meals.</p> <p>A review of the CNA task response history (from [DATE] to [DATE]) revealed staff had documented the resident had consumed less than 1500 ml of fluids on 16 of 30 days and consumed less than 100 ml on five of the 30 days.</p> <p>-The facility failed to ensure documentation revealed the resident consumed the recommended amount of fluids to maintain hydration in 16 of 30 days between [DATE] and [DATE].</p> <p>III. Resident #39</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #39, over the age of 65, was admitted to the facility on [DATE]. According to the [DATE] CPO, diagnoses included dementia, cardiomegaly (an enlarged heart) and chronic kidney disease.</p> <p>The [DATE] MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of two out of 15. The resident required supervision or touching assistance with eating. She was dependent on staff for oral hygiene, dressing, toileting and personal hygiene.</p> <p>The assessment documented the resident was 63 inches (5 foot, 3 inches) tall and weighed 132 pounds. It indicated the resident had not had any significant weight loss or weight gain.</p> <p>B. Record review</p> <p>The nutrition care plan, initiated on [DATE] and revised on [DATE], revealed the resident had unintentional weight loss related to dementia on [DATE]. The care plan documented the resident enjoyed eating snacks and coffee between meals. The interventions included having snacks available to the resident, providing handled cups at meals, offering the resident preferred foods, and monitoring the resident's intake.</p> <p>-The facility failed to document new interventions in the comprehensive care plan after significant weight loss was documented on [DATE], [DATE], and [DATE].</p> <p>The [DATE] CPO revealed Resident #17 was to be weighed weekly on Wednesday evenings, initiated on [DATE].</p> <p>Resident #39's weights were documented in the EMR as follows:</p> <ul style="list-style-type: none"> -On [DATE], the resident weighed 146 lbs; -On [DATE], the resident weighed 143 lbs; -On [DATE], the resident weighed 142 lbs; -On [DATE], the resident weighed 141 lbs; -On [DATE], the resident weighed 146 lbs; -On [DATE], the resident weighed 135.92 lbs; -On [DATE], the resident weighed 139 lbs; -On [DATE], the resident weighed 130 lbs; -On [DATE], the resident weighed 135 lbs; -On [DATE], the resident weighed 125 lbs; -On [DATE], the resident weighed 133 lbs; and, <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-On [DATE], the resident weighed 129.96 lbs.</p> <p>-The resident lost 9.04 lbs (6.7%) from [DATE] to [DATE] in three months.</p> <p>The [DATE] dietary nutrition data collection assessment documented the resident was eating ,d+[DATE]% of her meals.</p> <p>-No interventions for the focus area of nutrition were identified. The assessment documented the resident's weight had been stable for the last six months.</p> <p>The [DATE] dietary nutrition data collection assessment documented the resident was eating ,d+[DATE]% of her meals. The assessment documented the resident had sustained significant weight loss of greater than 5% in the last month or a loss of 10% or more in the last six months and was not on a prescribed weight loss regimen.</p> <p>The assessment documented Resident #39 required an estimated 1800 mL of fluids per day. The assessment documented the facility had been having problems with the scales in the facility. The RD questioned the accuracy of weights taken on [DATE] and [DATE].</p> <p>-The facility failed to implement person-centered nutritional interventions after it was identified the resident had sustained significant weight loss.</p> <p>-The facility did not reweigh the resident after it was identified there was an issue with the scale.</p> <p>-The assessment did not identify any additional interventions to prevent further significant weight loss for Resident #39.</p> <p>The [DATE] interdisciplinary care conference progress note documented the resident's spouse was in attendance. The progress note documented the facility was monitoring Resident #39 for weight loss. The resident had been eating less than 50%of her meals on average.</p> <p>A review of the CNA task response history (from [DATE] to [DATE]) revealed staff had documented the amount the resident had eaten for 72 out of 90 meals during the review period. It was documented the resident ate less than 50% of her meals for 17 of 72 documented meals.</p> <p>Nutrition and fluids documentation was reviewed in the EMR for 30 days between [DATE] and [DATE]. Resident #39 was documented to have consumed less than 1800 mL of fluids on 30 of those 30 days of opportunities. The resident was documented to have consumed less than 1000mL of fluids on 11 of those 30 days.</p> <p>-The facility failed to ensure Resident #39 consumed the estimated required amount of fluids to maintain physical function on 30 of 30 days between [DATE] and [DATE].</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #2 was interviewed on [DATE] at 1:28 p.m. CNA #2 said Resident #39 required set-up assistance for eating. She said the resident usually drank fluids without assistance. CNA #2 said Resident #39 sometimes needed to be prompted to drink fluids or to ask if the resident had enough. CNA #2 said Resident #39 usually ate his meals in the dining room. CNA #2 said the CNAs and the nurses were responsible for documenting the amount of food consumed at meals in the EMR.</p> <p>Registered nurse (RN) #4 was interviewed on [DATE] at 1:34 p.m. RN #4 said Resident #17 preferred to eat his meals in his room. RN #4 said the dietary aides were responsible for passing out nutritional supplements to the residents. She said the CNAs and RNs delivered meal trays to the residents who preferred to eat in their rooms. RN #4 said whoever picked up a resident's meal tray when they were finished eating should document how much they ate and drank in the EMR under task documentation.</p> <p>The registered dietitian (RD) was interviewed on [DATE] at 11:12 a.m. The RD said when a resident sustained significant weight loss it was documented under the dietary progress notes. The RD said the comprehensive care plan should be updated when a resident experienced significant weight loss to include new person-centered nutritional interventions to help prevent further weight loss. She said the snack shake list documented if the resident was offered a nutritional supplement, but did not document how much of the nutritional supplement was consumed. The RD said she did not know whose responsibility it was to see how much of the nutritional supplement the resident was consuming. The RD said her process for assessing the effectiveness of the nutritional shake was to ask the resident if they were enjoying the nutritional supplement.</p> <p>The RD said she had concerns about how this assessment process would work for residents with cognitive impairment. The RD said staff did not measure the amount of nutritional supplement remaining after resident consumption. The RD said she used nursing staff documentation regarding what residents had consumed at meals to help make informed nutritional recommendations. The RD said she believed some of the documentation was inaccurate.</p> <p>The RD said she did not know how much of the nutritional supplement Resident #17 had been consuming. The RD said she was not receiving complete information regarding the resident's meal intakes to base her nutritional recommendations on for residents in the facility. The RD said it was important to know exactly how much of a nutritional supplement the residents consumed so she could make good resident-centered recommendations.