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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                    | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>065228 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                            | (X3) DATE SURVEY COMPLETED<br><br>07/23/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Orchard Valley Health and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>151 E 3rd St<br>Palisade, CO 81526 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 40467</p> <p>Based on observations, record review and interviews, the facility failed to maintain an environment for residents, staff and the public that is safe, functional, sanitary and comfortable.</p> <p>Specifically, the facility failed to ensure appropriate communication occurred regarding the facility's [AGE] year old hot water heater. The facility's failure to address the concerns timely resulted in the hot water heater failing and the facility was without hot water to provide a comfortable bathing experience for residents during a three week time period.</p> <p>Finding include:</p> <p>I. Facility policy and procedure</p> <p>The Promoting/Maintaining Resident Dignity policy, dated 1/1/23, was obtained from the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part,</p> <p>All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</p> <p>The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.</p> <p>II. Group resident interview</p> <p>Four residents (#16, #49, #59 and #65), who were identified as interviewable by the facility and assessment, were interviewed on 7/22/24 at 9:30 a.m. The following comments were made regarding the lack of hot water:</p> <p>-A resident said the facility had a hard time the first couple of days without hot water. The staff was not sure how to meet all the hot water needs when the hot water heater went down. The facility purchased basins to help with bathing. The staff would fill the basins with hot and cold water.</p> <p>-A resident said she normally had two showers a week. She said it would have been nice to have a shower but gave herself a sponge bath. She said it was hard to scrub her own back. She said the staff would offer to give her a bed bath at times.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>-A resident said she was worried that the lack of hot water would affect her personal hygiene and health. She said her skin had itched because she had not felt clean.</p> <p>-A resident said the staff would offer bed baths sometimes during the time the hot water heater was out and he would wash himself in the private areas but it was difficult. He said he felt the facility could have done more to make sure there was hot water for the showers. He said he was used to two showers a week and did not feel completely clean when he could not shower.</p> <p>III. Additional resident interviews</p> <p>Resident #16 was interviewed on 7/18/24 at 10:31 a.m. Resident #16 said the hot water went out for three or four weeks. Resident #16 said she was not able to shower during that time, and her wound care had to be provided differently than normal. Resident #16 said the lack of hot water made her feel like she wasn't getting cleaned as well or as often. Resident #16 said most residents hated the bed bath alternative that was offered during the three week period, but she said the only other choice was a cold shower. Resident #16 said she had not felt comfortable without hot water since that was a basic necessity of everyday life.</p> <p>Resident #65 was interviewed on 7/18/24 at 2:39 p.m. Resident #65 said he did not like either of the alternative bathing options presented so he chose to shower in cold water when the facility did not have hot water. Resident #65 said that showering with cold water day after day was an aggravating experience for him.</p> <p>Resident #59 was interviewed on 7/18/24 at 2:50 p.m. Resident #59 said when the hot water went out, many residents were not offered showers as often as they preferred. Resident #59 said she was offered alternative shower options but only once per week. Resident #59 said she preferred to shower three times per week. Resident #59 said she felt dirty and upset when the hot water was out and the bathing experience offered was uncomfortable for her. Resident #59 said she felt she had no other choice.</p> <p>Resident #10 was interviewed on 7/23/24 at 2:54 p.m. Resident #10 said the hot water was out for about three or four weeks in the facility and no one could take a hot shower. Resident #10 said she was not offered showers per her normal preference without the hot water. Resident #10 said she hated the bed bath option with water heated from the kitchen, but she would have tried that if she had ever been offered that option from staff. Resident #10 said she felt like any facility should have hot water and not being able to access warm water when she needed to had been very frustrating.</p> <p>Resident #40 was interviewed on 7/23/24 at 3:12 p.m. Resident #40 said she was never offered a bath in the period when the facility was without hot water. Resident #40 said she had wanted a normal hot shower like any facility should have and she just didn't want to take a cold shower. Resident #40 said she felt the bed bath option was demeaning for residents who normally showered themselves.</p> <p>IV. A frequent visitor (FV) was interviewed on 7/17/24 at 9:16 a.m. The FV said there was no hot water in the facility for resident showers for over three weeks between May 2024 and June 2024. She said there was a significant odor in the facility during that period of time.</p> <p>V. Resident council minutes</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>The 5/28/24 resident council minutes documented the NHA said she would contact the facility's corporation on the afternoon of 5/28/24 to discuss the water heater and then would inform the residents on the water status when she knew more.</p> <p>The 6/24/24 resident council minutes documented the hot water heater has been fixed.