

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Pioneer Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S 12th St Rocky Ford, CO 81067	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821</p> <p>Based on observations and staff interviews, the facility failed to maintain a sanitary, orderly and comfortable environment for residents in 28 of 55 resident rooms.</p> <p>Specifically, the facility failed to ensure:</p> <ul style="list-style-type: none"> -The walls, ceilings, baseboards and floors were properly maintained; -The resident's rooms were cleaned and free of mice feces, flies; and, -The wooden handrails in the hallways were cleaned and free of wood splinters. <p>Findings include:</p> <p>I. Observations</p> <p>Observations of the resident's living environment were conducted on 8/27/24 at 9:44 a.m. and revealed the following:</p> <p>room [ROOM NUMBER]: The ceiling had three missing 12 inch by 12 inch tiles. The walls had several sections approximately four inches in circumference on the wall next to the bathroom. The resident had a five drawer dresser in the corner of his room with each drawer containing dried mice droppings. The floor was sticky. There were tissues and other trash under the resident's bed.</p> <p>room [ROOM NUMBER]: The wall next to the bathroom had chipped and peeling plaster approximately 14 inches high by four inches wide. The floors were sticky and there was a strong odor of urine. The window blinds had four broken slats with seven missing slats close to the bottom of the blinds.</p> <p>The ceiling tiles outside of room [ROOM NUMBER] had a large water stain approximately 48 inches long by 50 inches wide.</p> <p>room [ROOM NUMBER]: The bottom of the baseboard next to the bathroom was missing. The resident had a five drawer dresser, which had mice droppings in all of the drawers. There were three unpainted areas next to the bathroom approximately three inches in circumference. The floors were sticky and had not been cleaned, with remnants of spilled liquids.</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>room [ROOM NUMBER]: There was a puddle of urine underneath the resident's bed. The walls in the room had five areas of unfinished repair work. The five drawer dresser had mice feces in all drawers.</p> <p>room [ROOM NUMBER]: The wall north of the sink had five areas of chipped and peeling paint. There were two other large chips above the sink approximately three inches in circumference. The ceiling had approximately six 12 inch by 12 inch tiles missing. The baseboard cover, which covered the joint between the wall and the floor next to the bed, was missing a section approximately 24 inches long by four inches wide. The floor was dusty, had dried urine stains, was cluttered and had debris underneath the beds.</p> <p>room [ROOM NUMBER]: The resident room had several areas of white repair work on the green wall which had not been completed. The floors were sticky and stained with urine.</p> <p>room [ROOM NUMBER]: The wall next to the bed was missing a section of the baseboard that was approximately 12 feet long by four inches wide. The wall had deep scratches. The corner edging, which protected the corners from damage, was missing a section which was approximately five feet high by four inches wide. The lights above the residents' beds had chipped and peeling paint approximately four feet long by six inches wide. The hand sanitizer next to the door had an area surrounding it that was approximately 12 inches long by six inches wide of chipped paint. The floor in the whole room was cluttered with trash, food packages, tissue and an empty plastic cup.</p> <p>room [ROOM NUMBER]: The wall underneath the sink had an area approximately 30 inches by 29 inches of bubbling paint from water damage. There were 10 areas of unfinished hole spackled repair work next to both beds. The corner wall next to the bathroom had chipped and cracked paint approximately 12 inches high by eight inches wide. The floors were sticky with urine stains. The floor in the whole room had dirt accumulation and was cluttered with debris underneath the beds.</p> <p>room [ROOM NUMBER]: The wall which the light fixture was mounted to had chipped and peeling paint approximately four feet long by six inches wide. The walls above both of the beds had chipped and peeling paint approximately five inches in circumference. The corner strip on the wall was missing a section which was approximately five feet high by four inches wide. The five drawer dresser had mice feces in all of the drawers. The floors were sticky with remnants of spilled liquid.</p> <p>room [ROOM NUMBER]: The wall behind the resident's bed was damaged from the bed being lifted and lowered. The wall which the light was mounted to had chipped and peeling paint approximately four feet long by six inches wide. The baseboard cover, which covered the joint between the wall and the floor, was missing next to the bathroom. There was a large chipped area approximately 10 inches long by five inches wide next to the door. The floor had an accumulation of dirt and was sticky from liquid being spilled.