</p> <p>The maintenance director (MA) was interviewed on [DATE] at 3:13 p.m. The MA said the scale was calibrated on [DATE]. The MA said all of the scales were properly functioning and were routinely calibrated. The MA said he was not notified that a particular scale was having an issue with weight accuracy.</p> <p>The director of nursing (DON) was interviewed on [DATE] at 7:27 p.m. The DON said the facility should assess and address significant weight loss. The DON said person-centered nutritional interventions should be implemented after the assessment was completed. She said the nutritional interventions should be included on the resident's comprehensive care plan.</p> <p>The DON said the amount consumed of a nutritional supplement should be documented by nursing staff. The DON said the facility recently changed who was responsible for documenting the amount of supplements a resident had consumed recently.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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 0692 Level of Harm - Actual harm Residents Affected - Few	The DON said she was worried the nursing staff did not have time to correctly documented how much of a nutritional supplement the resident had consumed. The DON said she the documentation for Resident #17 and Resident #39's nutritional supplements did not include how much the residents had consumed. The DON said both Resident #17 and Resident #39 did not drink enough fluids. The DON said the facility needed to improve on documentation and provide education to improve resident record accuracy.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on observations, interviews and record review, the facility failed to ensure residents received the appropriate treatment and services to maintain their highest practicable physical, mental and psychosocial well-being for two (#6 and #66) of six residents reviewed for dementia care out of 38 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Effectively implement a meaningful activity program for Resident #6 and Resident #66 to prevent resident-to-resident abuse; and, -Implement person-centered interventions for Resident #6's and Resident #66's behaviors. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Guidelines for Memory Support Programs and Services, revised February 2015, was provided by the director or nursing (DON) on 5/22/24 at 5:53 p.m. It read in pertinent part,</p> <p>The facility's memory support program or services operates under a person-centered model, with emphasis on the whole person. This model recognizes that all persons have physical, social, emotional, intellectual, occupational and spiritual needs, regardless of their level of cognitive function.</p> <p>Activity-focused living recognizes that all aspects of the residents'- anything they do or are involved with - are their activity at that moment. Activities, either individual or in groups, create a purposeful use of time and are adapted from tasks the residents would be doing if they did not have dementia. Memory support programs engage residents in cognitive, physical and psychosocial activities that focus on abilities, not limitations.</p> <p>The Activities Programs policy, revised 8/2/23, was provided by the corporate consultant (CC) on 5/23/24 at 3:53 p.m. It read in pertinent part,</p> <p>Varied activities will be planned and routinely scheduled. Activities will focus on the following:</p> <ul style="list-style-type: none"> -To stimulate socialization and encourage fell owship; -To help maintain muscle tone and coordination; -To encourage and provide opportunities for mental functioning; -To provide sensory stimulation; -To reduce isolation, build self-esteem and strengthen coping capabilities and identity; <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-To provide entertainment; and,</p> <p>-To strengthen existing spiritual tenets and to provide an opportunity to express individual beliefs.</p> <p>II. Observations</p> <p>On 5/20/24 at 10:00 a.m. an informational video about bees was being played in the common area of the memory care unit. There were five residents in the common area during the activity and Resident #66 was sitting hunched over the counter by the common area.</p> <p>-However, four of the residents were asleep in recliners during the activity and Resident #66 was asleep at the counter.</p> <p>A continuous observation was conducted on 5/22/24, beginning at 3:00 p.m. and ending at 5:28 p.m. The following observations were made:</p> <p>At 3:00 p.m. six residents were observed in recliners in the common area with a movie playing on the television (TV). Resident #6 and Resident #66 were sitting in the dining room without staff interaction.</p> <p>At 3:30 p.m. Resident #66 and Resident #6 were still not being interacted with by the staff. Activity aide (AA) #1 sat in the common area watching the movie. Resident #66 was hunched over the kitchen counter and Resident #6 was looking for her money.</p> <p>At 3:42 p.m. AA #1 offered to paint a female resident's fingernails. AA #1 did not interact with the other residents. A resident was having some difficulty and Resident #6 was becoming agitated and concerned for the other resident.</p> <p>-Certified nurse aide (CNA) #5 told Resident #6 the female resident was okay but no one offered Resident #6 an activity or redirection.</p> <p>At 4:00 p.m. the residents were being moved to the dining room for dinner.</p> <p>At 4:35 p.m. CNA #5 said dinner was usually late and the residents were restless by the time the meal arrived on the unit.</p> <p>At 4:48 p.m. the meal cart arrived at the unit. Two male residents had left the dining room and went to their bedrooms because dinner was taking too long to arrive. Resident #6 was becoming agitated while waiting for dinner and said someone stole my money.</p> <p>At 4:59 p.m. cook #3 started serving meals after returning from the main kitchen. The unit staff tried to keep the residents at the tables for dinner.</p> <p>On 5/23/24 at 10:30 a.m. Resident #66 was sitting in the dining room, four residents were asleep in the recliners in the common area and one resident was watching the movie playing on the TV. Staff interactions were not provided because there were only two staff members on the unit at the time.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>III. Resident #6</p> <p>A. Resident status</p> <p>Resident #6, age greater than 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included mild dementia.</p> <p>The 3/6/24 minimum date set (MDS) assessment documented Resident #6 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of one out of 15. Resident #6 experienced hallucinations, delusions, physical behavioral symptoms and behavioral symptoms not directed at others including wandering.</p> <p>B. Record review</p> <p>Resident #6's behavioral care plan, revised 8/22/23, documented the resident had a severe cognitive loss. Interventions included keeping the resident separated from Resident #66 as much as possible with direct staff supervision if they were in the common area together, offering crafts and one-on-one time, offering crafts and religious shows on TV, offering to go outside when she was agitated, offering her to read her bible and coloring, offering sweet treats, tea, juice, water and soda, approaching the resident in a calm manner and documenting behaviors and resident's response to interventions.