

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Fairacres Manor, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 18th Ave Greeley, CO 80631	

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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>50219</p> <p>Based on observations, record review and interviews, the facility failed to ensure menus were followed to meet the residents nutritional needs.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Follow the weekly menu to ensure adequate nutrition was provided to the residents; and, -Ensure Resident #38 and Resident #10 were provided with the correct mechanically altered diet. <p>Findings include:</p> <p>I. Failure to follow the weekly menu to ensure adequate nutrition was provided to the residents</p> <p>A. Observations and record review</p> <p>Review of the menu and the menu extensions for the 6/3/24 lunch meal revealed that 2% (percent) milk was to be served.</p> <p>On 6/3/24 the lunch service was observed during a continuous observation in the main and rear dining rooms, beginning at 10:50 a.m. and ending at 11:58 p.m.</p> <p>-The dietary aides in the main and rear dining rooms did not offer residents milk as a beverage during the observation period, but offered soda and juice instead.</p> <p>Review of the menu and menu extensions for the 6/3/24 dinner meal revealed that a side of tartar sauce was to be served to all residents and 2% milk was to be served</p> <p>The altered texture menu extension revealed residents receiving altered diet textures were to receive pasta salad in place of the regular menu's potato chips.</p> <p>On 6/3/24 the dinner service was observed during a continuous observation in the kitchen, beginning at 4:30 p.m. and ending at 6:25 p.m.</p> <p>Observations revealed the following:</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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Only one resident was served a side of tartar sauce; and,</p> <p>-Cook (CK) #1 served a scoop of mashed potatoes to the minced and moist, soft and bite-sized and puree altered diet textures as a substitute for the potato chips on the regular menu instead of the pasta salad that was to be served.</p> <p>The 6/3/24 dinner service was observed during a continuous observation in the main and rear dining rooms, beginning at 4:45 p.m. and ending at 5:50 p.m.</p> <p>The dietary aides in the main and rear dining rooms did not offer residents milk as a beverage during the observation period, but offered soda and juice instead.</p> <p>-Menu nutritional information was requested from the regional dietary consultant (RDC) on 6/5/24 at 4:05 p.m. but was not received by the survey exit date on 6/6/24.</p> <p>B. Resident group interview</p> <p>On 6/4/24 at 3:05 p.m. a group interview was conducted with three residents (#15, #42 and #21) who frequently attended monthly resident council meetings and were identified as interviewable by the facility and assessment.</p> <p>All residents in attendance said they only received milk at meals when they asked for it and that no alternative dairy products were offered in place of milk.</p> <p>All residents in attendance said menu items changed without informing the residents, and the residents would not know what they would be eating until it was served.</p> <p>C. Staff interviews</p> <p>Dietary aide (DA) #2 was interviewed on 6/3/24 at 5:45 p.m. DA #2 said the dietary aides asked residents what they wanted to drink. DA #2 said she was not told if a beverage was on the menu. DA #2 said dietary aides did not offer alternatives if a resident did not select milk as their beverage during meals.</p> <p>The registered dietitian (RD) was interviewed on 6/4/24 at 2:05 p.m. The RD said everything on the menu needed to be served. The RD said milk was offered to residents but they did not have to take it.</p> <p>-However, observations revealed residents were not offered a choice of milk during the meals (see observations above).</p> <p>The RDC was interviewed on 6/5/24 at 4:05 p.m. The RDC said tartar sauce was never given during meals, especially not for menu items like tuna melt sandwiches.</p> <p>-However, tartar sauce was listed on the menu for the 6/3/24 dinner meal (see record review above).