</p> <p>room [ROOM NUMBER]: The floors were stained with urine and sticky and the bathroom had a strong odor of urine.</p> <p>room [ROOM NUMBER]: The wall next to the closet had chipped and missing plaster approximately 12 inches high by six inches wide. The floors were sticky and had dirt build up under the bed.</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 - Some</p>	<p>room [ROOM NUMBER]: The wall next to the door had an area approximately eight inches high by four inches wide of chipped and peeling plaster. There were several areas of chipped and peeling paint next to the sink. The window next to the resident's bed had a large piece of plywood covering the window. The floor was sticky and had remnants of spilled liquid.</p> <p>room [ROOM NUMBER]: The wall next to the bathroom had chipped and peeling plaster approximately six inches high by four inches wide. The wall behind the dresser had an area approximately 24 inches by 24 inches wide which had chipped and peeling paint. The room had a strong odor of urine. The floors were sticky and stained with urine. The resident had a five drawer dresser. There was mice feces in all of the drawers.</p> <p>room [ROOM NUMBER]: The room had a strong odor of urine. The floors were sticky and stained with urine. There was urine around the base of the toilet. The resident had a five drawer dresser. All of the drawers had mice feces. The floor was cluttered with used tissues, empty plastic cups and plastic silverware was underneath the beds.</p> <p>room [ROOM NUMBER]: The lights above the residents' beds had chipped and peeling paint approximately four feet long by six inches wide. The floors were dirty and sticky. The wall next to the dining room was missing a section of wood railing approximately eight feet long.</p> <p>room [ROOM NUMBER]: The air conditioner was not working and had a large amount of dust on the outside of the unit. The wall next to the resident's bed had four dime sized holes with an outline of the electrical system approximately 32 inches high by two inches wide when it was removed. The room was cluttered and the floors were sticky.</p> <p>room [ROOM NUMBER]: The wall next to the bathroom had chipped and peeling paint approximately 24 inches high by three inches wide. The floors were sticky and there was a strong odor of urine in the room.</p> <p>room [ROOM NUMBER]: The wall next to the resident's bed had three areas approximately three inches in circumference which had not been repaired. The floors were sticky and had remnants of spilled juice.</p> <p>room [ROOM NUMBER]: The room had approximately 14 areas of spackled hole repair work next to the resident's bed.</p> <p>room [ROOM NUMBER]: The room had several exposed glue traps on the floor with several large bugs on them.</p> <p>room [ROOM NUMBER]: The wall next to the bathroom had three dime sized holes and peeling paint. The wall next to the door had an area approximately six by three which was unpainted.</p> <p>room [ROOM NUMBER]: The floors had an accumulation of dirt built up with dust mites underneath the bed.</p> <p>room [ROOM NUMBER]: The window blinds were broken with six broken slats and approximately six slats missing and the floors were sticky with urine stains.</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 - Some</p>	<p>room [ROOM NUMBER]: The floors were sticky and water stained.</p> <p>room [ROOM NUMBER]: The floors were sticky and had an accumulation of dirt and urine stains. There was a strong odor of urine in the bathroom.</p> <p>room [ROOM NUMBER]: The floors were sticky. There was a strong odor of urine and there were urine stains on the bathroom floor. The floor had chipped tiles approximately 12 inches by 12 inches.</p> <p>room [ROOM NUMBER]: The floors were sticky with remnants of spilled liquid.</p> <p>The hallway next to room [ROOM NUMBER] had damaged floor tile approximately 12 feet long by 12 inches wide.</p> <p>The shower room on the south hall had approximately 18 12 inch by 12 inch ceiling tiles missing. The sheetrock on the walls had water damage and repair had not been completed.</p> <p>The hand rail from room [ROOM NUMBER] to room [ROOM NUMBER] was dirty and sticky and had chipped and splintering wood. The plastic rail bracket was broken with sharp edges between room [ROOM NUMBER] and room [ROOM NUMBER].</p> <p>The shower room on the south hall had approximately 18 12 inch by 12 inch ceiling tiles missing. The sheetrock on the walls had water damage and repair had not been completed.</p> <p>The maintenance closet had a glue trap with several large bugs in it.</p> <p>The wall next to the dining room was missing a section of wood railing approximately eight feet long.</p> <p>II. Environmental tour and staff interview</p> <p>The environmental tour was conducted with the maintenance supervisor (MS) on 8/28/24 at 11:06 a.m. The above detailed observations were reviewed. The MS said the facility utilized work orders as well as a computer system to identify environmental issues. The MS said he did not have work orders for the damage identified during the environmental tour. The MS said repairs should have been repaired and addressed in a timely manner.