</p> <p>VI. Record Review</p> <p>A 5/13/24 impromptu QAPI meeting agenda/summary form was provided by CC #4 on 7/18/24 at 5:30 p.m. The summary form read the form was to be used between meetings to address an opportunity for improvement which required immediate response. According to the summary, the opportunity for improvement was a malfunction of the singular hot water heater that provided hot water to the entire building. The form identified the facility's response/plan:</p> <ul style="list-style-type: none"> <li>-The HVAC vendor attempted to repair the hot water heater on 5/12/24. It was determined to be nonrepairable.</li> <li>-Ensure adequate paper products for the meals.</li> <li>-Ensure adequate bath packets for all residents three times a week for three weeks.</li> <li>-Notify residents and their families.</li> <li>-5/12/24 notification of the company and landlord.</li> <li>-Completion of a provided proposal for replacement on 5/13/24.</li> <li>-Educate staff on hand hygiene, bed baths and temperature safety.</li> <li>-Kitchen hot water and sanitation education.</li> <li>-Kitchen hot water and sanitation log.</li> </ul> <p>The 5/10/24 HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice identified the water heater was inspected, repairs were made and the counter steamer transformer was replaced. The invoice read the water heater was not firing and water was leaking from the heat exchanger tubes, which was a sign that the water heater was going bad.</p> <p>The 5/12/24 HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice read the water heater was not lighting. According to the invoice, the vendor was contacted on 5/12/24 due to the water heater not operating. The vendor arrived at the facility and observed water from the water heater was leaking onto the burners and water was leaking from the tubes of the heat exchanger. After multiple attempts to light and repair the hot water heater it was determined it was no longer safe for use and needed to be replaced.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>An undated HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice read the vendor received a monetary deposit on 5/30/24 and ordered the water heaters on 5/30/24. The water heaters would be delivered from two separate supply distributors. The estimated arrival delivery date of the water heaters was on 6/4/24. The demolition of the old water heater system was started on 6/4/24. The first water heater arrived on 6/4/24 and was installed and identified as in normal operation condition.</p> <p>According to the invoice, the original freight company that was scheduled to deliver the remaining water heaters was not available to deliver as scheduled. The HVAC vendor company offered to pick up the water heaters and deliver them to the facility on [DATE]. Installation was started and completed between 6/7/24 and 6/10/24. The invoice read, on 6/10/24, all three water heaters were in normal operating condition.</p> <p>A 5/31/24 mandatory manual wash in-service was provided by CC #4 on 7/18/24 at 5:30 p.m. The attendance for the in-service was signed by 12 staff members between 5/31/24 and 6/7/24. The inservice reviewed the policy and procedure to manually wash and sanitize all cookware, silverware and serviceware that was not processed through the dish machine.</p> <p>The 6/10/24 HVAC vendor service receipt was provided by the DMS on 7/22/24 at 1:40 p.m. The receipt read the failure of one water heater should no longer affect the hot water supply to the facility.</p> <p>The June 2024 quality assurance and performance improvement (QAPI) meeting minutes were provided by the NHA on 7/23/24 at approximately 9:15 a.m. The QAPI minutes documented the following in pertinent part: Hot water heater stopped working on 5/12/24. Final repairs completed on.</p> <p>-The QAPI minutes did not include the date the final repairs were completed.</p> <p>-The QAPI minutes did not include additional review of the lack of hot water facility response or revisions made to the facility ' s emergency plan.</p> <p>VII. Staff interviews</p> <p>The director of maintenance services (DMS) was interviewed on 7/18/24 at 1:52 p.m. The DMS said on 5/12/24 the hot water heater broke. He said he contacted the NHA and the regional consultant. He said he contacted a heating, ventilation and air conditioning (HVAC) service vendor and attempts were made to repair the hot water heater but it was determined the hot water heater was not repairable. He said he and the NHA started a plan of correction. He said the facility started boiling water from the kitchen, bed bath kits were ordered and hot water was collected from the hot and cold water drink dispensing towers. He said the kitchen started using paper products for meals.</p> <p>The DMS said the facility corporation was contacted and told it was an emergency. The corporation requested bids for a new water heater and repairs. The DMS said the facility's landlord and stakeholder had to also approve of the process. The DMS said, overall, the whole process went well and the residents seemed accepting of the changes and complained very little.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>The DMS said he did not believe the facility had a hot water heater policy to outline the procedures of what to do if the facility did not have hot water readily available. He said before the hot water heater broke, the facility did not have a back up plan. The DMS said the facility now had a three water heater system so if one went out, the other water heaters would still be able to provide the facility with hot water. He said each of the new hot water heaters were 100 gallons each.</p> <p>The DMS said the prior water heater was over [AGE] years old and was leaking before it stopped working. He said the HVAC vendor came out to service the heater and recommended the facility get a new water heater. The DMS said he informed the NHA and his regional consultant of the recommendations but he was not sure exactly when he informed them. He said he was told to do the best he could as long as the hot water heater was still working.