STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065163	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eben Ezer Lutheran Care Center	122 Hospital Rd Brush, CO 80723

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure one (#26) of six out of 32 sample residents were provided services that met professional standards of quality. Specifically, the facility failed to: -Ensure the physician's orders for Resident #26 contained the dose of the medication the nurse was to administer to the resident. Findings include: I. Professional reference According to the National Institutes of Health (NIH), National Library of Medicine, Nursing Rights of Medication Administration (September 2023), retrieved on 8/21/24 from https://www.ncbi.nlm.nih.gov/books/NBK560654/, It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. Incorrect dosage is a prevalent modality of medication administration error. This error type stems from nurses giving a patient an incorrect dose of medications, even if it is the correct medication and the patient's identity is verified, without first checking to ensure it is the correct strength for the patient. According to the National Institutes of Health (NIH), National Library of Medicine, Lidocaine 4% cream. (January 2019), retrieved on 8/21/24 from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=a3216e25-82bb-4905-ac0b-b2ef4aa32ea0&type=display, Apply externally to the affected area up to three to four times a day. According to the National Institutes of Health (NIH), National Library of Medicine, Silver Sulfadiazine (January 2023), retrieved on 8/21/24 from https://www.ncbi.nlm.nih.gov/books/NBK556054/, A layer one sixteenth of an inch should be applied to entirely cover the cleaned area. According to the National Institutes of Health (NIH), National Library of Medicine, Triamcinolone (February 2024), retrieved on 8/21/24 from https://www.ncbi.nlm.nih.gov/books/NBK544309/, Instructions are to apply a thin layer to the affected area and rub gently. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to IcyHot, retrieved on 8/21/24 from https://www.icyhot.com/en-us/products/creams-rubs/lidocaine-cream, Apply a thin layer to affected area every six to eight hours, not more than three to four times daily. Massage until thoroughly absorbed into the skin. II. Facility policy and procedure The Nursing Medication Administration policy, revised 7/10/24, was received from the nursing home administrator (NHA) on 8/15/24 at 4:05 p.m. It read in pertinent part, Ensure the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time, right documentation. III. Resident #26 A. Resident status Resident #26, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus with diabetic neuropathy (nerves damaged in the feet, organs or muscles), open wound on right lower leg and left lower leg, dependent on supplemental oxygen, venous insufficiency (the veins in the legs had trouble pumping blood back to the heart) and hypertension (high blood pressure). The 7/3/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15.The resident was independent with eating, oral hygiene, toileting, dressing and personal hygiene. The resident required substantial assistance from staff with showering. The assessment revealed the resident had one venous ulcer (an open sore on the skin when there are problems with blood flow in the veins). The resident was treated with an application of nonsurgical dressings and ointments. B. Resident interview and observation Resident #26 was interviewed on 8/12/24 at 2:03 p.m. Resident #26 had a white bandage approximately five to seven inches long that was covering half of each of her lower extremities. Resident #26's lower extremities had a white substance surrounding the bandages. The resident said she had bandages because she had a sore on each of her legs. She said she had pain surrounding her sores. She said the facility gave her medication to treat the sores and for the pain. C. Record review Review of the August 2024 CPO revealed Resident #26 had the following physician's orders: Lidocaine 4% cream, apply to the right lower leg ulcer topically two times a day every other day for wound pain, ordered on 8/5/24. -The physician's order did not include a dose to direct the nursing staff how much medication to administer to the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Silver sulfadiazine 1% cream, apply to the right lower leg stasis ulcer (a venous ulcer when valves in the leg veins can not stop blood from being pulled down by gravity), ordered on 8/5/24. -The physician's order did not include a dose to direct the nursing staff how much medication to administer to the resident. Silver sulfadiazine 1% cream, apply to the right lower leg stasis ulcer every eight hours as needed for the right lower leg stasis ulcer, ordered on 8/5/24. -The physician's order did not include a dose to direct the nursing staff how much medication to administer to the resident. Icy hot lidocaine 4% cream, apply to the neck every four hours as needed for pain, ordered on 9/1/22. -The physician's order did not include a dose to direct the nursing staff how much medication to administer to the resident. Triamcinolone acetonide 0.5% cream, apply to itchy areas due to rash topically every twelve hours as needed for rash to bilateral arms, legs, back and abdomen, ordered on 10/3/23. -The