</p> <p>Resident #6's mood care plan, revised 6/26/23, documented the resident experienced an alteration in feelings of well-being and hallucinations that altered her mood. Interventions included approaching the resident warmly and positively, identifying the resident's interests and involving the resident in meaningful activities.</p> <p>Resident #6's dementia care plan, revised 4/4/23, documented she had mild dementia without behavioral disturbances. Interventions included approaching the resident in a calm, slow manner and reapproaching at a later time as needed, keeping daily routines consistent with the same repetition to promote memory cueing, keeping the environment constant and items in reach and providing activities or recreation of resident's choice and praising efforts when tasks were completed.</p> <p>Resident #6's activity and life enrichment care plan, revised 9/19/23, documented the resident had interests and preferences in activities that she wished to continue for as long as possible. Interventions included 7 Day Adventist, Bible study was important to the resident and, incorporating this into her plan providing the resident with her interests which included books and magazines, country music, movies, sitting in the day room, her own room and spending time outdoors, familiarizing the resident with the facility environment and activity programs regularly and providing the resident with independent activities of reading, writing and computer use, assisting only as needed.</p> <p>-However, the facility failed to update Resident #6's care plan with effective interventions to prevent resident-to-resident abuse and behaviors following a resident to resident altercation with Resident #66 on 5/6/24.</p> <p>(Cross-referenced F600: failure to prevent abuse)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Additionally, the facility failed to provide Resident #6 with meaningful activities as care planned (see observations above).</p> <p>IV. Resident #66</p> <p>A. Resident status</p> <p>Resident #66, age 78, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included dislocation of the right shoulder, dementia with other behavioral disturbances and adjustment disorder with depressed mood.</p> <p>The 4/3/24 MDS assessment documented Resident #66 had a severe cognitive impairment with a BIMS score of two out of 15.</p> <p>Resident #66 experienced hallucinations, physical behavioral symptoms, verbal behavioral symptoms and behavioral symptoms not directed toward other people including wandering.</p> <p>Resident #66 put herself and other residents at significant risk for physician injury, her behaviors interfered with the resident's care, interfered with the resident's participation in activities or social interactions and potentially put Resident #66 at risk for wandering into a dangerous area or situation.</p> <p>B. Record review</p> <p>Resident #66's dementia care plan, initiated 3/7/24, documented the resident had dementia, unspecified severity of dementia with other behavioral disturbances. Interventions included keeping a daily routine consistent with the same repetition to promote memory cueing, keeping the resident's environment constant and items in reach, providing activities or recreation of the resident's choice and praising efforts when tasks were completed.</p> <p>Resident #66's behavioral care plan, initiated 3/11/24, documented the resident's target behaviors included agitation, angry outbursts, crying, restlessness, sadness, throwing items, yelling, hallucinations and paranoia. Interventions included providing one-on-one activities such as crafts, keeping the resident separated from Resident #6 as much as possible with direct staff supervision if they were in the common area together, offering coffee and soda to the resident as well as sweet snacks, redirecting the resident and reapproaching the resident after a few moments, removing the resident from a high-stress area or common area, taking the resident outside to calm her down, turning on sports on the television (TV) as she enjoyed golf and softball, approaching the resident in a calm manner, not arguing with the resident, documenting behaviors and the resident's response to interventions and talking with the resident in a calm voice when behavior was disruptive.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #66's activity and life enrichment care plan, revised 3/12/24, documented the resident had interests and preferences in activities that she wished to continue for as long as possible. Resident #66 was prone to behaviors of hitting and being disruptive during the day. Interventions included during behaviors resident will be taken to a quiet area and redirected to decrease behaviors, giving the resident the opportunity to express opinions of activities attended, giving the resident verbal reminders of activity before the commencement of activity, posting personal activity schedules in the resident's room, providing the resident with group activities and transporting the resident to activities.</p> <p>-However, the facility failed to update Resident #66's care plan with effective interventions to prevent resident-to-resident abuse and behaviors following a resident-to-resident altercation with Resident #6 on 5/6/24.</p> <p>(Cross-reference F600: failure to prevent abuse)</p> <p>-Additionally, the facility failed to provide Resident #66 with meaningful activities as care planned (see observations above).</p> <p>(Cross-reference F600: failure to prevent abuse)</p> <p>V. Staff interviews</p> <p>CNA #5 was interviewed on 5/23/24 at 4:25 p.m. CNA #5 said the staff provided activities but some days were crazier than other days. CNA #5 said with a resident constantly up and down the staff relied on the activity aide (AA) scheduled on the unit.</p> <p>CNA #9 was interviewed on 5/23/24 at 4:30 p.m. CNA #9 said staff tried to provide activities but right before and after dinner it was hard to complete activities.</p> <p>AA #1 was interviewed on 5/23/24 at 4:35 p.m. AA #1 said she was assigned to the memory care unit as the unit's AA. She said most of the residents slept during the movie so she waited around until there was an activity to do and that was why she offered to paint a female resident's nails. AA #1 said after she painted the resident's nails she waited for dinner to be served.</p> <p>Registered nurse (RN) #2 was interviewed on 5/23/24 at 4:38 p.m. RN #2 said the AAs provided activities to the residents and it was the AAs responsibility. RN #2 said that was the reason an AA was assigned to the unit.</p> <p>The memory care coordinator (MCC) was interviewed on 5/23/24 at 11:05 a.m. The MCC said the nursing staff needed to provide activities to the residents, not just the AAs. The MCC said during the day when she worked on the unit the staff provided a lot of activities. The MCC said she wondered if the evening shift provided activities when she was not there. The MCC said she needed to provide more supervision to the evening shift because she noticed residents had more behaviors, falls and resident-to-resident interactions in the late afternoon to early evening. The MCC said a lack of activities for the residents with dementia led to more problematic behaviors because they had nothing to do. The MCC said she was planning on working with the activity director (AD) to get some tailored activities for the memory care unit.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The AD was interviewed on 5/23/24 at 1:44 p.m. The AD said she planned the activities on the memory care unit but received input from the MCC. The AD said the AA assigned to the unit was supposed to provide activities all day long, whether it was one-on-one or group activities. The AD said she was unaware the residents were not offered activities and were just left to sleep in the recliners. The AD said not interacting with the residents was not okay and she was going to discuss it with AA #1.