</p> <p>The DMS said there were no follow up meetings after the new hot water heaters were installed. He said the facility did not review the event after the incident to put new procedures in place. He said the facility was still pulling everything together.</p> <p>Certified nurse aide (CNA) #7 was interviewed on 7/18/24 at 1:55 p.m. CNA #7 said the hot water was out for about almost a month in the facility in May 2024. CNA #7 said the facility had offered residents bed baths with water warmed from the kitchen, or prepackaged bathing cloths during that time period. CNA #7 said most residents did not like either alternative bathing option. CNA #7 said a lot of residents in the facility refused baths while the hot water was out.</p> <p>CNA #8 was interviewed on 7/18/24 at 2:01 p.m. CNA #8 said the facility did not have hot water for three or four weeks in May 2024. CNA #8 said the facility had offered residents prepackaged bathing cloths or bed baths during that time period. CNA #8 said many residents refused both alternative bathing options while the hot water was out.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 7/18/24 at 2:10 p.m. LPN #1 said the facility had offered residents prepackaged bathing cloths or a warm water basin bath as alternative bathing options while the hot water was out. LPN #1 said the residents who showered themselves independently were the most upset when the facility was without hot water.</p> <p>The director of nursing (DON) was interviewed on 7/18/24 at 2:29 p.m. The DON said when the hot water heater broke, her main focus was the residents' personal hygiene and sanitary conditions for preparation and service. She said wound care was not impacted by the lack of hot water. The DON said more disposable paper products were ordered for meal services. She said the facility ordered shower caps, more bed bath kits and water basins.</p> <p>The DON said the staff tried to offer bed baths on the same days the residents were usually scheduled for their showers. She said the residents were told they could also ask for bed baths and/or wipes if they felt they needed additional bathing opportunities. She said some residents were able to bathe at their family's homes. The DON said bathing wipes were warmed to help the residents feel more comfortable. She said the temperature of the hot water from the hot water drinking dispensers was taken and used for personal washing. She said the facility verbally informed the residents about the limited hot water and families were informed by letters. She said the lack of hot water from the hot water heater lasted for about three weeks, from May 2024 to June 2024. She said the facility now had three hot water heaters so if one water heater went down the facility would still have two working hot water heaters.</p> <p>(continued on next page)</p> |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>The DON said staff expressed some frustration during the event. She said the bed baths took more staff time and there were more resident refusals than expected. The DON said many of the residents expressed understanding of the situation. She said once the hot water heaters were replaced, all residents were back to having their regular showers scheduled. She said everything was now back to normal.</p> <p>The NHA was interviewed on 7/18/24 at 2:50 p.m. The NHA said when the DMS informed her of the broken hot water heater, she informed her corporate consultants and regional operation managers of the situation and started to put interventions in place. The NHA said on 5/13/24 she created a plan to review and identify needed supplies such as paper products, and bathing kits. She said she notified the residents of the situation and sent letters out by email to families.</p> <p>The NHA said she put together a three week plan because the HVAC vendor estimated it would take two to three weeks to have the water heater ordered and replaced. She said she discussed the costs with the corporation after getting quotes. The NHA said the facility had to decide on whether to have the hot water heater replaced quickly or take a little longer and get a better system that would include three water heaters so if one went down there would be a backup. She said by the end of the week of 5/13/24, the facility had decided to go with the three tank system. She said the hot water heaters needed to be ordered and transported from several miles away because there was nothing compatible in the area.</p> <p>The NHA said the HVAC vendor informed her that he would be able to do the labor within 24 to 48 hours of the delivery of the tanks. She said most of the delay for getting the hot water heater tank replaced was related to the release of the funds to the HVAC vendor so the tanks could be ordered. She said when the HVAC vendor received payment he ordered the tanks but the transportation company to deliver the tanks could only do part of the trip. She said the HVAC vendor had to find another company to transport the tanks the remainder of the way. The NHA said the tanks were delivered and installed on 6/4/24 and by 5:30 p.m. that day, the facility had running hot water throughout the facility with one domestic tank/heater operational. She said by 6/7/24, the other two tanks were installed and running. The NHA said the event was discussed in the June 2024 quality assurance and performance improvement (QAPI) meeting with the interdisciplinary team (IDT) (see record review above).</p> <p>Corporate consultant (CC) #4 was interviewed on 7/18/24 at 4:52 p.m. CC #4 said the facility did not have a lack of hot water policy and procedure. She said the closest the facility had was the plan created on 5/13/24, after it was determined the facility would be without hot water until the parts and repairs were in place.</p> <p>The DMS was interviewed again on 7/22/24 at 1:40 p.m. The DMS said he did not document his observations of the leaks with the hot water heater or communication of the leaks or invoices from the HVAC vendor when they came out to look at the leaks prior to May 2024.