

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 04/18/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150</p> <p>Based on record review and interviews, the facility failed to notify the provider according to physician orders for one (#29) of three residents reviewed for unnecessary medications out of 28 sample residents.</p> <p>Specifically, the facility failed to notify and document Resident #29's elevated blood sugar levels to the provider as directed on the physician's order.</p> <p>Findings include:</p> <p>I. Facility policy and procedures</p> <p>The Diabetic Care Policy, revised November 2020, was provided by the director of nursing (DON) on 4/18/24 at 11:20 a.m. The policy read in pertinent part,</p> <p>The physician will order desired parameters for monitoring and reporting information related to blood sugar management.</p> <p>The staff will incorporate such parameters into the medication administration record and care plan.</p> <p>II. Resident #29</p> <p>A. Resident status</p> <p>Resident #29, over the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included type II diabetes mellitus with diabetic autonomic polyneuropathy (occurs when there is damage to the nerves that control automatic body functions), chronic obstructive pulmonary disease, hyperlipidemia, and anxiety disorder.</p> <p>The 1/25/2024 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident required staff supervision for bed mobility, grooming, toileting, and transfers. The resident had no behaviors.</p> <p>The assessment documented the resident received insulin and injections for seven days during the seven-day assessment look back period.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Record review</p> <p>The physician's order dated 7/27/23 at 7:45 p.m. revealed to check blood glucose via finger stick at bedtime for diabetic maintenance. If blood glucose is less than 60 mg/dl (milligrams/deciliter) or greater than 350 mg/dl, notify the medical provider .</p> <p>The physician's order dated 2/28/24 at 9:31 a.m. revealed to administer Basaglar Kwipen subcutaneous solution (insulin glargine) pen-injector 100 units/ml (milliliter).</p> <p>The physician's order dated 3/7/24 at 9:33 a.m. revealed to administer Trulicity Subcutaneous Solution pen-injector 4.5 milligrams (mg)/0.5 ml in the morning every Saturday for diabetes mellitus.</p> <p>A review of the March 2024 medications administration record (MAR) from 3/1/24 to 3/31/24 revealed the following:</p> <p>On 3/2/24 Resident #29's blood sugar was 430 mg/dl, which was above the parameter of 350 mg/dl set in the physician's order;</p> <p>On 3/3/24 Resident #29's blood sugar was 438 mg/dl, which was above the parameter of 350 mg/dl set in the physician's order;</p> <p>On 3/5/24 Resident #29's blood sugar was 421 mg/dl, which was above the parameter of 350 mg/dl set in the physician's order;</p> <p>On 3/8/24 Resident #29's blood sugar was 444 mg/dl, which was above the parameter of 350 mg/dl set in the physician's order;</p> <p>On 3/11/24 Resident #29's blood sugar was 480 mg/dl, which was above the parameter of 350 mg/dl set in the physician's order;.</p> <p>On 3/12/24 Resident #29's blood sugar was 445 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/13/24 Resident #29's blood sugar was 425 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/15/24 Resident #29's blood sugar was 484 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/16/24 was Resident #29's blood sugar was 505 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/17/24 was Resident #29's blood sugar was 402 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/18/24 Resident #29's blood sugar was 404 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>(continued on next page)</p>

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/24 Resident #29's blood sugar was 398 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/20/24 Resident #29's blood sugar was 407 mg/dl, which was above the 350 mg/dl set in the physician's order;</p> <p>On 3/22/24 Resident #29's blood sugar was 37 .mg/dl, which was above the 350 mg/dl set in the physician's order; and,</p> <p>On 3/24/24 Resident #29's blood sugar was 437 mg/dl.</p> <p>A review of the April 2024 MAR (4/1/24 to 4/18/24) revealed the following:</p> <p>On 4/12/24 Resident #29 blood sugar was 392 mg/dl, which was above the 350 mg/dl set in the physician's order;.</p> <p>On 4/13/24 Resident #29's blood sugar was 418 mg/dl, which was above the 350 mg/dl set in the physician's order;.</p> <p>On 4/15/24 Resident #29's blood sugar was 416 mg/dl, which was above the 350 mg/dl set in the physician's order, and</p> <p>On 4/17/24 Resident's #29's blood sugar was 391 mg/dl, which was above the 350 mg/dl set in the physician's order.</p> <p>-A 45 day record review revealed Resident #29 had elevated blood sugar levels 19 times out of the 45 days and there was no documentation to indicate staff notified the physician.</p> <p>The care plan, initiated 8/7/22, revealed Resident #29 had limited physical mobility related to type II diabetes mellitus. The interventions included evaluating the resident, documenting and reporting to the physician, administering medications as ordered.</p> <p>The care plan revealed the resident was noncompliant with her diabetic diet.</p> <p>III. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 4/18/24 at 9:40 a.m. RN #1 said the dates reviewed on the resident's MAR revealed the resident insulin levels were elevated above the parameters indicated on the physician's order. She said there should be documentation in the resident's medical record that indicated the physician was notified.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RN #1 said nurses should follow physician orders and inform the provider when results were over the physician's parameters. She said since there was not documentation indicating the physician was notified that Resident #29's blood sugar was not within parameters that indicated it did not happen. She said insulin parameters were important because the resident might have experienced high blood sugar levels which could require the physician to adjust the amount of insulin to administer. She said not notifying the physician for the proper dose of insulin could cause serious health complications. RN #1 said the resident could experience shock and have an increase in symptoms related to her diagnosis.</p> <p>The director of nursing (DON) was interviewed on 4/18/24 at 10:21 a.m. The DON said the dates reviewed on the resident's MAR revealed the resident's blood glucose levels were elevated above the parameters on the physician's order and the staff should have notified the provider and documented in the nursing progress note. The DON said there was no documentation indicating the physician was notified. She said she expected the staff to inform the physician and document in the resident's medical chart of the action taken. The DON said failing to notify the physician of elevated blood glucose levels could have serious health issues leading to death.