</p> <p>II. Failure to ensure residents were served the correct mechanically altered diets</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A. Professional reference</p> <p>The International Dysphagia Diet Standardization Initiative (IDDSI) altered texture diet information, revised 7/31/2019, was retrieved on 6/12/24 from www.iddsi.org/IDDSI/media/images/Complete_IDDSI_Framework_Final_31July2019.pdf. It read in pertinent part, For level six soft and bite sized texture, no regular dry bread, sandwiches or toast of any kind.</p> <p>Level five minced and moist texture meat should be finely minced or chopped. (Pieces of meat should be equal to or less than four millimeters in width and no more than 15 millimeters in length. Serve in mildly, moderately or extremely thick, smooth, sauce or gravy.</p> <p>B. Facility policy and procedure</p> <p>The Therapeutic Diets policy, revised 4/2023, was provided by the nursing home administrator (NHA) on 6/6/24 at 11:34 a.m. It read in pertinent part, Therapeutic diets must be prescribed by the attending physician.</p> <p>When a therapeutic diet is ordered, it is served correctly. Therapeutic diets are physician orders and must be followed.</p> <p>C. Observations and record review</p> <p>Review of the altered texture menu extensions for the 6/3/24 dinner meal revealed residents receiving altered diet textures were to receive tuna and noodles which had been food processed instead of the regular texture tuna melt sandwich.</p> <p>On 6/3/24 the dinner service was observed during a continuous observation in the kitchen, beginning at 4:30 p.m. and ending at 6:25 p.m.</p> <p>At 5:40 p.m. cook (CK) #1 prepared Resident #38's meal, which included a regular texture tuna melt sandwich served between two pieces of toasted plain white bread.</p> <p>Upon prompting, the registered dietitian (RD) removed the sandwich from Resident #38's plate and replaced it with the soft and bite-sized textured meal item (see menu extension above).</p> <p>At 5:50 p.m. dietary aide (DA) #1 prepared Resident #10's meal, which included a deli ham and cheese sandwich served between two pieces of toasted plain white bread. The ham was sliced deli meat and was not mechanically altered.</p> <p>Upon prompting the RD removed the sandwich from Resident #10's plate and it was replaced with a sandwich with minced and moist meat.</p> <p>-However, without prompting Resident #38 and Resident #10 would have been served a regular texture meal.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The RD was interviewed on 6/3/24 at 5:40 p.m. The RD said Resident #38 could not have bread due to her prescribed diet texture of soft and bite sized.</p> <p>The RD said the sandwich originally made for Resident #10 did not have the correct texture of meat within the sandwich.</p> <p>The RD was interviewed again on 6/4/24 at 2:05 p.m. The RD said there was a three point system to ensure residents got the correct diet texture that started with the cook, followed by the dietary aide, then the certified nurse aide (CNA) that served the resident's food. The RD said she frequently watched the kitchen tray line and saw the kitchen staff follow the mechanically altered diet orders.</p> <p>The RD was interviewed again on 6/5/24 at 9:13 a.m. The RD said she provided education on 6/5/24 (during the survey) to the kitchen staff on the IDDSI diet textures. The RD said her education emphasized that residents with an IDDSI texture less than seven could not receive bread products.</p> <p>The regional dietary consultant (RDC) was interviewed on 6/5/24 at 4:05 p.m. The RDC said soft and bite-size diet textures should have food pieces approximately 15-17 millimeters in size. The RDC said some residents could tolerate bread and serving bread products was left to the decision of the RD.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 6/6/24 at 11:24 a.m. LPN #2 said she had not received any education on altered diet textures and what they included. LPN #2 said altered textures prevented aspiration and choking risks for residents with difficulty swallowing. LPN #2 said Resident #38 had issues with swallowing.</p> <p>The speech language pathologist (SLP) was interviewed on 6/6/24 at 12:02 p.m. The SLP said the facility transitioned to IDDSI diet texture structures in October 2023. The SLP said residents often received downgrades in diet textures due to issues with dentition, mentation and of ease of swallowing.