</p> <p>The DON was interviewed on 5/23/24 at 2:11 p.m. The DON said the facility's management team was trying to approve an AA position on the memory care unit that worked directly under the MCC. The DON said the AAs rotated who covered the memory care unit so they did not know the residents as well as an AA who was permanently assigned to the unit. The DON said the memory care unit and residents needed an AA who worked well on the unit and management was hoping to find someone.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on interviews and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications for two (#30 and #21) of five residents reviewed for medications out of 38 sample residents.</p> <p>Specifically, the facility failed to ensure as needed (PRN) psychotropic medications were discontinued after 14 days for Resident #30 and Resident #21.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Psychoactive medication use policy, revised 8/14/23, was provided by the nursing home administrator (NHA) on 5/23/24 at 7:34 p.m. It read in pertinent part, PRN orders for psychotropic medications are limited to 14 days, but orders may be extended beyond 14 days if the attending physician or prescribing practitioner believes it is appropriate to extend the order.</p> <p>II. Resident #30</p> <p>A. Resident status</p> <p>Resident #30, age 87, was admitted on [DATE]. According to the May 2024 computerized physician order (CPO), diagnoses included Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills) and dementia (impaired ability to remember, think and make decisions).</p> <p>The 4/26/24 minimum data set (MDS) assessment documented Resident #30 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of three out of 15.</p> <p>B. Record review</p> <p>A review of the September 2023 CPO revealed the resident had a physician's order Lorazepam oral concentrate (anti-anxiety medication) 0.5 milliliter (ml) every four hours PRN for anxiety or agitation related to dementia for 90 days, ordered on 6/13/23 and discontinued on 9/11/23.</p> <p>-The anti-anxiety medication was prescribed for over 14 days on an as needed basis. A review of the resident's electronic medical record (EMR) did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>A review of the January 2024 CPO revealed the resident had a physician's order w for Lorazepam oral concentrate 0.5 ml every four hours PRN for anxiety or agitation related to dementia for 90 days, ordered on 10/31/23 and discontinued on 1/29/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The anti-anxiety medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>A review of the May 2024 CPO revealed the resident had a physician's order for Lorazepam oral concentrate 0.5 ml every four hours PRN for anxiety or agitation related to dementia, ordered on 2/14/24 and discontinued on 5/14/24.</p> <p>-The anti-anxiety medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>A review of the May 2024 CPO revealed the resident had a physician's order for Lorazepam oral tablet 1 milligram (mg) every four hours PRN for anxiety or agitation related to dementia for 60 days, ordered on 5/16/24 and was scheduled to be discontinued on 7/15/24.</p> <p>-The anti-anxiety medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>50314</p> <p>III. Resident #21</p> <p>A. Resident Status</p> <p>Resident #21, over the age of 65, was admitted on [DATE]. According to the May 2024 CPO, diagnoses included dementia, cerebrovascular disease (disease affecting the blood vessels) and insomnia (difficulty sleeping).</p> <p>The 4/17/24 MD) assessment revealed the resident was severely cognitively impaired with a BIMS assessment score of three out of 15. She required substantial or maximal assistance with eating, oral hygiene, and personal hygiene. She was dependent on staff for bathing, dressing, and toileting.</p> <p>B. Record review</p> <p>A review of the CPO revealed the resident had a physician's order for Seroquel (antipsychotic medication) 400 milligrams (mg) orally at bedtime for agitation and give 100 mg orally every 12 hours as needed for agitation, ordered on 8/8/23 and was discontinued on 9/11/23.</p> <p>-The antipsychotic medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>Further review of the May 2024 CPO revealed a physician's order for Lorazepam oral tablet 1 mg every 6 hours for anxiety/agitation and give one tablet by mouth every four hours as needed for anxiety/agitation for 90 days, ordered on 8/16/23 and discontinued on 9/21/23.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The anti-anxiety medication was prescribed for over 14 days on an as needed basis. A review of the resident's electronic medical record (EMR) did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.</p> <p>IV. Staff interviews</p> <p>The pharmacist (PH) was interviewed on 5/23/24 at 4:44 p.m. The PH said psychotropic medications can only be ordered for more than 14 days if there was a documented reason by the physician. The PH said she did not have a documented reason why Resident #21's PRN Lorazepam or Seroquel was ordered for more than 14 days.</p> <p>The director of nursing (DON), nursing home administrator (NHA) and the corporate consultant (CC) were interviewed together on 5/34/24 at 7:27 p.m. The DON said PRN psychotropic medications could only be ordered for more than 14 days if there was a documented reason by the physician, up to a maximum of 90 days.</p> <p>The DON and the CC said there was not a documented reason why Resident #21 was prescribed Lorazepam and Seroquel for more than 14 days. The CC said it was against the regulation to have PRN psychotropic medications ordered without a reason for more than 14 days.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>40467</p> <p>Based on interviews, record review and observations, the facility failed to ensure residents consistently receive food prepared by methods that conserved nutritive value, palatable in taste, texture, appearance and temperature.</p> <p>Specifically, the facility failed to ensure the residents' food was palatable in taste, texture, appearance and temperature.</p> <p>Findings included:</p> <p>I. Resident interviews</p> <p>Resident #23 was interviewed on 5/20/24 at 3:02 p.m. Resident #23 said some of the meals she had been served were cold.</p> <p>Resident #16 was interviewed on 5/20/24 at 4:54 p.m. She said the beef was often tough.</p> <p>Resident #54 was interviewed on 5/21/24 at 8:58 a.m. He said the facility was a lost cause when it comes to food and tried to eat as little of the food provided by the facility as possible. He said he bought most of his own food. He said the food was frequently served cold.</p> <p>Resident #46 was interviewed on 5/21/24 at 9:06 a.m. She said the food was served cold and had limited seasoning.</p> <p>Resident #45 was interviewed on 5/21/24 at 10:25 a.m. She said the vegetables were usually overcooked.</p> <p>Resident #4 was interviewed on 5/21/24 at 12:49 p.m. She said the food was often over cooked and the cooked vegetables squirted water out of them when she tried to eat them. She said the food was usually cold even though the plate it was served on was warm.</p> <p>Resident #53 was interviewed in the dining room on 5/22/24 at 12:55 p.m. after her meal. She said her meal was served cold.