physician's order did not include a dose to direct the nursing staff how much medication to administer to the resident. IV. Staff interviews Certified nurse assistant with medication aide authority (CNA-Med) #1 was interviewed on 8/15/24 at 12:44 p. m. CNA-Med #1said some of the key components of a prescription were the right resident's name, the right birthdate, the right dose, the right route and the right frequency. She said if the provider left a component out of the prescription, she did not give the medication until the order was clarified. CNA-Med #1 said the medication administration order (MAR) and the medication container should direct how much cream to dispense. CNA-Med #1 said the different creams in her medication cart had a label attached to the creams that indicated how much cream to use during the skin treatment. CNA-Med #1 said the creams were kept in a locked cabinet in the residents' room. CNA-Med #1 said the creams located in the cabinet in Resident #26's room did not say how much cream to use during treatment. Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 2:07 p.m. LPN #1 said some of the key components of a prescription were the right route, the right resident and the right dose. She said if the provider left a component out of the prescription, she contacted the provider to clarify the order. LPN #1 said she did not give the medication until the order was clarified. She said she knew how much cream to use because the physician's order would include how much of the medication was to be given. She said she was not familiar with Resident #26. She said she reviewed the different physcian's orders for cream medications for Resident #26. LPN #1 said she did not see the dose for the creams on the physician's orders. She said it was important to know how much to apply because one of the creams was for a wound. LPN #1 said it should be a sufficient amount to cover the wound but not so much that the wound would be smothered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on 8/15/24 at 3:08 p.m The DON said some of the key components of a prescription were the right route, the right resident and the right frequency. She said if the provider left a component out of the prescription, the nurse should contact the provider to clarify the order. The DON said the nurse should not administer the medication until the nurse obtained a clarification. She said was not aware Resident #26's prescription creams did not say how much for the nurse to administer. V. Facility follow up The NHA provided additional information on 8/16/24 at 2:27 p.m. The following physician's order was updated on 8/16/24: Silver sulfadiazine 1% cream. Apply to the right lower leg stasis ulcer topically two times a day for right lower leg stasis ulcer. Apply one sixteenth inch or 120 cubic centimeters (cc) layer to the right lower extremity; and, apply to the right lower leg stasis ulcer topically every eight hours as needed for the right lower leg stasis ulcer. Apply one sixteenth inch or 120 cc layer to the right lower extremity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to ensure residents were provided an environment as free of accident hazards as possible for one (#55) of four residents reviewed for accidents and hazards out of 32 sample residents. Specifically, the facility failed to: -Ensure identified interventions were implemented consistently and monitored for effectiveness; and, -Update and revise Resident #55's care plan with new interventions after each skin injury. Findings include: I. Resident #55 A. Resident status Resident #55, age 79, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included dementia, abdominal aortic aneurysm, acute kidney disease, localized edema and history of falling. The 7/10/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 15 out of 15. He required total assistance with toileting and dressing. He required setup assistance for oral hygiene and he was independent for eating. The assessment revealed the resident did not have skin tears. B. Resident observations On 8/12/24 at 12:15 p.m. Resident #55 was observed in the hallway in front of his room. Resident #55 did not have protection sleeves on either of his arms. C. Resident interview Resident #55 was interviewed on 8/13/24 at 9:30 a.m. He had protection sleeves on both of his arms. Resident #55 said he bled easily. He said he wore protection sleeves most of the time. Resident #55 said the staff did not remind him to wear the sleeves and he asked for assistance when needed. During the interview, the resident's room was observed. Resident #55's bathroom had an additional pair of protection sleeves hanging on a towel rack. Resident #55 had a white dressing on the back of his right hand. D. Record review (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #55's wound management skin care plan, revised 7/7/24, revealed the resident had bruising to bilateral upper extremities, right hip, left calf and abrasions to bilateral elbows. Interventions included notifying providers of no signs of improvement and providing wound care per treatment. Resident 55's skin breakdown care plan, revised 3/15/24, revealed the resident had potential for pressure ulcer development or skin breakdown due to history of ulcers and excoriation to buttocks. Interventions included administer treatments as ordered, apply geri sleeves (protection sleeves) and encourage the resident to wear sleeves to protect his arms. -The intervention to apply protection sleeves was not added to the care plan until 8/14/24, during the survey (see director of nursing (DON) interview below). Resident #55's activities of daily living self care performance deficit care plan, revised 3/15/24, revealed the resident had a deficit due to kidney failure and weakness. Interventions included using a bell to call for assistance, offering night light to the resident, and physical therapy and occupational therapy evaluation and treatment. The 6/24/24 nurse progress note revealed the resident was found in his room sitting on the floor with his back against the wall under his window. The resident was bleeding from both elbows. The resident had a skin tear on the left inner elbow and on the right elbow. The 6/24/24 fall committee progress note revealed the new interventions were to provide a night light and physical therapy. The 6/28/24 nurse progress note revealed the resident had a new bruise that was dark purple in color to the left elbow and to the right wrist. The resident said he had no idea what happened. The 7/1/24 nurse progress note revealed the resident had a new bruise on the right posterior thigh. -The progress note failed to identify any new intervention put into place to prevent further skin injuries. The 7/2/24 nurse progress note revealed the resident had a u shaped skin tear to the right elbow. -The progress note failed to reveal any new interventions put into place to prevent further skin injuries. The 7/3/24 nurse progress note revealed the resident had a skin tear on the back of his right hand. Resident #55 said he hit the back of his hand on the sit to stand mechanical assistance when he adjusted his pants. -The progress note failed to reveal any new interventions put into place to prevent further skin injuries. The 7/9/24 nurse progress note revealed arm sleeves were offered for both arms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, the intervention was not added to the care plan until 8/14/24, during the survey (see DON interview below). The 7/20/24 nurse progress note revealed the resident had a skin tear on his left forearm. The resident went to the dining room to show the nurse the new skin tear. The nurse asked what happened and the resident said he was messed up everywhere while pointing to both arms. -The progress note failed to reveal any new interventions put into place to prevent further skin injuries. The 8/1/24 nurse progress note revealed the resident had a new dark purple bruising proximal to his left antecubital (a small depression on the front of the elbow). The resident said he did not know what happened. The 8/9/24 nurse progress note revealed the resident had a new dark purple bruising on his right elbow. The resident did not know what happened. The 8/10/24 nurse progress note revealed the resident had a new skin tear with dark purple bruising on his left hand. The resident said he needed help because he bumped his elbow on the side table and he was bleeding. -The progress note failed to reveal any new interventions put into place to prevent further skin injuries. A request for the incident reports for Resident #55's skin injuries (from 6/24/24 through 8/10/24) was made to the nursing home administrator (NHA) on 8/13/24. A verbal description of the incidents was provided by the NHA on 8/14/24 (see NHA interview below). II. Staff interviews The NHA was interviewed on 8/14/24 at 1:30 p.m. The NHA said the 6/28/24 skin incident (bruises) was due to the resident's fall on 6/24/24. She said the interventions were offering a night light, physical and occupational therapy and offering a new recliner. The NHA said the 7/1/24 skin incident report revealed the resident's bruising was from the 6/24/24 fall. The NHA said the 7/2/24 skin incident report revealed the resident's skin was rubbed on the recliner during a transfer. She said the interventions were to help him transfer, anticipate his needs, use the call light and gain strength through physical therapy and occupational therapy. The NHA said protection sleeves were offered but the sleeves were not added as an intervention in the resident's care plan and were not communicated to the care team. The NHA said the 8/2/24 skin incident report revealed Resident #55 did not remember what happened. He said the resident had his protection sleeves on while he was riding the therapy bike in the therapy room. The NHA said an unidentified certified nurse aide (CNA) was interviewed and said the day after his skin injury, the resident was not wearing the protection sleeves. The NHA said the skin incident report revealed the intervention was to wear protection sleeves. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The interventions listed on the skin incident reports were not added to Resident #55's care plan (see record review above). Certified nurse aide with medication aide authority (CNA-Med) #1 was interviewed on 8/15/24 at 12:44 pm. CNA-Med #1 said if she saw a new skin condition she told the charge nurse, the assistant director of nursing (ADON) or director of nursing (DON). She said she documented new skin injuries under a task to monitor for skin injury. She would tell the next CNA at shift change. She said she knew if a resident was at risk for skin injury and what interventions to use to prevent skin injuries because it should be on the resident's care plan. Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 2:07 p.m. LPN #1 said if she saw a new skin condition, she documented the condition on an incident report and communicated to the family, provider, wound nurse and other staff. LPN #1 said she completed a skin assessment. She said she told the provider about the skin condition so new orders could be obtained to review if there were signs of infection. LPN #1 said Resident #55 had sustained several skin injuries since he was admitted to the facility. She said interventions used to prevent skin injuries were for the resident to wear protective sleeves and be careful to avoid bumping his arms on hard surfaces. The DON was interviewed on 8/15/24 at 3:08 p.m. The DON said if a nurse saw a new skin condition, the nurse completed an incident report that included the details of what happened, skin assessment, and notified the family and the provider. She said the nurse documented what contributed to the injury and identified an immediate intervention to prevent further injuries. The DON said the nurse documented in the incident report and sometimes as a progress note. She said some interventions to prevent skin injuries included padding hard surfaces and positioning pillows. She said social services, nursing and medical records were responsible for updating the residents' care plans and care plans were updated at care conferences, quarterly and as needed. The DON said Resident #55 had been at risk for skin injury since his admission to the facility. She said interventions to prevent future skin injury were protection sleeves for both of his arms and CNAs were to monitor his skin. She said the protection sleeves were added as an intervention on 8/14/24 (during the survey) but the intervention was put into place in July 2024. III. Facility follow up The NHA provided a timeline of interventions added after each skin injury on 8/16/24 at 3:13 p.m. (after the survey). The intervention information provided included the following: The intervention added after the 7/1/24 incident was an x-ray to rule out injury, environment assessment, education on call light and changed pain medication from as needed to scheduled. The interventions added after the 7/1/24 incident were environment assessment, occupational therapy, treatment orders from the provider, temperature adjusted in the resident's room, tested for COVID-19, warm blanket and pillow offered. The interventions added after the 7/3/24 incident were physical therapy, medical management, lab monitoring, treatment orders and education to the resident on hand placement using the lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The interventions added after the 8/2/24 incident were protection sleeves for both arms, continued physical therapy and occupational therapy, lab monitoring, medical management, fluid restriction, daily nursing assessment and education on the use of protection sleeves. The interventions added after the 8/9/24 incident were medical management, education on protection sleeves, physical therapy, occupational therapy, fluid restriction, lab monitoring, daily nursing assessment and resident declined protection sleeves. The interventions added after the 8/10/24 incident was medical management, education on protecting arms, physical therapy, occupational therapy, lab monitoring, fluid restriction and daily nursing assessment. The resident refused to have his side table moved or padded. -However, the interventions provided by the NHA had not been updated on the resident's care plan prior to the survey.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations, record review and interviews, the facility failed to use a person-centered approach when determining the use of bed rails for one (#57) of 15 residents reviewed for bed rails out of 32 sample residents. Specifically, for Resident #57, the facility failed to: -Assess and review what interventions were attempted prior to the use of side rails; -Ensure the resident's comprehensive care plan was person centered; -Ensure assessments of the resident's use of the bed rails were completed regularly after they were installed; and, -Obtain consent that included the risks and benefits for using bed rails from the resident and/or the resident's representative before the bed rail installation. Findings include: I. Professional reference The U.S. Food and Drug Administration (FDA) Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, (2/27/23) was retrieved on 8/19/24 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails included bed rail safety guidelines. It read in pertinent part, Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. II. Facility policy and procedure The Nursing Proper Use of Positioning Bars policy, undated, was provided by the nursing home administrator (NHA) on 8/15/24 at 4:05 p.m. It revealed in pertinent part, An assessment will be made to determine the resident's symptoms or reason for using positioning bars. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When used for mobility or transfer, an assessment will include a review of the resident's bed mobility and the ability to transfer between positions, to and from bed or chair, to stand and toilet. The use of positioning bars as an assistive device will be addressed in the resident's care plan. Informed consent for the use of less restrictive devices will be obtained from the resident or legal representative per facility protocol. Less restrictive interventions that will be incorporated in care planning include providing restorative care to enhance abilities to stand safely and to walk; a trapeze to increase bed mobility; placing the bed lower to the floor and surrounding the bed with a soft mat; equipping the resident with a device that monitors attempts to arise; providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to arise to use the bathroom and furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information. Documentation will indicate if less restrictive approaches are not successful and orders to apply and monitor the use of positioning bars for a specific time frame. III. Resident #57 A. Resident status Resident #57, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following cerebral infarction (an ischemic stroke), myocardial infarction (heart attack), chronic kidney disease, dementia, mood disturbance, anxiety and depression. The 7/1/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident had an impairment on one side of her upper and lower extremities and used a wheelchair. The resident was dependent on staff assistance for toileting, showering and dressing. The resident required partial assistance with personal hygiene and oral hygiene. The assessment revealed the resident did not use bed rails or physical restraints. B. Resident interview and observations Resident #57 was interviewed on 8/12/24 at 2:53 p.m. Resident #57 was in her reclining chair in her room. Her bed was to the left of her recliner. There was a bed rail on the right side of her bed near the head of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57 said she did not know what the bed rail was used for and she did not remember when she last used the bed rail. On 8/13/24 at 9:47 a.m. the bed rail was attached to the right side of the resident's bed. On 8/14/24 at 1:16 p.m. the bed rail was attached to the right side of the resident's bed. C. Record review The fall care plan, revised 10/31/23, revealed Resident #57 was at risk for falls due to a cerebral vascular accident with right-sided weakness. The pertinent intervention included positioning bars to assist with transfer and mobility. -The comprehensive care plan failed to include a reason for the use of the bed rail. The August 2024 CPO revealed Resident #57 had a physician's order for positioning bars to assist with transfers, mobility and fall prevention, ordered on 3/13/24. -The physician's order did not specify if the bed rail was to be placed on both sides of the bed or one side of the bed. The 3/12/24 safety device assessment revealed the resident required the assistance of two staff members with transfers using a gait belt and a front-wheel walker. The safety device recommended was positioning bars on bed. The assessment revealed the resident's representative provided consent for the bed rail on 3/12/24. -The assessment did not specify if the bed rail was on the left side, right side or both sides of the bed. -The assessment did not reveal why the bed rail was recommended. -The assessment did not reveal what actions were attempted prior to the use of the bed rail. -The assessment did not indicate the risks and benefits to use a bed rail and what alternatives were tried and failed prior to the use of a bed rail were reviewed with the resident's representative prior to providing consent on 3/12/24. The 3/12/24 nursing progress note revealed the resident's representative gave consent for use of bed rails. -The progress note failed to identify what was tried and failed prior to the use of bed rails and the risks and benefits to the use of bed rails. The 4/24/24 social services note revealed a care conference was held. The resident's care plan was reviewed and updated. -The social services note failed to identify the use of the bed rails were reviewed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews Certified nurse assistant with medication aide authority (CNA-Med) #1 was interviewed on 8/15/24 at 12:44 p. m. CNA-Med #1 said she knew if a resident was supposed to have a bed rail by looking at the care plan, through a verbal report at shift change and if there was a sticker on the resident's door. Licensed practical nurse (LPN) #1 was interviewed on 8/15/24 at 2:07 p.m. LPN #1 said if a resident had a bed rail, the nurse contacted the physician for an order. She said she informed maintenance so the bed rail could be installed and restorative nursing was notified. LPN #1 said restorative nursing was responsible for completing the bed rail assessment. She said the nursing staff or the restorative staff obtained consent from the resident or the resident's representative for the bed rail. LPN #1 said the risk and benefits of using a bed rail were reviewed with the resident or the resident's representative when consent was obtained. She said the consent form was documented in the assessment and in a progress note. The director of nursing (DON) was interviewed on 8/15/24 at 3:08 p.m. The DON said the use of bed rails was evaluated quarterly when the care plan was reviewed by the interdisciplinary team (IDT). -However, record review did not reveal a quarterly evaluation had been completed after the bed rail was installed in March 2024 (see record review above). The DON said Resident #57 used the bed rail to help with positioning. The DON said sometimes the staff helped the resident with repositioning and sometimes the resident used the bed rail for self-positioning. The DON said she was not aware the risks and benefits were not documented in Resident #57's electronic medical record (EMR) and the assessment was incomplete. The DON said she did not know the assessment was missing information regarding the placement of the bed rail, why the bed rail was recommended and what actions were attempted before the use of the bed rail.