</p> <p>The HVAC service vendor was interviewed via telephone on 7/22/24 at 2:10 p.m. He said he was called out to the facility on [DATE] because the hot water heater was not firing up. He said the water was leaking from the heat exchanger tubes. He said he recommended replacing the water heater. The HVAC vendor said he replaced the burner assembly unit and transformer on 5/10/24.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>The HVAC vendor said he came out again on 5/12/24 when the hot water heater was not working again. He said water was leaking onto the burners and water was leaking from the heat exchanger. He said the water heater was shut off on 5/12/24 because it was no longer safe to run it.</p> <p>The HVAC vendor said he was at the facility in January 2024 or February 2024. He said the expansion unit on the hot water heater had a hole in the unit, but the unit was not leaking at that time. He said, due to the price, the facility did not proceed with replacing the expansion tank. He said without a working expansion unit, he was not able to determine if there were additional problems with the system. The HVAC vendor said the facility had a separate tank that was working for domestic water. He said he did not have access to the invoices from January 2024 or February 2024 to determine the date when he came out to the facility because he was no longer working for that company.</p> <p>The HVAC vendor said he asked the facility if they had a policy for the hot water heater and he asked for one but never got an answer or the policy.</p> <p>The NHA and the DMS were interviewed together on 7/23/24 at approximately 9:15 a.m. The DMS said the facility did not have a safety meeting but plant operations were reviewed in QAPI. He said the review was mainly regarding fire drills or tabletop reviews of a potential emergency. He said the facility did not identify the lack of hot water if the hot water heater went out as a potential facility emergency, however he was concerned the hot water heater would go out in the middle of the night. He said the hot water heater was over [AGE] years old and there was some leaking and some corrosion on the old pipes. He said the system would shut itself off if there was a problem for safety.</p> <p>The DMS said, on 5/10/24, the hot water heater system would not light. The NHA was informed of the above interview with the hot water heater service vendor. The DMS said he also saw some leaking in April 2024 and had the vendor look at it, however, he said he had not informed the NHA that the hot water heater was leaking at that time. He said part of the system related to the copper coils boiler was disconnected to stop the leak. He said the facility had been operating with the one [AGE] year old hot water heater tank since April 2024. He said the one tank was due to be replaced. He said he did not think the corporation was aware that the facility had only one tank available that was [AGE] years old. The DMS said he did not record or document the past repairs, recommendations or observations to reference but he should have.</p> <p>The NHA said she was not aware that a new expansion tank was recommended by the vendor in January 2024 or February 2024.</p> <p>The NHA said during the hot water heater event, the residents were not in danger and basic needs were accommodated for. She said after the hot water heater event she learned that the facility needed to be more prepared with needed supplies, such as disposable paper products for food. She said the facility needed to make sure they had at least three days worth of supplies on site. She said the facility needed to have more bathing kits available in case of an emergency. She said the water heater event was an emergency.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>The NHA said, in retrospect, the facility could have benefited from an extra certified nursing assistant (CNA) on some of the busier days. She said staff did not complain a lot but she felt some of the staff needed more training on how to manage the situation with less frustration versus increasing the number of staff. She said she would like to have the staff go through additional training on crisis management. The NHA said nothing had been scheduled yet for the training and she needed to look at the training schedule to determine when it could be set up. She said she would reach out to CC #4 and other sister facilities to see if there were training materials available.</p> <p>The NHA said to directly prevent the lack of hot water available, the new hot water system was purchased. The NHA said she did not have documentation that a post review of the hot water event was conducted or actions moving forward to prevent similar situations other than a reference in QAPI. She said she and the dietary manager verbally talked about the needed kitchen supplies and steps to take during the water heater event, but a procedure was not created and put in place after the water heater event to help mitigate future emergencies that involved the kitchen. The NHA said she would like to have three weeks for some supplies in the event of an emergency but had to see where there was enough space to stock the supplies. The NHA said reviewing the event following the incident on what the facility learned and what the next steps were to put in motion to help with future emergencies could use improvement.</p> <p>The NHA said the facility did not have a specific lack of hot water plan but it would be appropriate to have a policy in place. She said she would reach out to her corporate resources on how to create the policy and procedures. She said the policy would be implemented and added to the facility's emergency plan. The NHA said if the facility had a policy and procedure available, she would have added it with her plan as part of the facility's response and use it as additional guidance.</p> <p>50314</p> |   |  |