</p> <p>II. Observations</p> <p>During a continuous observation on 5/22/24 beginning at 3:40 p.m. and ending at 6:01 p.m. the following was observed during the dinner meal preparation and service in the main kitchen:</p> <p>At 4:25 p.m. cook #2 took the temperature of the cooked carrots and mixed vegetables. The cooked carrots and mixed vegetables sat in covered containers with water. The temperature of the first container of carrots was 200 degrees F. The second container of carrots were 185 degrees F. The last container of carrots was 179 degrees F. The mixed vegetables were 200 degrees F.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-At 4:29 p.m. cook #2 tested how soft the carrots were with a fork and said some of the carrots had bounced back and some were easily mashed with a fork.</p> <p>-At 4:49 p.m. cook #2 placed the containers in the steam table.</p> <p>-At 4:54 p.m. cook #2 took the temperatures of the food that was in the steam table. The mashed potatoes were 125 degrees F. The pureed carrots were 136 degrees F. The hamburger patties were 122 degrees F. The DM said the hamburger patties needed to be above 135 holding temperature. She said she would reheat the hamburger patties to 165 degrees F. because the meat fell into the danger zone.</p> <p>-At 5:03 p.m. meal service began in the main dining room.</p> <p>-At 5:31 p.m. the dining room service was completed and cook #2 started plating the room trays to load onto a hot holding cart.</p> <p>Two test trays were evaluated immediately after the last resident had been served their room tray for dinner on 5/22/24 by three surveyors.</p> <p>The regular diet test tray consisted of salisbury steak with gravy, mashed potatoes and carrots.</p> <p>-The temperature of the salisbury steak covered in gravy was 120 degrees F. Portions of the steak that were not covered in gravy and were 111 degrees F. The steak was lukewarm.</p> <p>-The mashed potatoes and gravy were 136.8 degrees F.</p> <p>-The carrots were 100.5 degrees F. The carrots were lukewarm, watery in taste and over cooked texture.</p> <p>The pureed diet test tray consisted of salisbury steak with gravy and pureed carrots.</p> <p>-The salisbury steak was 111 degrees F.</p> <p>-The pureed carrots were 121 degrees F.</p> <p>III. Record review</p> <p>The January 2024 resident council minutes indicated concerns with the cooked vegetables identifying the vegetables tasted like wall paper paste.</p> <p>-The resident council minutes did not identify a plan to correct the vegetables after residents identified a concern (cross-reference F565 grievances of a group).</p> <p>The February 2024 resident council minutes read the vegetables were too watery. One resident said she felt the dietary staff did not love food. Another resident said she no longer loved food after living at the facility.</p> <p>The March 2024 resident council minutes read a resident said her vegetables were mushy. According to the minutes, the other residents agreed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The March 2024 food committee minutes read the pasta salad and the tuna salad needed to be less watery and the overcooked broccoli was gross.</p> <p>The May 2024 resident council minutes read the meat was too tough, the quality of the soup had declined and the broth and chicken tasted bad, the food had been cold and the vegetables were mushy. According to the minutes, the quality of the food was worse later in the week.</p> <p>The May 2024 food committee read the dietary department was working on ways to improve food temperatures.</p> <p>IV. Staff interview</p> <p>The dietary manager (DM) was interviewed on 5/23/24 at 1:17 p.m. The DM said she was aware there were resident concerns with food temperatures for the last couple of months. The DM said some of the cooks did not turn the steam table on prior to the meal services. She said she also had identified that the staff were plating the meals too early and the meals were sitting too long before the staff delivered the meals to the residents. She said she has retrained all of the staff on timing and on 5/20/24 she changed the order of delivery service. She said the dining room was now served first and the room trays were served last in hopes to improve the meal temperatures.</p> <p>The DM said the residents had expressed concerns with the taste of the food. She said some of the residents felt the food was too salty or too tough to chew. The DM said she observed the weekend cook and identified some food preparation concerns. She provided additional training to the weekend cook. The DM said other concerns that had been identified were the overcooking and taste of the vegetables. The DM said the steamer had ongoing concerns with not working correctly and had been reviewed by the facility maintenance department and the equipment service vendor. The DM said the steamer helped the dietary department maintain food temperatures and helped prevent the overcooking and undercooking of the vegetables. She said a new part was ordered on 5/15/23 for the steamer but it had not arrived at the facility yet.</p> <p>The DM said she identified concerns with the cooks preparing the meals. She said the cooks were leaving the vegetables in the steamer for too long. She said this caused the vegetables to get overcooked. She said the cooks were also not setting the steamer at the correct temperature. She said she started seeing concerns with overcooking since the beginning of the year.</p> <p>The DM said she felt it was a combination of the cooks error and a need for new equipment. The DM said the steamer not working correctly had been an ongoing concern over the last couple of years. She said the steamer has had parts replaced and fixed but still was not working correctly. She said she was currently waiting on invoices and then would present her concerns to the nursing home administrator (NHA).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DM said she has tried to train the cooks on different methods of cooking to improve palatability and make sure the vegetables were not mushy in taste and texture. She said she was at the facility for two and a half days a week to provide kitchen and cooking oversight. She said the charge cook was here five days a week for three meals a day. The DM said there was an overlap between her schedule and the charge cook which caused the kitchen to not have a supervisor for two days a week. She said the limited oversight of the food could have been part of the palatability concerns and not using proper cooking techniques. The DM said when she was not at the facility, the charge cook was the one to ensure cooks were cooking the food properly, however, the charge cook needed to be retained on proper cooking methods too. The DM said she had scheduled to retrain the charge cook on 5/28/24. The DM said she had provided training to the charge cook off and on since March 2024 but was still identifying concerns. She said one possible reason was a language barrier. She said she acquired training handouts in Spanish on 5/17/24 but had not handed the training material out yet to the staff who primarily spoke Spanish. The DM said she tried to communicate with the charge cook by using a translating hot line but there was still communication barriers. She said the charge cook was responsible for oversight of the other cooks for three of the cooks only spoke English which could also be a breakdown in communication.</p> <p>The SSD was interviewed on 5/23/24 at 5:57 p.m. She said she frequently received grievances on food concerns.