</p> <p>The MS said the mice were an ongoing problem. He said with the bad weather, the mice were coming into the facility. He said the building was old and the heat vents gave mice easy access to the facility.</p> <p>The MS said housekeeping had initiated a new program called safety culture. He said the program had been going on for about two months and he was hoping it would result in a better cleaning system.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821</p> <p>Based on observations, record review and interviews, the facility failed to ensure residents received proper respiratory treatment and care for three (#3, #2 and #7) of four residents reviewed for supplemental oxygen use out of 10 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Administer oxygen in accordance with the physician's order for Resident #3 and #2; and, -Ensure a physician's order was in place for Resident #7's continuous use of oxygen. <p>Findings include:</p> <p>I. Facility policy</p> <p>The Oxygen Administration Policy, revised October 2010, was provided on 8/29/24 at 10:47 a.m. by the corporate consultant (CC). It read in pertinent part,</p> <p>The purpose of this procedure is to provide guidelines for safe oxygen administration.</p> <p>II. Resident # 3</p> <p>A. Resident status</p> <p>Resident #3, age 74, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included depression, delusional disorder, chronic obstructive pulmonary disease (COPD).</p> <p>According to the 7/17/24 minimum data set (MDS) assessment, the resident had no cognitive impairment with a brief interview for mental status (BIMS) score of 15 out of 15. The resident had no behavioral symptoms. The resident had no upper or lower body impairment.</p> <p>The assessment did not identify the resident used oxygen.</p> <p>B. Observations and interviews</p> <p>On 8/28/24 at 4:00 p.m. Resident #3 was observed in the hallway sitting in her wheelchair with her oxygen nasal cannula on and connected to a portable oxygen concentrator. The resident's portable oxygen concentrator was set on 2 LPM.</p> <p>Resident #3 said she had been out of her room since lunch. She said she could not remember when anyone checked her portable oxygen concentrator last.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>At 4:00 p.m. registered nurse (RN) #2 was asked to check the resident's oxygen saturation level (measure of oxygen in the blood) and the resident's portable oxygen concentrator. RN #2 checked Resident #3's oxygen saturation level which read 90 % (percent). RN #2 checked Resident 3's portable oxygen concentrator. RN #2 said the portable oxygen concentrator was empty. RN #2 wheeled the resident into her room and placed the resident on her room's oxygen concentrator. RN #2 exited the resident's room and proceeded to take the portable oxygen concentrator to fill it up with oxygen.</p> <p>At 4:10 p.m. Resident #3 said, No wonder I was feeling a little loopy.</p> <p>C. Record review</p> <p>The care plan, initiated 3/22/21 and revised 8/25/24, identified the resident had oxygen therapy related to ineffective gas exchange due to COPD and impaired respiratory status related to hypoxia (low levels of oxygen in the body's tissues). Interventions included evaluating for signs and symptoms of respiratory distress and reporting to medical doctor (MD) as needed (respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough and, pleuritic pain).</p> <p>The August 2024 CPO included a physician's order dated 5/13/24 for the continuous use of oxygen at 2 liters per minute (LPM) via nasal cannula.</p> <p>D. Staff interview</p> <p>RN #2 was interviewed on 8/28/24 at 4:15 p.m. He said oxygen was a medication. RN #2 said Resident #3's oxygen concentrator was usually filled up in the morning and staff refilled all residents' portable oxygen concentrators again in the afternoon. RN #2 said a negative outcome for having an empty portable oxygen concentrator would be hypoxia and confusion.</p> <p>III. Resident #2</p> <p>A. Resident status</p> <p>Resident #2, age 70, was admitted on [DATE]. According to the August 2024 CPO, diagnoses included chronic respiratory failure whether with hypoxia or hypercapnia (too much carbon dioxide in the blood), schizoaffective disorder, bipolar, COPD.</p> <p>According to the 6/4/24 MDS assessment, the resident had severe cognitive impairment with a BIMS score of six out of 15. The resident had no behavioral symptoms.</p> <p>The assessment indicated the resident received oxygen therapy.</p> <p>B. Observation</p> <p>On 8/27/24 at 11:35 a.m. Resident #2 was sleeping with his nasal cannula on. His oxygen concentrator was at the foot of his bed and was set at 2 LPM.</p> <p>-However, the physician's order indicated the resident should be receiving 3 LPM of oxygen (see record review below).</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 11:20 a.m. Resident #2 was lying in bed watching television in his room. He was wearing his nasal cannula with his oxygen concentrator set at 2 LPM.</p> <p>-However, the physician's order indicated the resident should be receiving 3 LPM of oxygen (see record review below).