</p> <p>The SLP said Resident #38 was ordered for an altered texture diet on 6/8/23 and changed to a soft and bite-size texture diet on 10/16/23. The SLP said bread products were deemed safe for Resident #38 because she was on an IDDSI level six diet, but that the sandwich should have been cut up into pieces 1.5 to 2 inches in size.</p> <p>The SLP said if the cooks and dietary aides did not provide the residents with the correct diet texture it could potentially result in choking, occlusion or aspiration pneumonia. The SLP said he had not done a formal speech evaluation for any of the residents on altered texture diets as they had not had any incidents that indicated they needed an evaluation.</p> <p>The SLP said Resident #10 had issues with his dentition. The SLP said Resident #10 was prescribed to receive an altered meat texture on 5/24/23. The SLP said any kind of meat that was not ground was fibrous and therefore more difficult to chew. The SLP said whenever residents had dentition issues he wanted to make sure things were not getting stuck. He said Resident #10 had not had any choking incidents. The SLP said there were no indicators that Resident #10 would have issues chewing deli slices of meat, but that meat should be ground up because it was easier for him to chew.</p> <p>IV. Performance improvement plan</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A performance improvement plan and subsequent root cause analysis, initiated 3/15/24, was received from the NHA on 6/6/24 at 11:34 a.m. It read in pertinent part: Problem: Therapeutic diets not followed. Root cause: staff not checking therapeutic menu.</p> <p>Action plan to correct issues identified: education on therapeutic menu. Responsible team members: RD and dietary manager. Start date: 3/20/24. Estimated completion date: 3/25/24.</p> <p>-However, the performance improvement plan addressed concerns with therapeutic diets and not mechanically altered diets.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50219</p> <p>Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the kitchen.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure safe holding temperatures for food items were maintained; -Ensure kitchen staff wore appropriate hair restraints when preparing and serving food to residents; and, -Ensure kitchen staff handled ready-to-eat foods in an appropriate sanitary manner to prevent cross contamination. <p>Findings include:</p> <p>I. Maintain safe holding temperatures for food items</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 6/10/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part,</p> <p>Time/temperature control for safety food cold holding shall be maintained at 5 degrees Celsius (C) (41 degrees Fahrenheit) or less.</p> <p>Time/temperature control for safety food that is cooked to a temperature and for a time specified under SS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57 degrees C (135 degrees Fahrenheit) or above.</p> <p>According to the product guidelines for MedPass Fortified Nutritional Shake, retrieved on 6/11/24 from https://www.hormelhealthlabs.com/resources/for-healthcare-professionals/product-protocols/med-pass-fortified-nutritional-shake-medication-pass-program/,</p> <p>MedPass products can safely remain on a medication cart as long as it is kept at refrigerated temperature range 34 to 40 degrees F.</p> <p>Cover, label and refrigerate opened containers of MedPass products and discard after four days as long as the product has been kept at the proper refrigerated temperature range.</p> <p>According to the product guidelines for ReadyCare Nutritional Drink, retrieved on 6/11/24 from https://lyonsreadycare.com/collections/unintended-weight-loss/products/vanilla-2-0,</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Shelf Life: 9 (nine) months from date of manufacture. Refrigerate after opening and use within 72 hours.</p> <p>B. Facility policy</p> <p>The Food Wholesomeness: Procurement, Storage, Preparation and Service Sanitary Conditions Policy, dated 1/2024, was provided by the NHA on 6/6/24 at 11:34 a.m. It read in pertinent part,</p> <p>Cold foods are kept between 34 to 41 degrees Fahrenheit F before serving and frozen foods are kept at 0 degrees F or below. Hot foods are cooked to above 165 degrees F or per USDA (United States Department of Agriculture) Food Code and held at least 140 degrees F until service.