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 48112 Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for one of five certified nurse aides (CNA) reviewed. Specifically, the facility did not provide regular in-service education based on the outcome of the annual performance review for CNA #5. Findings include: I. Record review CNA #5 (hired before 8/14/23) had an annual performance review on 10/1/23. The performance review indicated CNA #5 scored a 50% in the areas of complaints and grievances, environment, quality improvement, workplace violence and sexual harassment. -CNA #5 did not have an in-service education plan based on the outcome of the annual performance review. II. Staff interview The director of nursing (DON) was interviewed on 8/15/24 at 1:52 p.m. The DON said she was not aware the performance reviews needed to include a regular in-service plan based on the outcome of the reviews. The DON said if a CNA scored 50% on a test, the score indicated the CNA did not meet the expectations. She said CNA #5 worked per diem (as needed) and had worked at the facility for at least a year. She said an annual performance review should be completed for all CNAs. She said if there was an area of improvement, she met with the CNA one-on-one to provide education and training.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48112 Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and two of four kitchenettes. Specifically, the facility failed to: -Ensure food was labeled, dated and discarded in a timely manner; -Ensure staff performed hand hygiene before donning (putting on) gloves to serve ready-to-eat food; and, -Ensure food was reheated to the appropriate temperature. I. Failed to ensure food was labeled, dated and disposed of timely A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 8/21/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, A date marking system that meets the criteria may include: Using a method approved by the Department for refrigerated, ready-to eat potentially hazardous food (time/temperature control for safety food) that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded; marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded or using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the department upon request. B. Observations and interviews On 8/12/24 at 9:13 a.m., during the initial kitchen tour, there were 24 avocados in a cardboard box in the large refrigerator in the main kitchen. The avocados were dark and had a mushy texture. The registered dietitian (RD) said the avocados needed to be thrown away and she threw them away in the trash. In the large freezer, there was a large sheet pan on the top shelf that had a red pureed item that was not labeled and was uncovered. There was a large cookie sheet with red cake and white frosting that was not labeled and was uncovered. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/14/24 at 11:19 a.m. there were three cartons of liquid thickener in the East [NAME] unit refrigerator. Two of the cartons were apple and lemon flavored that were opened and did not have an opened date. The third carton was orange juice and was dated 7/20. The label on the carton said the thickener was good for seven days once it was opened. On 8/15/24 at 10:09 a.m. the refrigerator on the Somerly unit had one carton of orange flavored thickener that was opened and dated 6/18. C. Staff interview The dietary manager (DM) was interviewed on 8/15/24 at 10:51 a.m. The DM said the avocados should have been discarded prior to the avocados rotting. The DM said the pureed frozen food and the cake should have been covered. II. Failed to ensure ready-to-eat foods were handled in a sanitary manner A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 8/21/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles, and after touching bare human body parts other than clean hands and clean, exposed portions of arms; and during food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks; before donning gloves to initiate a task that involves working with food and after engaging in other activities that contaminate the hands. Except when washing fruits and vegetables as specified, food employees may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. B. Observations During a continuous observation on 8/14/24, beginning at 11:46 a.m. and ending at 12:15 p.m. the following was observed in the Elim/Deaconess dining unit: Dietary aide (DA) #3 served multiple residents their meals. DA #3 had disposable gloves on her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:59 a.m. DA #3 placed two slices of bread in the toaster with her gloved hands and touched the toaster button to toast the bread. DA #3 