</p> <p>C. Record Review</p> <p>The care plan, initiated 6/3/23 and revised, on 8/1/24, identified the resident had altered respiratory status, difficulty breathing/ shortness of breath (SOB) related to COPD, chronic respiratory failure, unspecified and asthma. Interventions include providing oxygen as ordered.</p> <p>-The August 2024 CPO included a physician's order dated 7/27/23 for the continuous use of oxygen at 3 LPM via nasal cannula to maintain an oxygen saturation level at or above 88% percent.</p> <p>D. Staff interview</p> <p>RN #1 interviewed on 8/28/24 at 11:20 a.m. RN #1 said oxygen was a medication. She said Resident #2 was supposed to be on 3 LPM of oxygen continuously. RN #1 said she adjusted Resident #2's oxygen to 3 LPM per the physician's order, instead of 2 LPM. She said a negative outcome of receiving the wrong amount of oxygen could be the resident getting confused and hypoxic.</p> <p>IV. Resident #7</p> <p>Resident #7, age 69, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 CPO, diagnoses included respiratory arrest, schizoaffective disorder, bipolar, COPD, acute respiratory failure with hypoxia, major depression.</p> <p>According to the 7/4/24 MDS assessment, the resident had no cognitive impairment with a BIMS score of 15 out of 15. The resident had verbal behaviors directed at others.</p> <p>The assessment indicated the resident received oxygen therapy.</p> <p>C. Record review</p> <p>The care plan, initiated 8/1/23 and revised 7/22/24, identified the resident had COPD related to smoking. The resident was encouraged to wear his oxygen and stated that staff were idiots and he did not need his oxygen. Interventions included administering 10 LPM of oxygen continuously as the resident allowed, observing for difficulty breathing on exertion, and reminding the resident not to push beyond his tolerated endurance.</p> <p>-The August 2024 CPO did not include a physician's order for oxygen.</p> <p>C. Observation</p> <p>On 8/27/24 at 10:35 a.m. Resident #7 was sleeping in his room. The resident was wearing an oxygen nasal cannula and an oxygen concentrator was next to his dresser and set to 3 LPM.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/28/24 at 8:50 a.m. Resident #7 was lying down in his bed. The resident was wearing an oxygen nasal cannula and his oxygen concentrator was set at 3 LPM.</p> <p>D. Staff interview</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 8/29/24 at 9:00 a.m. LPN #1 said oxygen was a medication and required a physician's order. LPN #1 checked her computer to verify the physician's order for oxygen for Resident #7. She said Resident #7 did not have a physician's order for his oxygen. She said the resident should have had a physician's order to receive oxygen.</p> <p>V. Additional staff interview</p> <p>The assistant director of nursing (ADON) was interviewed on 8/29/24 at 12:13 p.m. The ADON said oxygen was a medication. She said staff should be checking all portable oxygen concentrators for all residents to ensure they were not empty. She said staff should ensure all oxygen was being administered in accordance with the physician's orders and all residents who were on oxygen should have a physician's order in place for the use of oxygen.</p> <p>The ADON said a negative outcome from not being administered oxygen when ordered could be altered mental status, dizziness, falls and hypoxic events. She said not receiving the correct amount of oxygen could put the residents in respiratory distress.</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31821</p> <p>Based on observations, record review and interviews, the facility failed to provide an effective pest control program to ensure the facility was free of pests.</p> <p>Specifically, the facility failed to take the appropriate measures to control a fly infestation in the facility.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Center for Disease Control (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities, updated 2/15/19, pp. 94-95, retrieved on 9/5/24 from https://www.cdc.gov/infection-control/media/pdfs/Guideline-Environmental-H.pdf,</p> <p>Cockroaches, spiders, and mice are among the typical pest populations found in health-care facilities. Insects and rodents can serve as agents for the mechanical transmission of microorganisms, or as active participants in the disease transmission process by passing pathogens from one source to another. Insects and rodents should be kept out of all areas of a health-care facility.</p> <p>From a public health and hygiene perspective, pests should be eradicated from all indoor environments. Approaches to institutional pest management should focus on:</p> <ul style="list-style-type: none"> -Eliminating food sources, indoor habitats, and other conditions that attract pests; -Excluding pests from entering the indoor environments; and, -Applying pesticides as needed. <p>Insect habitats are characterized by warmth, moisture, and availability of food.</p> <p>II. Observations/resident interviews:</p> <p>On 8/27/24 at 9:50 a.m. room [ROOM NUMBER] was observed. The resident who resided in the room was lying in bed. The resident was swatting flies away from his face.