

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  South Platte Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Edison St 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)
<p>F 0584</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 a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50853</p> <p>Based on observations and interviews, the facility failed to ensure residents had the right to a safe, clean and comfortable homelike environment on two of three hallways</p> <p>Specifically, the facility did not facilitate the necessary maintenance services to maintain resident rooms in a sanitary, safe and comfortable manner.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Quality of Life Homelike Environment policy, dated 12/19/16, was provided by the nursing home administrator (NHA) on 10/7/24 at 2:10 p.m. It read in pertinent part,</p> <p>Residents are provided with a safe, clean, comfortable and homelike environment.</p> <p>The facility's designated environmental services director is responsible for developing and implementing a cleaning schedule for common areas and resident rooms to assure that each area of the facility is maintained in a safe, clean and comfortable manner.</p> <p>The environmental services director shall report any concerns related to maintaining the facility in a safe, clean, comfortable or homelike environment to the Quality Assessment and Assurance Committee for review as needed.</p> <p>II. Observations</p> <p>Observations of resident rooms were conducted on 10/3/24. The following observations were made:</p> <p>At 1:34 p.m., an observation of room [ROOM NUMBER] revealed broken floor tiles and a loose kick plate on the door.</p> <p>At 1:35 p.m., an observation of room [ROOM NUMBER] revealed a broken plastic kick plate on the door with a sharp piece of wood exposed which caused a potential safety hazard.</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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 1:40 p.m. an observation of room [ROOM NUMBER] revealed floor tiles broken in the bedroom and bathroom and floor tiles separated by gaps between each tile in the bathroom. The separated bathroom tiles had dirt and debris in the cracks.</p> <p>At 1:42 p.m. an observation of room [ROOM NUMBER] revealed a large piece (approximately six inches by nine inches) of floor tile missing near the sink and water damage on the wall behind the missing flooring. In addition, the kick plate on the door was broken with exposed sharp edges.</p> <p>The resident who resided in room [ROOM NUMBER] said he felt like he was living in a cockroach motel.</p> <p>III. Staff interviews</p> <p>The housekeeping supervisor (HS) was interviewed on 10/7/24 at 11:10 a.m. The HS said the floor tile in room [ROOM NUMBER] had been missing since he started working at the facility over one year ago.</p> <p>On 10/8/24 1:20 p.m. an environmental tour of the facility was conducted with the maintenance supervisor (MS). The MS said the facility used a computer program to remind them of maintenance repairs that needed to be completed in the facility. The MS said the facility had purchased paint for the hallways but were waiting for approval from the new ownership company to paint.</p> <p>The MS acknowledged and documented the above observations. The MS said the broken kick plates on the residents' doors were a safety concern and the facility had some extra kick plates in storage to replace the broken ones. The MS said she had some extra floor tiles to patch the broken tiles. The MS said the facility had discussed replacing the entire floor in room [ROOM NUMBER], but she said she would patch it for now.</p> <p>The NHA was interviewed on 10/8/24 at 2:09 p.m. The NHA said the facility had an ambassador program where staff visited assigned rooms daily. The NHA said staff were expected to report any repairs needed in the residents' rooms on Fridays. The NHA said maintenance requests should be completed and turned in to the MS. The NHA said the many maintenance concerns (including the damaged flooring and kick plates) had been previously reported but she said since the new company had taken over, the facility had to wait for approvals. The NHA said the facility did not have a current performance improvement plan for the physical environment. The NHA said they would repair the issues that were safety concerns immediately.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50853</b></p> <p>Based on observations, record review and interviews, the facility failed to manage pain in a manner consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences for two (#10 and #12) of three residents reviewed for pain out of 25 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure adequate pain management for Resident #10 and Resident #12;</li> <li>-Ensure a pain care plan was initiated for Resident #12; and,</li> <li>-Ensure pain medications were reconciled upon readmission for Resident #12.