</p> <p>The quality assurance nurse (QAN) was interviewed on 5/23/24 8:01 p.m. The QAN said resident food palatability had been discussed in the quality assurance and improvement (QAPI) meetings after residents had grievances about food temperatures being off or food being mushy. The QAN said the DM and registered dietitian (RD) were working on correcting the concerns. The QAN said the following resident council meeting there were no further concerns and the grievance was resolved. The QAN was informed of ongoing resident concerns and test tray observations. The QAN said the facility would look at opportunities for improvement and needed to get a better oversight on the issues.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>40467</p> <p>Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in two of three dining rooms and one of one kitchenette.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure hand hygiene was offered and provided to residents during meal times; -Ensure staff plating ready-to-eat food used hand hygiene after touching potentially contaminated surfaces; and, -Ensure staff used hand hygiene before donning gloves to serve ready-to-eat food. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Infection Prevention and Control Program policy, revised 2/25/19, was provided by the director of nursing (DON) on 5/20/24 at 2:00 p.m. It read in pertinent part, The Infection Prevention and Control Program will utilize the policies and procedures within the Infection Control Manual. The program includes employee health, management of residents with infectious diseases, hand hygiene for staff, residents and visitors; cleaning and disinfection procedures including appropriate surfaces and equipment, food safety and linen handling. Staff education is provided at orientation, yearly, during outbreaks and as needed includes handwashing.</p> <p>-The Hand Washing policy, dated 2021, was provided by the corporate consultant (CC) on 5/23/24 at 3:53 p. m. The policy identified staff should perform hand hygiene when entering the kitchen, immediately before engaging in food preparation, before donning disposable gloves before and after working with food and after engaging in other activities that would contaminate the hands. According to the policy, staff should be educated and reminded of the importance of hand washing.</p> <p>-The Hand Hygiene policy and procedure, dated 8/21/23, was provided by the CC on 5/23/24 at 3:53 p.m. It read in pertinent part,</p> <p>The hands of the conduits for almost every transfer of potential pathogen from one patient to another, from a contaminated object to a patient, and from a staff member to a patient. Because of this, hand hygiene is the single most important procedure to prevent infection. To protect patients from healthcare associated infection, hand hygiene must be performed routinely and thoroughly. Clean and healthy hands with intact skin, short fingernails, and no rings minimize the risk of contamination.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Centers of Disease Control (CDC) recommends that patients perform hand hygiene with soap and water or alcohol-based hand sanitizer before and after eating food, before touching the eyes, nose, or mouth, after using the restroom, after blowing the nose, coughing, or sneezing and after touching any surfaces in healthcare facility, such as the bed rail or remote control, to decrease the spread of infection.</p> <p>The Bare Hand Contact with Food and Use of Plastic Gloves policy, dated 2021, was provided by the CC on 5/23/24 at 3:53 p.m. It read in pertinent part, Single-use gloves will be worn when handling food directly with hands to ensure that bacteria was not transferred from the food handlers hands to the food product being served. Bare hand contact with food is prohibited.</p> <p>Hands are to be washed when entering the kitchen and before putting on single-use gloves and after removing single-use gloves.</p> <p>Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched the gloves must be changed, and the hands must be washed.</p> <p>II. Observations</p> <p>The main dining room was observed continuously on 5/20/24, beginning at 11:23 a.m. and ending at 12:55 p.m. Observations identified the following:</p> <ul style="list-style-type: none"> -19 residents were not offered hand hygiene before they were served their meal of fish, rice and zucchini or a hamburger and chips or sandwich. -Three residents self propelled their wheelchairs into the dining room by using their hands on the wheels of the wheelchair. Staff did not offer or encourage the residents to use hand hygiene before they ate their meal in the dining room. -Hand hygiene supplies were not passed out in the dining room or provided on the dining room tables. <p>The memory care unit dining room was observed during a continuous observation on 5/20/24, beginning at 11:00 a.m. and ending at 12:07 p.m. Observations identified the following:</p> <p>On 5/20/24 at 11:00 a.m. 10 residents were in the memory care dining room.</p> <ul style="list-style-type: none"> -The residents were not offered hand hygiene. -A male resident and a female resident entered the dining room using their walkers, The residents were not not offered hand hygiene before lunch after touching the handles of their walkers. <p>At 11:04 a.m. a male resident self-propelled his wheelchair by placing his hands on the wheels of his wheelchair into the dining room.</p> <ul style="list-style-type: none"> -The male resident was not offered hand hygiene. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Between 11:36 a.m. and 12:07 p.m. four residents were served hand held food which included a grilled cheese sandwich, an egg salad sandwich, a fried egg sandwich or a peanut butter and jelly sandwich. The remainder of the residents were serviced cod, chips, asparagus, and angel food cake.</p> <p>The memory care unit dining room was observed during a continuous observation on 5/22/24, beginning at 11:42 a.m. and ending at 12:36 p.m. Observations identified the following:</p> <p>On 5/22/24 at 11:42 a.m. six residents were in the dining room.</p> <p>-At 11:43 a.m., four residents were brought into the dining room and not offered hand hygiene.</p> <p>-At 11:45 a.m. another resident was brought into the dining room and was not offered hand hygiene.</p> <p>-At 11:46 a.m. three tables were observed with hand sanitizer placed on them while nine tables were without hand sanitizer.</p> <p>-At 11:47 a.m. a male resident walked into the dining room and a female resident entered the dining room with staff, neither of the residents were offered hand hygiene.</p> <p>-At 11:48 a.m. a female resident wrapped tissue around her finger and stuck her finger up her nostril to clean out her nose. The resident then grabbed a lemon, with the finger that was in her nose, and squeezed it on her fish.</p> <p>-At 11:52 a.m. two residents were brought into the dining room and were not offered hand hygiene.</p> <p>-At 11:57 a.m. a female resident was assisted to the dining room and was not offered hand hygiene.</p> <p>-At 11:58 a.m. a male resident was assisted to the dining room and was not offered hand hygiene.</p> <p>At 12:00 p.m. two residents at the assistance table were offered hand hygiene.</p> <p>-At 12:04 p.m. a male resident was brought into the dining room and not offered hand hygiene.</p> <p>-At 12:07 p.m. a female resident was brought to the dining room and was not offered hand hygiene but the staff completed hand hygiene after she placed the resident at the table.