</p> <p>On 8/27/24 at 9:55 a.m. room [ROOM NUMBER] was observed. One of the residents who resided in the room was sitting on the end of his bed and his roommate was sleeping. Flies were observed throughout the room flying on or around the residents' faces. There was a fly glue ribbon hanging from the ceiling. The fly trap was full of dead flies.</p> <p>On 8/27/24 at 9:57 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the room landing on resident's personal items, such as drinking cups.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/27/24 at 10:00 a.m. room [ROOM NUMBER] was observed. The resident who resided in the room was lying in bed with flies landing on his head and face.</p> <p>On 8/27/24 at 10:04 a.m. room [ROOM NUMBER] was observed. The resident who resided in the room was sitting on her bed and was swatting flies away from her face. The room had two glue fly ribbons on each side of the room. The fly traps were full of dead flies.</p> <p>On 8/27/24 at 10:07 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the room landing on the residents' personal belongings.</p> <p>On 8/27/24 at 10:12 a.m. room [ROOM NUMBER] was observed. The room had two glue fly ribbons hanging from the ceiling. The glue traps were full of flies.</p> <p>On 8/27/24 at 10:16 a.m. room [ROOM NUMBER] was observed. The resident who resided in the room was lying in bed sleeping with flies landing on his head and pillows. The resident had a drinking cup on his dresser with dead flies in the bottom of the glass.</p> <p>On 8/27/24 at 10:21 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the room landing on personal items.</p> <p>On 8/27/24 at 10:35 a.m. room [ROOM NUMBER] was observed. The resident who resided in the room was eating her breakfast and swatting flies away from her food. The resident said the flies were terrible but they were even worse when it was hotter. She said they got on her face and her food and they were just a bother.</p> <p>On 8/27/24 at 10:42 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the room landing on the resident who resided in the room and his personal belongings. The resident said the flies were a problem because they were all over the place.</p> <p>On 8/27/24 at 10:55 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the room landing on personal items of the resident who resided in the room. The resident had a fly swatter at the foot of his bed. The resident said the flies were the worst, especially since they got on his food.</p> <p>On 8/27/24 11:00 a.m. room [ROOM NUMBER] was observed. Flies were observed throughout the resident's room landing on the personal items of the resident who resided in the room. The resident said the flies were a problem but felt like the flies were only in his room.</p> <p>III. Building observations</p> <p>Throughout the survey (8/27/24 to 8/29/24) flies were observed in all areas of the secure unit and long term care living environment of the facility.</p> <p>IV. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 8/28/24 at 11:20 a.m. RN #1 said the flies had been getting worse ever since the area had been getting a high amount of rain. She said the flies were mainly in the residents' rooms.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065235	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Pioneer Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S 12th St Rocky Ford, CO 81067	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Licensed practical nurse (LPN) #1 was interviewed on 8/28/24 at 11:40 a.m. LPN #1 said the flies had been getting worse in the secure unit. She said staff had been trying to keep the main doors closed to try to keep the flies from coming into the building.</p> <p>Housekeeper (HSK) #1 was interviewed on 8/28/24 at 11:58 a.m. HSKP #1 said the flies had been a problem and they seemed to be getting worse. She said facility staff tried not to let the doors stay open for any long periods of time but it was hard to keep them closed with the residents frequently going in and out.</p> <p>LPN #2 was interviewed on 8/29/24 at 8:59 a.m. LPN #2 said the flies seemed to be in the residents' rooms much more than anywhere else in the building. She said the facility had a blue light in the dining areas and that appeared to keep the flies out of the dining room. LPN #2 said the flies were bad in the residents' rooms. She said some residents' families got the residents fly swatters for their rooms.</p> <p>The maintenance supervisor (MS) was interviewed on 8/28/24 at 11:06 a.m. The MS said the flies were a problem because of the area the facility was located in. He said the weather had also been a factor in the increase of flies. He said the facility had placed glue fly traps in three rooms. He said the fly traps were high enough to be out of the residents' way and they were supposed to be changed regularly. The MS said the fly traps should have been changed monthly or as needed when they were full of dead flies.</p> <p>The NHA was interviewed on 8/29/24 at 8:40 a.m. The NHA said he was not aware of the fly issues in the facility but he would look into it.</p>