plated another resident's lunch. During this time she touched serving utensils. DA #3 used the same gloved hands to take the toast from the toaster to a plate. She took two pads of butter and an individual size jam for the toast. She touched the toast with her same gloved hands and used a knife to butter and jam the toast. She took off her gloves and put them into the trash and then put on new gloves without performing hand hygiene. At 12:15 p.m. DA #3 took a baked sweet potato out of the unit's oven with the same gloved hands. She unwrapped the plastic wrap from the potato. DA #3 used her gloved hands to take the skin off the sweet potato. She disposed of the plastic gloves in the trash and then put on new gloves without performing hand hygiene. C. Staff interview The DM was interviewed on 8/15/24 at 10:51 a.m. The DM said staff should wash their hands between every task and after changing their gloves. The DM said it was important for staff to wash their hands between tasks to avoid cross-contamination and food borne illnesses. III. Failed to ensure food was reheated properly A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 8/21/24 from:https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, Food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 74 degrees Celsius (C) (165 degrees Fahrenheit (F)) for 15 seconds. Food reheated in a microwave oven for hot holding shall be reheated so that all parts of the food reach a temperature of at least 74 degrees C (165 degrees F) and the food is rotated or stirred, covered, and allowed to stand covered for 2 minutes after reheating. B. Observation and interview During a continuous observation on 8/14/24, beginning at 11:46 a.m. and ending at 12:15 p.m., the following was observed on the Elim/Deaconess dining unit: At 11:56 a.m. DA #3 opened a single-serve-size can of tomato soup and poured the soup into a plastic soup bowl. DA #3 placed the soup in the microwave. DA #3 took the soup out of the microwave and placed the soup on a meal tray for the server to deliver the soup. DA #3 said she reheated the soup for 30 seconds. -DA #3 did not take the temperature of the soup to ensure it reached the correct internal temperature. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Staff interview The DM was interviewed on 8/15/24 at 10:51 a.m. The DM said food should be reheated long enough so the food reached the temperature of 165 degrees F for 10 seconds. The DM said it was important to reheat food correctly to kill any bacteria.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to establish a sanitary environment to help prevent the transmission of communicable diseases and infections on two of four hallways. Specifically, the facility failed to: -Ensure housekeeping completed proper hand hygiene when cleaning resident rooms; and, -Ensure nursing followed proper standards of practice during wound care and followed enhanced barrier precautions appropriately. Findings include: I. Failure to ensure housekeeping completed proper hand hygiene when cleaning resident rooms A. Facility policy and procedure The Hand Hygiene policy, revised 5/6/21, was received from the nursing home administrator (NHA) on 8/15/24 at 10:18 a.m. It documented in pertinent part, All staff will perform proper hand hygiene to prevent the spread of infection to other personnel, neighbors and visitors. This applies to all working staff in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. B. Observations During a continuous observation on 8/13/24, beginning at 11:21 a.m. and ending at 11:50 a.m., the following was observed: Housekeeper (HSKP) #1 was observed cleaning resident room [ROOM NUMBER]. She started with donning (putting on) clean gloves. -HSKP #1 did not perform hand hygiene prior to donning the clean gloves. HSKP #1 removed the bedroom and bathroom trash. She grabbed a towel out of a bucket filled with cleaning solution. She did not know what kind of solution it was. She wiped down the bedroom door handles, closet door handles, light switches, bedside tables and the dresser. She took the towel into the bathroom and wiped down the sink, grab bars and toilet. She disposed of the soiled towel. She started to mop the floor of the bedroom and brought it into the bathroom. She mopped the bathroom and then finished mopping the bedroom with the same mop head. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HSKP #1 did not change the mop head when she went from the bathroom to the bedroom. -HSKP #1 did not change her gloves or perform hand hygiene after cleaning the bathroom prior to mopping the floor. HSKP #1 removed her gloves, threw them away and wiped her hands on a dry towel. She wiped her hands on her scrub pants. She donned a clean pair of gloves. -HSKP #1 did not perform hand hygiene after removing the gloves or prior to donning clean gloves. HSKP #1 moved the housekeeping cart to room [ROOM NUMBER]. She checked the trash in the bedroom and in the bathroom. She grabbed a towel from out of a bucket filled with cleaning solution. She wiped down the bedroom door handles, closet door handles, light switches, bedside tables and the dresser. She took the towel into the bathroom and wiped down the sink, grab bars, and the toilet. She disposed of the soiled towel. She started to mop the floor of the bedroom and brought it into the bathroom. She mopped the bathroom