

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  065234	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/29/2024
NAME OF PROVIDER OR SUPPLIER  Evergreen Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  1991 Carroll Ave Alamosa, CO 81101	

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 - Few</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** 48114</b></p> <p>Based on observations and interviews, the facility failed to provide a functional, comfortable and homelike environment for residents on two of two units.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure the residents residing in room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER] were provided with appropriate hot water in the bathroom sinks; and,</li> <li>-Ensure high back dining room chairs in the secure unit dining room and the main dining room were free from cracks and tears.</li> </ul> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Resident Rights policy and procedure, revised 9/25/23, was provided by the director of nursing (DON) on 8/29/24 at 9:32 a.m. It read in pertinent part, At the time of admission and periodically throughout their stay, the facility will inform each resident, orally and in writing of their rights.</p> <p>A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.</p> <p>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.</p> <p>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to, receiving treatment and support for daily living safely.</p> <p>II. Observations and interviews</p> <p>On 8/26/24 at 12:43 p.m. the hot water in the bathroom sink of room [ROOM NUMBER] was observed to be cool to the touch.</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 - Few</p>	<p>The resident who resided in room [ROOM NUMBER] said the hot water had always been cold and not hot.</p> <p>On 8/26/24 at 2:40 p.m. the hot water in the bathroom sink of room [ROOM NUMBER] was observed to be cool to the touch.</p> <p>The resident who resided in room [ROOM NUMBER] said the water had never been hot and was always cool.</p> <p>On 8/28/24 at 12:58 p.m. the hot water temperature in the bathroom sink of room [ROOM NUMBER] was taken with a traceable thermometer held under the running water for three minutes and 58 seconds. The temperature of the water was 102.1 degrees Fahrenheit (F).</p> <p>On 8/28/24 at 1:30 p.m. the hot water temperature in the bathroom sink of room [ROOM NUMBER] was taken with a thermometer held under the running water for three minutes. The temperature of the water was 94.8 degrees F.</p> <p>On 8/28/24 at 2:03 p.m. the hot water temperature in the bathroom sink of room [ROOM NUMBER] was taken with a thermometer held under the running water for one minute. The temperature of the water was 109.7 degrees F.</p> <p>On 8/29/24 at 9:16 a.m. four high back dining room chairs in the secure unit dining room were observed to have several cracks and tears on the seats of the chairs.</p> <p>On 8/29/24 at 10:37 a.m. three high back dining room chairs in the main dining room were observed to have several cracks and tears on the seats of the chairs.</p> <p>An environmental tour was conducted on 8/29/24 at 12:19 p.m. with the maintenance director (MTD) and the above concerns were observed. The MTD said he needed to replace the circulation pump on the water heater. He said the facility had had the circulation pump for a year and he had not replaced it. He said he would be working on getting it replaced.</p> <p>The MTD was shown the dining room chairs in the main dining room and the secure unit dining room. He said he did an audit a year ago (2023) on all the chairs that needed to be replaced. He said he had been trying to get them replaced. He said he had not heard back from corporate management about getting them replaced.</p> <p>The MTD said he did a walk through of the facility every morning. He said he looked at the exit light signs, lights and fire extinguishers. He said there was a maintenance request book at each of the nurse's stations. He said when staff saw something that needed to be repaired or fixed they wrote it down in the maintenance request book. He said he looked at the maintenance request book every day. He said the facility's system that was supposed to communicate staff requests for facility repairs into maintenance repair tickets was not up and running and he was the only one who had been trained on the system. He said if the facility had the system up and running it would make things easier for him to see what repairs needed to be done.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MTD said if he had any issues with the repairs he would notify the NHA. He said the NHA did not do rounds with him. He said she did her own rounds. He said if the NHA had any questions for him regarding items needing repair she would notify him. He said if he had to get a part from the local hardware store, the NHA had to approve it. He said anything that cost above \$500.00 to repair had to be approved by the NHA. He said if he had a question about a room or bigger projects that needed fixed or repaired, he would bring the NHA to see the concern. He said he communicated with the NHA all the time regarding repairs around the facility.</p> <p>III. Additional staff interviews</p> <p>The housekeeping and laundry manager (HLM) was interviewed on 8/29/24 at 9:20 a.m. The HLM said the dining room chairs on the secure unit and main dining room were cleaned as needed and weekly. She said the facility was working on getting the torn chairs replaced.</p> <p>The nursing home administrator (NHA) was interviewed on 8/29/24 at 9:25 a.m. The NHA said she was not aware that the dining room chairs in the main dining room and secure unit had cracks and tears on the seats of the chairs.</p> <p>-However, according to the MTD, he communicated with the NHA all the time about items in the facility that needed repair (see MTD interview above).</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064</b></p> <p>Based on record review and interviews, the facility failed to ensure one (#18) of three residents out of 26 sample residents reviewed for assistance with activities of daily living (ADL) received appropriate treatment and services to maintain or improve his or her abilities.