STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065142	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lemay Avenue Health and Rehab LLC	4824 S Lemay Ave Fort Collins, CO 80525

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on two of eight units.Specifically, the facility failed to:-Ensure the vital signs machine was disinfected after being used in a COVID-19 positive room;-Ensure the vital signs machine was disinfected between each resident's use on the secure unit; and,-Ensure housekeeping staff doffed (took off) their personal protective equipment (PPE) and closed the trash bags before exiting a COVID-19 positive room.Findings include:I. Failed to ensure the vital signs machine was disinfected after being utilized in a COVID-19 positive roomA. Professional referenceAccording to the Centers for Disease Control And Prevention's (CDC) Guideline for Disinfection and Sterilization in Healthcare Facilities, updated June 2024, retrieved from https://www.cdc.gov/infection-control/hcp/disinfection-and-sterilization/index.html on 9/15/25, Medical equipment surfaces blood pressure cuffs, stethoscopes, hemodialysis machines, and Xray machines) can become contaminated with infectious agents and contribute to the spread of healthcare-associated infections. For this reason, non-critical medical equipment surfaces should be disinfected with an EPA-registered low-level or intermediate-level disinfectant.B. Facility policy and procedureThe Infection Prevention policy and procedure, revised March 2025, was provided by the nursing home administrator (NHA) on 9/12/25 at 2:25 p.m. it read in pertinent part, When a resident is placed on transmission-based precautions, the staff should implement the following: Clearly identify the type of precautions and the appropriate personal protective equipment (PPE) to be used, make PPE readily available near the entrance to the resident's room; use disposable or dedicated noncritical resident-care equipment (blood pressure cuff, bedside commode). If noncritical equipment is shared between residents, it will be cleaned and disinfected with an environmental protection agency (EPA)-registered disinfectant after use. C. ObservationsOn 9/8/2025 at approximately 3:06 p.m. certified nurse aide (CNA) #1 entered a COVID-19 positive room with the vital signs machine. The vital signs machine did not have disinfectant wipes available on the vital signs machine cart.On 9/8/2025 at 3:10 pm CNA #1 exited the COVID-19 positive room but did not disinfect the machine. CNA #1 proceeded to enter another resident's room (the resident did not have COVID-19) with the same vital signs machine. III. Failed to disinfect the vital signs machine after each resident's use on the secure unitA. ObservationsOn 9/9/25 at 4:02 p.m. an unidentified female CNA took four different residents' vital signs in the secure unit dining room without disinfecting the vital signs machine in between each resident's use. The vital signs machine did not have disinfectant wipes available on the machine.IV. Failed to ensure housekeeping staff doffed their PPE and sealed the trash bags inside the COVID-19 positive room A. Professional referenceAccording to the CDC's Summary of Recommendations of the Guidelines for Isolation Precautions, updated September 2024, retrieved on 9/15/25 from https://www.cdc.gov/infection-control/hcp/isolation-precautions/summary-recommendations.htmll, Before leaving the patient's room or cubicle, remove and discard PPE. B. Facility policy and procedureThe Infection Prevention policy and procedure, revised March 2025, was provided by the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing home administrator (NHA) on 9/12/25 at 2:25 p.m. it read in pertinent part, Remove all PPE before exiting the resident's room except a respirator, if worn. Remove the respirator after leaving the room.C. ObservationsOn 9/8/25 at 2:48 p.m. an unidentified housekeeper exited a COVID-19 positive room (room [ROOM NUMBER]) still wearing her full PPE, which included a face shield, mask, gloves and a gown. The housekeeper was carrying an open bag of used PPE and trash from the resident's room. The housekeeper proceeded to doff her PPE and put her used PPE in the open bag of trash in the hallway. She then proceeded to tie the trash bag closed in the hallway.IV. Staff interviewsThe infection preventionist (IP) and the assistant director or nursing (ADON) were interviewed together on 9/10/25 at 3:43 p.m. The IP said the vital signs machine should be wiped down with disinfectant after each use. She said all of the vital signs machine carts should contain disinfecting wipes. She said COVID-19 positive rooms or isolation rooms had carts that were placed outside of each room that should contain all of the necessary PPE to use in the room. She said the carts also contained plastic containers which housed vital signs equipment specifically for that isolation room alone. She said the staff should not be taking the vital signs machines used for residents who were not on isolation into the isolation rooms. The IP said if a vital signs machine was taken into an isolation room, then it should be wiped down thoroughly with the disinfecting wipes. The IP said the housekeeper should not have doffed her PPE in the hallway. She said the housekeepers should not be closing the trash bags in the hallways. She said housekeepers should be doffing their PPE and closing the trash bags inside the isolation rooms. CNA #1 was interviewed on 9/11/25 at 12:15 p.m. CNA #1 said staff should be disinfecting the vital signs machine after each use. He said that staff should be using the designated vital signs equipment that was in the isolation carts for the COVID-19 positive rooms. He said if there was a piece of vital signs equipment missing from the bin outside the resident's room, then he would press the call light and ask another staff member to get him what he needed. He said he did not remember taking the vital signs machine into the COVID-19 positive room. He said he should have disinfected the vital signs machine completely before using it on another resident.