and then finished mopping the bedroom with the same mop head. -HSKP #1 did not change the mop head from the bathroom to the bedroom. -HSKP #1 did not change her gloves or perform hand hygiene after cleaning the bathroom prior to mopping the floor. HSKP #1 removed her gloves, threw them away and wiped her hands on the same dry towel from earlier. She wiped her hands on her scrub pants. She donned a clean pair of gloves. -HSKP #1 did not perform hand hygiene after removing the gloves or prior to donning clean gloves. C. Staff interviews The assistant director of nursing (ADON) and the director of nursing (DON) were interviewed together on 8/15/24 at 10:00 a.m. The DON said hand hygiene should be performed prior to donning gloves and after removal of gloves. She said housekeepers should change gloves after completing a room before moving to the next room. She said they should change gloves when moving from the bathroom to the bedroom to clean. She said the housekeepers should dispose of a dirty towel and use a new one when moving from room to room. She said the bedroom and bathroom should be treated as two separate rooms. 50690 II. Failure to ensure nursing followed proper standards of practice during wound care and followed enhanced barrier precautions appropriately A. Professional reference (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Centers for Disease Control and Prevention (4/2/24), Implementation of Personal Protective Equipment (PPE) - Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), was retrieved on 8/19/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds, regardless of MDRO colonization status. B. Facility policy and procedure The Wound Care policy, revised 12/29/23, was provided by the DON on 8/15/24 at 10:18 a.m. It read in pertinent part, Use disposable cloth to establish a clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field. Place a disposable cloth under the wound to serve as a barrier to protect the bed linen and other body sites. Wipe reusable supplies with alcohol as indicated (supplies that were outside of containers and touched by unclean hands such as scissors. C. Observations On 8/13/24 at 3:30 p.m., licensed practical nurse (LPN) #1 was observed during a dressing change for a resident's heel wound. LPN #1 entered the resident's room with her supplies and placed them on the bedside table. LPN #1 opened the supplies containers and took a pair of scissors from her pocket to cut the ace bandage that covered the resident's current dressing. -LPN #1 failed to wear a gown for high contact care with a resident who was on enhanced barrier precautions (EBP). -LPN #1 failed to use a disposable cloth to establish a clean field on top of the resident's bedside table. -LPN #1 failed to sanitize the pair of scissors she removed from her pocket prior to cutting off the ace bandage. LPN #1 removed the resident's old dressing. She cleansed the wound and placed the resident's heel back onto the bed. -LPN #1 failed to protect the cleansed wound by placing a clean disposable cloth underneath the resident's heel before resting it on the bed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 applied the new dressings and wrapped a clean bandage around the resident's foot to cover the dressings. She cut the bandage with the same pair of scissors. -LPN #1 failed to change gloves and perform hand hygiene prior to applying the new dressing. -LPN #1 failed to disinfect the dirty scissors before using them to cut the clean bandage. D. Staff interviews LPN #1 was interviewed on 8/13/24 at 3:30 p.m. LPN #1 said she did not think the resident was on any enhanced barrier precautions. LPN #1 said, after seeing the EBP sign outside the resident's door, that for a resident who was on EBP, dirty trash was put in a red bag and dirty clothes were put in a yellow bag. She said that if she were to do resident care, such as providing feeding assistance or giving medications, she would wear a disposable gown and gloves. -LPN #1 failed to identify that she should have worn a disposable gown while performing the resident's wound care. LPN #1 was interviewed again on 8/15/24 at 9:10 a.m. LPN #1 said on 8/13/24 during the wound dressing change, she forgot to wear the proper personal protective equipment (PPE). LPN #1 said she should have worn a gown when she was doing the dressing change because the resident was on EBP. She said she probably should have put something under the resident's heel to keep the bottom of the heel from contacting the resident's bed sheets while doing the dressing change. The DON was interviewed on 8/15/24 at 3:18 p.m. The DON said the residents who were on EBP had a tag on their door to indicate the need for PPE. She said that gloves and a gown should be worn to do wound dressing changes and most residents had their own supplies in the bathroom, including PPE gowns. The DON said before a dressing change, a clean disposable cloth should be put on top of the resident's tray table and the wound supplies should be placed on top of the cloth. She said, depending on where the wound was located, a clean disposable cloth should be positioned so that the wound and the resident's bed were kept clean during the wound care process. She said the nurses usually had their own scissors, but scissors should be sanitized in between dirty and clean stages and in between residents.