</p> <p>C. Observations</p> <p>On 6/3/24 at 5:04 p.m. initial temperatures were taken of food items that were to be served to residents during dinner service.</p> <p>A tuna melt sandwich, previously heated and meant to be served hot, had a temperature of 133.1 degrees F.</p> <p>Two trays of garden salad were checked for temperatures. One tray, which was sitting on ice on the serving line, had a temperature of 45.5 degrees F. The other tray, which was taken from the refrigerator, had a temperature of 48.9 degrees F.</p> <p>A slice of cheesecake had a temperature of 44.7 degrees F.</p> <p>On 6/4/24 temperatures of food items kept at the nurses' medication carts were obtained. Each medication cart had a small cooler with ice in it. The lid for the cooler on each cart was not able to be closed due to the height of the nutritional supplement bottles inside the coolers.</p> <p>At 1:20 p.m., on the Sagewood wing medication cart, the MedPass nutritional supplement measured 59 degrees F and the ReadyCare nutritional supplement measured 68 degrees F.</p> <p>-The temperatures of both nutritional supplements were above the safe temperature parameter for cold foods of 41 degrees F or less.</p> <p>At 1:27 p.m. on the Pinebrook wing medication cart, the ReadyCare nutritional supplement measured 62 degrees F.</p> <p>-The temperatures of the nutritional supplement was above the safe temperature parameter for cold foods of 41 degrees F or less.</p> <p>D. Staff interviews</p> <p>The nutrition services director (NSD) was interviewed on 6/3/24 at 5:04 p.m. The NSD said the ideal holding temperature for hot foods was 165 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 6/10/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, 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.</p> <p>B. Facility policy</p> <p>The Food Wholesomeness: Procurement, Storage, Preparation and Service Sanitary Conditions Policy, dated 1/2024, was provided by the NHA on 6/6/24 at 11:34 a.m. It read in pertinent part: Bare hands do not touch ready to eat foods.</p> <p>C. Observations</p> <p>The 6/3/24 dinner service was observed during a continuous observation, beginning at 4:30 p.m. and ending at 6:25 p.m. At several points throughout the observation period, CK #1 touched hamburger buns with his bare hands after handling tray cards and serving utensils.</p> <p>Additionally, CK #1 was observed using his bare hands to shift potato chips to the side of the plates to make room for the garden salad on several occasions.</p> <p>-At 5:45 p.m., dietary aide (DA) #1 was preparing sandwiches during the dinner service. DA #1, with bare hands, untied a bag of bread, pulled out two slices of bread with her hand, closed the bread bag and held the bread with her bare hands as she cut it with a knife.</p> <p>-DA #1 proceeded to place the bread, still with her bare hands, onto a plate.</p> <p>-DA #1 had been touching tray cards, a cart at the end of the tray line and serving utensils prior to touching the bread with her bare hands.</p> <p>At 6:25 p.m. DA #1 again took bread from the bread bag with her bare hands and placed it on a plate. DA #1 added egg salad, then placed another piece of bread on top of the sandwich with her bare hands.</p> <p>-Again, DA #1 had been touching tray cards, a cart at the end of the tray line, and serving utensils prior to touching the bread with her bare hands.</p> <p>D. Staff interview</p> <p>The RD was interviewed on 6/4/24 at 2:05 p.m. The RD said she had not seen staff handling ready-to-eat foods with their bare hands. The RD said ready-to-eat foods should be handled with tongs.</p>		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064</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 diseases and infection on two of four units.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfecting resident rooms and high frequency touch areas (call lights, bed controls and light switches); -Ensure housekeeping staff were trained appropriately on housekeeping procedures; and, -Ensure surface disinfectant dwell times (how long surfaces remained wet with disinfectant) were adhered to. <p>Findings include</p> <p>I. Professional reference</p> <p>Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 6/6/24 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part,</p> <p>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.