</p> <p>-At 12:13 p.m. two more residents at another assistance table were offered hand hygiene.</p> <p>-At 12:15 p.m. a female resident who was not offered hand hygiene, ate her fish and cake with her hands.</p> <p>At 12:24 p.m. a male resident struggled to put condiments on his hamburger. His tablemate took his hamburger and buns, applied condiments and sat them back on the table cloth. The resident took his burger back from his table mate and assembled his burger. The resident ate his hamburger.</p> <p>-Neither resident was offered hand hygiene.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-At 12:28 p.m. a female resident was eating a cookie with her hands. She was not offered hand hygiene and licked chocolate off her fingers.</p> <p>-At 12:36 p.m. two female residents were wiping their nose with their hands and proceeded to eat the fish with their hands.</p> <p>The memory care unit dining room was observed during a continuous observation on 5/22/24, beginning at 4:00 p.m. and ending at 5:13 p.m. Observations identified the following:</p> <p>-At 4:00 p.m. residents were being brought into the dining room by staff for the dinner meal. Hand sanitizer or hand wipes were not readily available on the tables.</p> <p>-At 4:13 p.m. 11 residents were seated at the dining room tables and none of the residents were offered hand hygiene.</p> <p>-At 4:15 p.m. a male resident walked into the dining room using his walker, he was not offered hand hygiene.</p> <p>At 4:48 p.m. cook #3 arrived at the unit with the meal cart. He grabbed the door handle to enter into the memory care unit.</p> <p>-Cook #3 did not perform hand hygiene when he entered the kitchenette after touching the door.</p> <p>At 4:53 p.m. cook #3 exited the memory care unit kitchenette and went to the main kitchen.</p> <p>-At 4:57 p.m. cook #3 returned to the memory care unit. He grabbed the door handle to the memory care unit and failed to perform hand hygiene when he entered the kitchenette. [NAME] #3 added food to the steam table and retrieved clean dishes. He touched the center of the clean plates with his thumb.</p> <p>-At 4:59 p.m. cook #3 wiped his right hand on his right thigh then put a glove on his left hand. He failed to wash his hands before applying the glove and cutting the residents ' sandwiches.</p> <p>-At 5:02 p.m. cook #3 removed the glove. He failed to wash his hands and proceeded to plate the main entree. He touched serving utensils, meal tickets and the surface of clean dishes.</p> <p>-At 5:09 p.m. cook #3 put on one glove without performing hand hygiene to cut an uncrustable peanut butter and jelly sandwich in half. He removed the glove and did not wash his hands.</p> <p>At 5:13 p.m. cook #3 broke down the steam table and left the unit.</p> <p>-Cook #3 again failed to wash his hands.</p> <p>III. Record Review</p> <p>The following trainings were provided by the registered dietitian (RD) on 5/23/24 at 1:19 p.m.:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A 1/16/24 memory care unit staff training identified hand hygiene during meals was reviewed with the certified nurse aides (CNA) and nurses who worked on the memory care unit.</p> <p>-The training did not identify dietary staff who served on the memory care unit received the hand hygiene training.</p> <p>-A 1/18/24 dietary meeting did not identify hand hygiene was reviewed with the two cooks and the dietary assistant who attended the meeting. Glove use was reviewed during the meeting.</p> <p>-A 3/27/24 dietary meeting identified hand hygiene and glove use was reviewed with four dietary assistants and two cooks. The signature sheet identified cook #3 attended the meeting.</p> <p>The undated online food handling training documented the goal of food safety was to prevent the hazards that cause foodborne illness. To prevent foodborne safety hazards from affecting food, staff must understand the relationship between their actions and potential risk of foodborne illness.</p> <p>According to the online training, the most important thing that anyone can do to prevent foodborne illness was to wash their hands.</p> <p>The training identified that, during food preparation, staff should perform hand hygiene as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks. Hand hygiene should be performed before eating food.</p> <p>III. Staff interviews</p> <p>The RD) was interviewed on 5/23/24 at 9:49 a.m. The RD said staff was trained on hygiene during the facility ' s annual skills fair and online training. The RD said the dietary staff received additional hand hygiene and infection control training with the dietary manager (DM).</p> <p>The DM was interviewed on 5/23/24 at 1:17 p.m. The DM said she reviewed hand hygiene with her staff. She said she reviewed how often and how long staff should clean their hands and proper glove use. She said the nursing department was responsible for training the nurses and CNAs.</p> <p>The DM said staff serving meals to the residents should perform hand hygiene between passing each plate, between helping each resident with their meal, when donning and doffing gloves and after touching any high touch surface area such as a door. She said hand hygiene helped prevent the spread of germs and bacteria.</p> <p>Observations of the memory care unit during meal service were shared with the DM. She said staff should have performed hand hygiene every time they stepped away and returned to the service line. She said touching a door or any high touch surface and then plating resident meals without hand hygiene increased the risk of spreading germs to the residents ' food.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The regional infection preventionist (RIP) was interviewed on 5/23/24 at 2:29 p.m. The RIP said staff should perform hand hygiene before and after resident cares and entering resident rooms and anytime after touching their face or high contact surfaces. He said residents should be offered hand hygiene after toileting, before food, and anytime as needed. He said staff should use alcohol based hand rub (ABHR) before handling anything resident food related and in between residents during meal service. He said residents should be offered hand hygiene just before they eat at the table so the resident would have clean hands while they ate and decrease the risks of consuming germs and/or bacteria.</p> <p>The RIP said if a resident was propelling themselves to the dining room table, staff should make sure to encourage residents to use ABHR near the entrance of the dining room. He said staff should offer hand wipes at the dining room tables before the residents received their meal.</p> <p>The RIP said residents should not touch another resident ' s food. He said staff should intervene and redirect the resident to their own food. He said if food contact occurred by another resident, staff should offer to replace the touched food to avoid potential cross contamination.</p> <p>The RIP said the facility had not set up a hand hygiene process before meals other than encouraging residents to use hand hygiene. He said the facility had not set up a process or procedure to make sure hand hygiene was offered to residents before meals. He said staff were educated on the importance of hand hygiene a couple of times a year.</p> <p>CNA #4 was interviewed on 5/23/24 at 7:44 p.m. CNA #4 said she offered hand hygiene before residents went to the dining room. She said the rehab dining room did not have hand wipes to clean the residents ' hands.