</p> <p>Specifically, for Resident #18, the facility failed to:</p> <ul style="list-style-type: none"> <li>-Ensure a wheelchair positioning device was care planned; and,</li> <li>-Ensure the wheelchair positioning device was positioned appropriately and consistently to keep the resident from leaning in her wheelchair.</li> </ul> <p>Findings include:</p> <p>I. Resident #18</p> <p>A. Resident status</p> <p>Resident #18, age greater than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease (abnormal memory), kyphosis (outward curve in the spine), dysphagia (difficulty swallowing) and hypertension (high blood pressure).</p> <p>The 6/26/24 minimum data set (MDS) assessment revealed the resident had short and long term memory issues. She was dependent on staff for toileting, personal hygiene, transfers, dressing and required supervision with eating. She was dependent on staff for mobility with a manual wheelchair.</p> <p>B. Observations</p> <p>On 8/26/24 at 1:41 p.m. Resident #18 was observed sitting in her wheelchair with a specialized positioning device on the left side of the wheelchair. Resident #18 was leaning to her left with her arm tucked in to her side. The resident's arm was not positioned on top of the positioning device.</p> <p>On 8/27/24 at 2:34 pm Resident #18 was sitting in her wheelchair participating in an activity in the dining room. Resident #18 was leaning to the left but there was no positioning device on the left side of the wheelchair.</p> <p>On 8/28/24 at 11:36 a.m. Resident #18 was in the dining room for lunch and was seated in her wheelchair with the positioning device positioned on the left side of the wheelchair. Resident #18 was leaning to her left side with her arm tucked into her side and not on top of the positioning device.</p> <p>The director of nursing (DON) entered the dining room and observed that Resident #18 did not have her left arm positioned on top of the positioning device. The DON proceeded to place Resident #18's left arm on top of the wheelchair positioning device.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said the resident's left arm should be resting on top of the positioning device to aid in positioning her appropriately because the resident leaned to her left.</p> <p>C. Record review</p> <p>The August 2024 CPO revealed a physician's order for an arm wedge under the resident's left arm while in the wheelchair to assist with positioning, ordered 8/28/24 (during the survey).</p> <p>The 5/9/22 comprehensive care plan failed to document Resident #18's use of the wheelchair positioning device.</p> <p>Review of occupational therapy (OT) notes for Resident #18 revealed the following:</p> <p>Resident #18 was working with OT services beginning 6/11/24 and the OT recommended further wheelchair positioning due to staff reporting the resident was leaning in her wheelchair at times.</p> <p>Resident #18 was to receive wheelchair management training two times a week for 12 weeks starting 8/7/24.</p> <p>On 8/7/24 staff reported an increase in Resident #18's left sided leaning in her wheelchair at times and wheelchair positioning devices were recommended by the OT.</p> <p>On 8/20/24 OT notes revealed Resident #18 had a significant forward flexion (forward bend) when sitting in the wheelchair but positioned midline (more upright in the middle) with a new left side support.</p> <p>-However Resident #18 was observed leaning to the left due to the positioning device not being positioned appropriately in the wheelchair (see observations above and DON interview below).</p> <p>-There was no documentation to indicate staff were educated on the appropriate way to position Resident #18's positioning device to ensure she did not lean to her left while she was in her wheelchair.</p> <p>III. Staff interviews</p> <p>The DON was interviewed on 8/28/24 at 11:36 a.m. The DON said Resident #18 had a wheelchair cushion on the left side of her wheelchair to aid in positioning the resident since she had a tendency to lean to the left. The DON said because the device was used for positioning, the resident's arm should be placed on top of the positioning device (see record review above).</p> <p>The DON said the wheelchair positioning device should be careplanned for use to ensure all staff were aware of Resident #18's need for the positioning device.</p> <p>The restorative nurse aide (RNA) #1 was interviewed on 8/28/24 at 12:45 p.m. RNA #1 said Resident #18 had been using the wheelchair positioning device for a while. RNA #1 said the device was used to assist Resident #18 to sit up straight in her wheelchair due to her tendency to lean to the left.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RNA#1 said Resident #18 should have her left arm at her side because she did not have great range of motion in her shoulder. RNA #1 said he did to know if it made a difference in the resident's positioning whether the resident kept her arm next to her or on top of the cushion.</p> <p>-However, according to the DON's interview (see above) the resident's arm should be positioned on top of the positioning device to ensure proper positioning in the wheelchair.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/28/24 at 12:49 p.m. LPN #1 said Resident #18 had had the wheelchair positioning cushion for a while. LPN #1 said Resident #18 leaned towards her left side but she was not sure why she leaned to that side. LPN #1 said she did not know if the resident had to have her arm on the cushion or if at her side was acceptable positioning.</p> <p>Certified nurse aide (CNA) #2 was interviewed on 8/29/24 at 12:33 p.m. CNA #2 said Resident #18's wheelchair positioning device was to be used when she was sitting in her wheelchair because she leaned to her left in the wheelchair.</p> <p>-Staff were aware Resident #18 used a positioning device on the left side of her wheelchair, however, staff were unable to verbalize how the resident's arm should be positioned on the positioning device to ensure the resident was sitting upright in her wheelchair.</p>		