</p> <p>The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 6/5/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part,</p> <p>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Fairacres Manor, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 18th Ave Greeley, CO 80631	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs.</p> <p>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.</p> <p>II. Facility policy and procedure</p> <p>The Cleaning and Disinfection of Environmental Surfaces policy and procedure, revised August 2019, was received from the nursing home administrator (NHA) on 6/6/24 at 12:59 p.m. revealed in pertinent part</p> <p>Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of health care facilities.</p> <p>Manufacturer's instructions will be followed for proper use of disinfecting products including: recommended use-dilution, material compatibility, storage, shelf-life, safe use and disposal.</p> <p>III. Disinfectants used in the facility</p> <p>The [NAME] Bay TableTop Sanitizer product sheet, undated, was provided by the NHA on 6/6/24 at 12:59 p.m. It revealed in pertinent part, Treated surfaces must remain wet for three minutes.</p> <p>The [NAME] Bay Acid Free Disinfectant Restroom Cleaner product sheet, undated, was provided by the NHA on 6/6/24 at 12:59 p.m. It revealed in pertinent part, Treated surfaces must remain wet for 10 minutes.</p> <p>IV. Observations</p> <p>During a continuous observation on 6/4/24, beginning at 8:55 a.m. and ending at 9:39 a.m., Housekeeper (HSK) #1 was observed cleaning room [ROOM NUMBER] (a shared resident room).</p> <p>HSK #1 sprayed the toilet and toilet riser with [NAME] Bay Bathroom Disinfectant. HSK #1 waited 10 minutes then took a dry rag and wiped the toilet down, however the surface did not remain wet for 10 minutes.</p> <p>HSK#1 cleaned the bathroom in the following order: starting with the toilet bowl rim, the outside toilet pedestal to the floor, toilet seat, toilet lid, and lastly the water tank reservoir on the back of the toilet. HSK #1 wiped down the toilet riser starting with the toilet seat, toilet lid and then the handle bars.</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 - Few</p>	<p>-HSK #1 failed to disinfect the toilet and toilet riser from the cleanest area to the dirtiest area.</p> <p>-HSK #1 failed to allow the toilet and toilet riser surfaces to remain wet for the recommended dwell time.</p> <p>-HSK #1 proceeded to wipe down the grab bars in the bathroom with the same rag used to clean the toilet. She did not spray the grab bars with the disinfectant prior to wiping them with the dirty rag.</p> <p>HSK #1 sprayed a new dry rag four times with [NAME] Bay Tabletop Sanitizer. She wiped the entrance door handles, the door, bedside tables and dressers for both residents in room [ROOM NUMBER]. The surfaces of the items remained wet for approximately 30 seconds.</p> <p>-HSK #1 failed to change rags between each resident's side of the room.</p> <p>-HSK #1 failed to spray the disinfectant on the surfaces and allow the surfaces to remain wet for the recommended dwell time.</p> <p>-HSK #1 failed to clean all high touch surfaces in the resident's room (see professional reference above).</p> <p>During a continuous observation on 6/4/24, beginning at 9:42 a.m. and ending at 10:04 a.m., HSK #1 was observed cleaning room [ROOM NUMBER] (a shared resident room).</p> <p>HSK #1 wiped down the bathroom in room [ROOM NUMBER] with a dry rag after spraying the bathroom with [NAME] Bay Bathroom Disinfectant in the following order: beginning with the sink faucet handles, sink bowl, toilet riser handles, seat of the toilet riser, grab bars on the walls in the bathroom.</p> <p>HSK #1 then wiped down the toilet in the following order: beginning with the toilet bowl rim, toilet seat, toilet lid and water tank reservoir on the back of the toilet. HSK#1 wiped down the paper towel dispenser with the same rag she used to wipe the sink, toilet riser and toilet.</p> <p>-HSK #1 failed to allow the surfaces in the bathroom, including the toilet and toilet riser surfaces, to remain wet for the recommended dwell time.</p> <p>-HSK #1 failed to disinfect the bathroom from the cleanest area to the dirtiest area.