</p> <p>CNA #2 was interviewed on 5/23/24 at 7:45 p.m. CNA #2 said she used hand hygiene before she entered and left each residents ' room. She said she washed with soap and water after three uses of hand sanitizer or using the restroom. She said she offered the residents hand hygiene before meals and after they used the bathroom. She said she offered and provided residents hand hygiene in their rooms because she typically took them to the restroom before meals then offered it again in the dining room. She said if residents refused, she would still offer hand hygiene at meals and sometimes she would place ABHR in her hands and ask the residents how they were while she would rub the ABHR into their hands.</p> <p>CNA #7 was interviewed on 5/23/24 at 7:48 a.m. CNA #7 said most residents washed their hands at the sink in their room or she offered hand wipes to them before they ate.</p> <p>The quality assurance nurse (QAN) was interviewed on 5/23/24 at 8:01 p.m. The QAN said, during a January 2024 and February 2024 quality and assurance performance improvement (QAPI) meeting, the interdisciplinary team (IDT) discussed the facility ' s dining room process. She said in January 2024 the facility identified the residents refused to wash their hands. She said staff needed to stay on top of hand hygiene in the dining room and in resident rooms. She said the staff needed to encourage the residents to perform hand hygiene before meals in the dining room and offer hand wipes when residents received meal room trays. She said the IDT discussed how they could have residents practice hand hygiene more often and how to make it more appealing for the residents.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The QAN said the dietary staff was provided hand hygiene education and the DM encouraged her staff to use hand hygiene. She said the staff providing the meals had tried hand wipe sanitizer packets on the meal trays and helped residents use the wipes. She said if the residents did not like the wipes, staff should offer the residents ABHR.</p> <p>Observations were reviewed with the QAN. She said the facility would start conducting more hand hygiene education with staff and complete audits of hand hygiene practices.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48412</p> <p>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 on two of two units.</p> <p>Specifically, the facility failed to wipe down a shared mechanical lift and slings between residents.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Infection Prevention and Control Program policy, revised on 2/25/19, was provided by the DON on 5/20/24 at 2:00 p.m. It read in pertinent part,</p> <p>The Infection Prevention and Control Program will utilize the policies and procedures within the Infection Control Manual. The program includes employee health, management of residents with infectious diseases, hand hygiene for staff, residents and visitors, cleaning and disinfection procedures including appropriate surfaces and equipment, food safety and linen handling. Staff education is provided at orientation, yearly, during outbreaks and as needed and includes cleaning and disinfecting of surfaces and equipment.</p> <p>The Infection Prevention and Control Manual, effective 12/2016, was provided by the DON on 5/23/24 at approximately 2:00 p.m. It read in pertinent part,</p> <p>All items, other than disposables, are cleaned and disinfected following federal, state and local guidelines and manufacturers'recommendations.</p> <p>The Transfer with a Mechanical Lift procedure, revised 5/20/24, was provided by the DON on 5/23/24 at approximately 2:00 p.m. It read in pertinent part,</p> <p>Inspect all equipment and supplies. Make sure that the accessory equipment (sling, straps and hooks) undergoes proper cleaning and disinfection before use to prevent microorganism transmission. Clean and disinfect the mechanical lift accessory equipment after use according to the manufacturer's instructions to prevent the spread of infection.</p> <p>II. Observations</p> <p>On 5/23/24 at 10:34 a.m. the memory care coordinator (MCC) and licensed practical nurse (LPN) #4 assisted a male resident to the bathroom. The unit had a mechanical lift, similar to a sit-to-stand mechanical lift, which used a partial sling. The resident used the small sling to be transferred.</p> <p>At 10:37 a.m. the MCC returned the mechanical lift to the common area of the unit.</p> <p>-The MCC did not wipe down the lift or the sling after using it with the male resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 10:39 a.m. a hospice services certified nurse aide (CNA) took the mechanical lift to provide another resident with a shower.</p> <p>-At 10:40 a.m. the MCC and LPN #4 asked the hospice services CNA for the mechanical lift first to move a female resident to her wheelchair. The resident was provided with the same small sling the first resident used.</p> <p>-At 10:47 a.m. the female resident was attached to the lift with the sling and her hands were placed on the handlebars which were not disinfected after the first resident.</p> <p>-At 10:48 a.m. the mechanical lift was given to the hospice services CNA without being disinfected.</p> <p>At 10:57 a.m. the hospice services CNA said the resident she was giving the shower to used the larger sling.</p> <p>III. Staff interviews</p> <p>LPN #4 was interviewed on 5/23/24 at 11:00 a.m. LPN #4 said the mechanical lifts were cleaned at the end of each shift, not after each resident used the lift. She said the sling touched the residents' clothes and not their skin, so the lift and sling did not need to be disinfected.</p> <p>The MCC was interviewed on 5/23/24 at 11:05 a.m. The MCC said the lift and sling needed to be disinfected after each use. She said after the first and second residents were assisted, she asked LPN #4 to disinfect the mechanical lift. The MCC said she did not watch to ensure LPN #4 disinfected the lift and sling.</p> <p>The DON was interviewed on 5/23/24 at 2:11 p.m. The DON said the slings did not need to be disinfected between each resident because they were applied over the residents' clothes. She said the mechanical lift needed to be disinfected after each use because the residents grabbed the handlebars to be transferred.</p> <p>The regional infection preventionist (RIP) was interviewed on 5/23/24 at 4:48 p.m. The RIP said the residents who used the full mechanical lift had their own slings. He said the sit-to-stand type mechanical lift on the memory care unit only had two slings that were shared between the residents. The RIP said the lift needed to be wiped down after each use and the staff needed to do their best to wipe down the shared slings, whether the sling touched the resident's skin or clothes.</p> <p>Registered nurse (RN) #1 was interviewed on 5/23/24 at 4:49 p.m. RN #1 said all items associated with the sit-to-stand mechanical lift needed to be cleaned between each use. RN #1 said it was important to disinfect the mechanical lifts for infection control and it was good practice to clean the mechanical lifts.</p> <p>CNA #6 was interviewed on 5/23/24 at 6:21 p.m. CNA #6 said all of the mechanical lifts and slings needed to be disinfected after each use.</p> <p>CNA #4 was interviewed on 5/23/24 at 6:23 p.m. CNA #4 said all of the mechanical lifts and slings needed to be disinfected after each use.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Valley Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1401 S Cascade Ave Montrose, CO 81401	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN #3 was interviewed on 5/23/24 at 6:31 p.m. RN #3 said the mechanical lift and the slings needed to be disinfected after each use.</p>		