</li> </ul> <p>Findings include:</p> <p>I. Facility policy</p> <ul style="list-style-type: none"> <li>-The pain management policy was requested on 10/8/24 at 10:57 a.m. but was not provided by the facility.</li> </ul> <p>II. Resident #10</p> <p>A. Resident status</p> <p>Resident #10, age less than 65, was admitted on [DATE]. According to the October 2024 computerized physicians orders (CPO), diagnoses included bipolar disorder, type 2 diabetes mellitus, chronic obstructive pulmonary disease (COPD - a common lung disease causing difficulty with breathing), acute respiratory failure, acute kidney failure, venous insufficiency (when legs have difficulty returning blood to the heart), unspecified osteoarthritis (degenerative joint disease) and chronic pain.</p> <p>The 7/1/24 minimum data set (MDS) assessment revealed Resident #10 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required total assistance from staff for transfers and toileting hygiene. She was unable to walk, but propelled herself in a wheelchair.</p> <p>The MDS assessment indicated the resident received scheduled and as needed pain medications. She had received non-medication interventions for pain during the seven-day assessment review period.</p> <p>The MDS assessment documented Resident #10 reported pain at a level of 8 out of 10 (on a scale of 1-10) that occasionally interfered with daily activities and made it difficult to sleep.</p> <p>B. Observations and resident interview</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/7/24 at 4:50 p.m. Resident #10 was observed during wound care. When the infection preventionist (IP) cleansed the resident's wounds, Resident #10 cried out in pain. When the IP touched the wound lowest on her abdomen, Resident #10 screamed and banged her hand on the wall. The IP asked if she wanted her to stop and Resident #10 said to just hurry and get it over with.</p> <p>On 10/8/24 at 9:03 a.m. Resident #10 was sitting outside smoking. Resident #10 said the waist band of her pants rubbed on her abdominal wounds and it was painful. Resident #10 said the staff had not offered her other clothing, such as a dress without a waist band.</p> <p>C. Record review</p> <p>The pain management care plan, initiated on 1/25/17 and revised 6/22/23, revealed Resident #10 had pain related to generalized chronic pain and neuropathy and often refused non-pharmacological interventions and preferred pain medication. Pertinent interventions included, administering pain medication as ordered and documenting effectiveness, informing the physician of pain not resolved by pain medication and providing diversion activities that could distract from pain such as positioning, music or television.</p> <p>The pain care plan revealed Resident #10 had an acceptable pain level of 4 out of 10.</p> <p>-The pain care plan did not indicate Resident #10 had pain related to her abdominal wounds.</p> <p>-The pain care plan interventions had not been updated since Resident #10 acquired abdominal wounds on 5/15/24.</p> <p>The October 2024 CPO revealed Resident #10 had the following physician's orders for pain management:</p> <p>ramadol 50 milligrams (mg) one tablet every six hours as needed for moderate to severe pain from 4 to 10, ordered on 8/22/24.</p> <p>Acetaminophen 1000 mg three times a day, ordered on 5/16/24.</p> <p>There was no order to monitor pain levels during wound care.</p> <p>According to the October 2024 medication administration record (MAR), Resident #10 received tramadol 50 mg on 10/7/24 at 1:42 p.m., three hours prior to wound care.</p> <p>-However, Resident #10 cried out in pain during wound care on 10/7/24 and no further pain medication was offered (see observation above).</p> <p>-Review of Resident #10's electronic medical record (EMR) did not reveal any documentation to indicate the resident's physician was notified regarding the resident's increased pain levels during wound care.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The IP, who was the facility's wound nurse, was interviewed on 10/7/24 at 5:00 p.m. The IP said she did not think staff had offered other clothing options to Resident #10 that would not cause pain by rubbing on her wounds.</p> <p>The wound physician (WP) was interviewed on 10/8/24 at 11:45 a.m. The WP said Resident #10 had had some pain when he was providing wound care. The WP said different clothing, such as a dress would be beneficial for Resident #10 to avoid the waistband rubbing on her wounds.</p> <p>The IP was interviewed again on 10/8/24 at 1:00 p.m. The IP said Resident #10's pain was not controlled. The IP said the facility would address this with the physician and ask for additional or alternative pain medication.