</p> <p>At 9:45 a.m. HSK #1 sprayed a dry cloth with [NAME] Bay Tabletop Sanitizer and proceeded to wipe the door handles, bedside tables, night stands and dressers for both residents in room [ROOM NUMBER]. The surfaces of the items remained wet for approximately 15 seconds</p> <p>-HSK #1 failed to change rags between each resident's side of the room.</p> <p>-HSK #1 failed to spray the disinfectant on the surfaces and allow the surfaces to remain wet for the recommended dwell time.</p> <p>-HSK #1 failed to clean all high touch surfaces in the resident's rooms (see professional reference above).</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 - Few</p>	<p>V. Staff interviews</p> <p>HSK #1 was interviewed on 6/4/24 at 10:05 a.m. HSK #1 said the [NAME] Bay Tabletop Sanitizer had a two to three minute dwell time and the bathroom disinfectant had a 10 minute dwell time. HSK #1 said the surfaces did not need to remain wet the entire dwell time to be effective.</p> <p>HSK# 1 said she used only two rags to clean resident rooms, one for the bathroom and a second one for the residents' room. HSK #1 said the number of rags used did not change if the resident room was a single resident room or a shared resident room.</p> <p>HSK #1 identified door handles, dresser handles, toilets and grab bars as high touch surface areas which needed to be cleaned daily. HSK #1 said she forgot to clean the call lights, bed controls and light switches in room [ROOM NUMBER] and room [ROOM NUMBER]. HSK #1 said she should have cleaned all high touch surfaces to help prevent infections.</p> <p>The housekeeping laundry manager (HLM) was interviewed on 6/5/24 at 1:07 p.m. HLM said the [NAME] Bay Bathroom Disinfectant had a 10 minute dwell time and the [NAME] Bay Tabletop Sanitizer had a two to three minute dwell time. The HLM said the [NAME] Bay Bathroom Disinfectant had a 10 minute dwell time however most times it would dry before the 10 minutes was up.</p> <p>The HLM said the housekeepers should re-wet the surface to ensure that it stayed wet for the entire 10 minutes. The HLM said dwell times were important to follow to ensure the disinfectant properly disinfected the areas being cleaned for infection prevention.</p> <p>The HLM said the bathroom should be wiped down from the cleanest areas to the dirtiest to prevent moving bacteria from higher soiled areas to a less soiled area. The HLM said bathrooms should be wiped down in the following order: sink handles, sink bowl, light switch, towel racks, and toilet areas last.</p> <p>The HLM said the toilet should be wiped down in the following order: tank reservoir, toilet lid, toilet seat, toilet bowl rim and last the outside pedestal to the floor.</p> <p>The HLM said if the housekeepers were not wiping in the correct order they were contaminating the other areas in the bathroom.</p> <p>The HLM said the housekeepers should use at least two rags in the bathroom to ensure proper cleaning and disinfection.</p> <p>The HLM said high touch areas in resident rooms, such as the call lights, television remotes, bed controls, bedside tables and door knobs/handles, should be disinfected/cleaned daily.</p> <p>-The HLM said housekeepers could use the same rag for both residents in one room as long as they used different sides of the rag for bed A versus bed B.</p> <p>The HLM said she would like to complete audits on housekeepers for proper cleaning and disinfecting techniques at least monthly but she had not been able to complete those audits yet.</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 - Few</p>	<p>The infection preventionist (IP) was interviewed on 6/6/24 at 10:40 a.m. The IP said he met with the HLM frequently about potential infections and to ensure correct soap/disinfectants were being used appropriately.</p> <p>The IP did not know the dwell time for the [NAME] Bay Tabletop Sanitizer or bathroom disinfectant. The IP said if the manufacturer's recommendations said the surface needed to remain wet for a certain amount of time, the dwell time should be followed to ensure proper disinfection was completed.</p> <p>The IP identified the bedside tables, grab bars, bed rails, television remotes, bed controls, door handles and resident water cups as high touch surface areas in residents' rooms.</p> <p>The IP said when housekeepers were cleaning a bathroom they should clean it from the cleanest area to the dirtiest area to prevent moving bacteria/germs from the dirtier area to a cleaner area.</p>