</p> <p>III. Resident #12</p> <p>A. Resident status</p> <p>Resident #12, age 73, was admitted on 1/8/24, discharged home on 9/3/24 and readmitted to the facility on [DATE]. According to the October 2024 CPO, diagnoses included a displaced fracture of the lateral malleolus of the left fibula (the bone on the outside of the ankle), chronic viral hepatitis C (lifelong liver infection), displaced trimalleolar (three bones in the ankle) fracture of the right lower leg, acute and chronic respiratory failure with hypoxia (low oxygen levels in tissues) and COPD.</p> <p>The 9/27/24 MDS assessment revealed Resident #12 was cognitively intact with a BIMS score of 15 out of 15. The assessment indicated Resident #12 required substantial assistance from staff for transfers and toileting hygiene. She required minimal staff assistance with upper body dressing and total assistance with lower body dressing. She was unable to walk, and used a wheelchair for mobility.</p> <p>The MDS assessment indicated the resident received scheduled and as needed pain medications. She had received non-medication interventions for pain during the seven-day assessment review period.</p> <p>The MDS assessment documented Resident #12 reported occasional pain at a level of 5 out of 10.</p> <p>B. Resident interview</p> <p>Resident #12 was interviewed on 10/2/24 at 1:42 p.m. Resident #12 said her pain medication was stopped a couple of weeks ago and the facility's physician did not talk to her about stopping it. Resident #12 said she had taken the pain medication for many years for her chronic pain. She said she currently only had Tylenol and ibuprofen prescribed for her pain and the medications did not adequately manage her pain.</p> <p>Resident #12 was interviewed again on 10/3/24 at 3:46 p.m. while she was lying in bed. Resident #12 said she was not having a good day and her pain level was a 9 out of 10. She said she had ibuprofen earlier in the day and would like something again for her pain.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #12's comprehensive care plan, initiated on 9/16/24, revealed there was not a care plan focus for pain management.</p> <p>The pain assessment dated [DATE] revealed Resident #12 had frequent severe pain that interfered with sleep and daily activities. Resident #12 indicated her acceptable level of pain was 1-4 on a scale of 1-10.</p> <p>The 9/3/24 primary care physician discharge note listed the plan for chronic pain to include the following medications:</p> <ul style="list-style-type: none"> <li>-Lyrica 150 mg two times per day;</li> <li>-Oxycodone 10 mg every six hours as needed for pain levels of 6 to 10;</li> <li>-Tylenol 325 mg two tablets every six hours for general discomfort; and,</li> <li>-Ibuprofen 200 mg two tablets as needed for pain.</li> </ul> <p>The September 2024 CPO revealed Resident #12 had the following physician's orders for pain management upon her readmission on 9/6/24:</p> <p>Lyrica (pregabalin) 150 mg one capsule two times a day for neuropathy (nerve pain), with a start date of 9/6/24.</p> <p>Acetaminophen (Tylenol) 325 mg two tablets every six hours as needed for general discomfort, with a start date of 9/6/24.</p> <p>Ibuprofen 200 mg two tablets every four hours as needed for pain, with a start date of 9/6/24.</p> <p>Percocet 5-325 mg (oxycodone 5 mg with acetaminophen 325 mg) one tablet every six hours as needed for pain for 14 Days, with a start date of 9/6/24 and discontinued 9/20/24.</p> <p>The nurse practitioner's readmission progress note, dated 9/14/24, documented Resident #12 was receiving the following physician orders for pain control:</p> <ul style="list-style-type: none"> <li>-Lyrica 150 mg two times per day;</li> <li>-Oxycodone 10 mg every six hours as needed for pain levels of 6 to 10;</li> <li>-Tylenol 325 mg two tablets every six hours for general discomfort;</li> <li>-Ibuprofen 200 mg two tablets every four hours as needed for pain; and,</li> <li>-Percocet 5-325 mg (oxycodone 5 mg with acetaminophen 325 mg) one tablet three times a day as needed for pain.</li> </ul> <p>-However, review of Resident #12's October 2024 CPO did not reveal a physician's order for oxycodone (see above).</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Despite the nurse practitioner's readmission progress note indicating Resident #12 was to be receiving oxycodone, there was no documentation in the resident's EMR indicating why the oxycodone was not entered into the EMR when the resident was readmitted on [DATE].</p> <p>D. Staff interviews</p> <p>The IP was interviewed on 10/8/24 at 1:00 p.m. The IP said the charge nurse reconciled the medications upon admission with a nurse manager. The IP said the facility had been managing Resident #12's pain with Tylenol and ibuprofen. The IP said she did not know why the oxycodone was not entered into the the physician's orders for Resident #12.</p> <p>The regional nurse consultant (RNC) was interviewed on 10/8/24 at 1:00 p.m. The RNC said the facility was revamping their admission process and had created a checklist for the nurses to use. The RNC said the new process should ensure medications were not missed in the admission process.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50853</p> <p>Based on observations and interviews, the facility failed to ensure medications and biologicals were properly stored and labeled in accordance with professional standards in one of two medication carts and one of two medication storage rooms.</p> <p>Specifically, the facility failed to ensure expired medications were removed from the medication carts and medication storage rooms.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>The United States Food and Drug Administration (USFDA) (2/8/21) Don't Be Tempted to Use Expired Medicines, was retrieved on 10/9/24 from <a href="https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines">https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines</a>. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.</p> <p>II. Facility policy and procedure</p> <p>The Medication Labeling and Storage policy, dated 2001, was provided by the nursing home administrator (NHA) on 10/8/24 at 3:50 p.m. It read in pertinent part,</p> <p>The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.</p> <p>The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.</p> <p>If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.</p> <p>Multi-dose vials that have been opened or accessed (needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.</p> <p>III. Observations</p> <p>On 10/7/24 at 3:01 p.m. the medication cart and treatment cart on the secure unit were observed with registered nurse (RN) #1. The following items were found:</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-One tube of anti-itch cream (topical analgesic and skin protectant) with an expiration date of July 2024.</p> <p>-One tube of anasep gel (antimicrobial wound gel) with an expiration date of 4/27/24.</p> <p>-One bottle of derma klenz wound cleanser with an expiration date of July 2024.</p> <p>On 10/7/24 at 3:53 p.m. the medication storage room on the west hall was observed with the director of nursing (DON). The following items were found:</p> <p>-Three bottles of aspirin 325 milligrams (mg) with an expiration date of August 2024.</p> <p>IV. Staff interviews</p> <p>The scheduler said she was responsible for ordering supplies and over the counter medication. The scheduler said she stocked the medication storage rooms weekly and checked for expired medications monthly. The scheduler said if she found expired medications she took them to the DON for disposal.</p> <p>The DON was interviewed on 10/7/24 at 4:11 p.m. The DON said the nurses should check medications for expiration dates before administering. The DON said if nurses found expired medications they should put them in the drug buster container (a medication disposal system). The DON said it was important to dispose of expired medications because they could cause an adverse effect or be less effective if they were expired.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50853</p> <p>Based on observations and interviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections on two of three hallways.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure appropriate infection control practices were followed during wound care; and,</li> <li>-Ensure housekeeping staff followed appropriate hand hygiene practices when cleaning resident's rooms.</li> </ul> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Centers for Disease Control and Prevention (CDC) Clinical Safety: Clean Hands for Healthcare Workers (2/27/24), retrieved on 10/9/24 from <a href="https://www.cdc.gov/clean-hands/hcp/clinical-safety;">https://www.cdc.gov/clean-hands/hcp/clinical-safety;</a></p> <p>If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings. Always clean your hands after removing gloves.</p> <p>II. Facility policy and procedure</p> <p>The Hand Washing and Hand Hygiene policy, dated 12/19/16, was provided by the NHA on 10/7/24 at 2:10 p. m. It read in pertinent part,</p> <p>This facility considers hand hygiene the primary means to prevent the spread of infections.</p> <p>Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.</p> <p>The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>Hand hygiene is the final step after removing and disposing of personal protective equipment.</p> <p>The Wound Care policy, dated 12/19/16, was provided by the nursing home administrator (NHA) on 10/7/24 at 3:45 p.m. It read in pertinent part,</p> <p>The purpose of this procedure is to provide guidelines for the care of wounds to promote healing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers when part of the treatment order.</p> <p>Wear sterile gloves when physically touching the wound or holding a moist surface over the wound.</p> <p>Disinfect reusable supplies per manufacturer's instructions (outsides of containers that were touched by unclean hands, scissor blades).</p> <p>III. Failure to follow appropriate infection control practices during wound care</p> <p>A. Observations</p> <p>On 10/7/24 at 12:55 p.m. licensed practical nurse (LPN) #1 was providing wound care to resident #201. LPN # 1 washed her hands with soap and water, put on a gown, donned (put on) gloves and a mask and obtained a pair of bandage scissors from a drawer in the resident's night stand. She placed the scissors on the clean field with the other wound care supplies.</p> <p>-LPN #1 did not disinfect the scissors prior to placing them on the clean field with the other clean wound care supplies.</p> <p>After cleaning the wound, LPN #1 donned clean gloves and applied silver cream (a cream used to prevent wound infections) directly to the wound bed with her gloved fingers.</p> <p>-LPN #1 did not use a sterile applicator when touching the wound bed.</p> <p>After applying cream to all wounds, removing her soiled gloves and donning clean gloves, LPN #1 cut the Hydrofera Blue (an antibacterial wound dressing) with the scissors and applied the dressings to the wounds. She did not disinfect the scissors before cutting the clean dressings.</p> <p>On 10/7/24 at 4:50 p.m. the infection preventionist (IP) was providing wound care for resident #10. The IP removed the soiled dressings from the wounds, donned cleaned gloves, sprayed wound cleanser on to the wounds and wiped all four wounds with the same piece of gauze.</p> <p>-The IP did not use a separate piece of gauze to clean each wound.</p> <p>The IP did not perform hand hygiene after removing her soiled gloves and before putting on new gloves.</p> <p>B. Staff interview</p> <p>LPN #1 was interviewed on 10/7/24 at 5:02 p.m. LPN #1 said she assumed the scissors in Resident #201's drawer were clean and so she did not clean them. LPN #1 said she should have cleaned them before cutting the new wound dressing. LPN #1 said she normally used a sterile applicator to apply cream directly to a wound.</p> <p>IV. Failure to follow appropriate hand hygiene practices when cleaning residents' rooms</p> <p>A. Observations</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065170	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/08/2024
NAME OF PROVIDER OR SUPPLIER  South Platte Rehabilitation and Nursing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2200 Edison St 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a continuous observation on 10/7/24, beginning at 10:40 a.m. and ending at 11:28 a.m., the following was observed:</p> <p>The housekeeping supervisor (HS) was observed cleaning room [ROOM NUMBER], a single occupancy room. The HS changed gloves frequently between cleaning tasks in the room. The HS sprayed disinfectant on the high touch surfaces in the room, moving the resident's personal items. The HS left the room, removed his soiled gloves, donned clean gloves and did not perform hand hygiene.</p> <p>After each task, such as cleaning the sink, sweeping, mopping and cleaning the toilet, The HS changed gloves.</p> <p>-However, the HS did not perform hand hygiene with any of the glove changes.</p> <p>At 11:12 a.m. the HS removed his gloves and exited room [ROOM NUMBER].</p> <p>-The HS did not perform hand hygiene after removing his gloves.</p> <p>The HS moved his cart to room [ROOM NUMBER], a double occupancy room. Without performing hand hygiene, the HS donned clean gloves and began cleaning room [ROOM NUMBER]. The HS cleaned high touch surfaces, removed his soiled gloves and donned clean gloves without performing hand hygiene.</p> <p>The HS changed gloves several times between cleaning tasks and between side one and side two of the room.</p> <p>-However, the HS did not perform hand hygiene with glove changes.</p> <p>B. Staff interview</p> <p>The HS was interviewed on 10/7/24 at 11:28 a.m. The HS said he should have performed hand hygiene when changing gloves. The HS said he used to have a bottle of hand sanitizer on his housekeeping cart, but he said the bottle ran out and he had not replaced it.</p> <p>V. Additional staff interview</p> <p>The IP was interviewed on 10/8/24 at 12:08 p.m. The IP said scissors should be disinfected before being used to cut clean bandages. The IP said a separate gauze should be used when cleaning different wounds to avoid cross contamination. The IP said, when applying ointments directly to a wound, an applicator should be used.</p> <p>The IP said staff should perform hand hygiene after removing soiled gloves and before applying clean gloves.</p>		