</p> <p>The DON said she would educate nursing staff to ensure they followed the physician's orders and documented their actions. She said she would inform the physician to incorporate the insulin parameters with the insulin order to prevent such errors in the future.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48114</p> <p>Based on observations, record review and interviews, the facility failed to provide assistance with activities of daily living (ADL) for one (#8) of five residents reviewed for ADL care out of 28 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #8 received oral and personal hygiene daily.</p> <p>A. Resident status</p> <p>Resident #8, age 67, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included acute embolism and thrombosis of unspecified deep veins of right lower extremity (blood clot), unspecified fracture of lower end of right tibia (larger bone of the two lower leg bones) and multiple sclerosis (deterioration of the nerves).</p> <p>The 12/1/23 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required set-up or clean up assistance with oral hygiene and eating. She required partial/moderate assistance with personal hygiene, showering/bathing and upper body dressing.</p> <p>B. Resident interview and observations</p> <p>Resident #8 was interviewed on 4/15/24 at 10:53 a.m. Resident #8 said the staff did not offer for her to wash her hands and face in the morning when she woke up. She said the staff did not bring her toothbrush for her to brush her teeth in the morning. She said it was important for her to have her oral hygiene completed in the morning because it made her feel complete.</p> <p>Resident #8 was interviewed again on 4/16/24 at 4:07 p.m. Resident #8 said she was not provided with oral and personal hygiene this morning (4/16/24). She said her care provider came to visit her this afternoon and wrote a note that stated, Morning and night give Resident #8 her pink basin with warm water and fresh washcloth daily for personal hygiene. The note was posted on the bathroom door. The resident said she was only provided with her toothbrush to brush her teeth last night (4/15/24). She said her face and hands were not washed before getting ready for bed.</p> <p>Resident #8 was interviewed again on 4/17/24 at 2:37 p.m. Resident #8 said staff did not provide her morning hygiene. She said she spoke with the nursing home administrator (NHA) this morning (4/17/24) and showed him her sign. She said the NHA said it was a great idea and he said he was going to work on it. She said when she was not provided with morning hygiene it made her feel incomplete for the day. She said it made her feel bewildered and surprised that oral and personal hygiene were not completed in the morning.</p> <p>Resident #8 said she did not let staff know about wanting her oral and personal hygiene done in the morning because she did not want to upset the staff. She said her care provider had voiced the concerns to staff. She said she was hoping the staff would look at the note and she would not have to say anything.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>C. Record review</p> <p>The activities of daily living (ADL) care plan, dated 11/25/23, documented Resident #8 had an ADL self-care performance deficit.</p> <p>The interventions included personal hygiene, providing moderate assistance by one staff with personal hygiene and oral care, encouraging the resident to participate to the fullest extent possible with each interaction, encouraging the resident to use her call bell to call for assistance and praising all efforts at self-care.</p> <p>The comprehensive care plan, dated 4/17/24 (during the survey), documented Resident #8 preferred to have her showers on Monday, Wednesday and Friday mornings. She liked to have a warm basin of water and wash cloth provided upon awakening to wash her face off and to promote independence in doing so.</p> <p>The interventions included offering showers in the morning on her preferred shower days.</p> <p>D. Staff interviews</p> <p>Registered nurse (RN) #3 was interviewed on 4/18/24 at 9:56 a.m. RN #3 said Resident #8 required set up assistance with her toothbrush and was able to brush her teeth on her own. He said when staff got her the supplies she was able to do everything on her own. He said ADL care should be provided every day. He said the certified nurse aides (CNA) were responsible for providing oral and personal hygiene care to the residents. He said the CNAs should be providing oral and personal hygiene every morning when the resident got up. He said Resident #8 should have received personal and oral hygiene care every morning.</p> <p>CNA #5 was interviewed on 4/18/24 at 10:13 a.m. CNA #5 said residents should be provided with personal and oral hygiene daily. He said he was responsible for providing personal and oral hygiene to the residents. He said</p> <p>Resident #8 required set-up assistance for personal hygiene as she was able to wash her own face. He said Resident #8 should be provided with personal and oral hygiene every day, however, he said he had never provided personal and oral hygiene for Resident #8.</p> <p>The DON was interviewed on 4/18/24 at 10:54 a.m. The DON said the CNAs were responsible for providing personal and oral hygiene for all the residents. She said personal and oral hygiene was part of the CNAs job duties.</p> <p>She said providing personal and oral hygiene should be done everyday. She said she spoke with Resident #8 on 4/17/24 (during the survey process) and put in an order to put her basin at her bedside upon awakening. She said Resident #8 required extensive assistance due to her physical functional ability. She said Resident #8 had good days and tried to be independent and other days she needed more help.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820</p> <p>Based on observations, record review and interviews, the facility failed to ensure the residents environment remained as free of accident hazards as possible and each resident received adequate supervision to prevent accidents for one (#13) of three residents reviewed for accidents/hazards out of 28 samples residents.</p> <p>Resident #13 had been evaluated and determined to be a supervised smoker, which included she was not able to keep smoking supplies with her. The supplies were to be kept and monitored by the facility. During the scheduled smoke breaks, the facility would provide the resident with the cigarette and light the cigarette with a lighter.</p> <p>On 3/29/24 at 12:30 a.m. certified nurse aide (CNA) #8 heard screams coming from Resident #13's room. When she went in the room to check on Resident #8 she found the dressing on her lower left leg on fire. CNA #8 yelled for help and put out the fire with a towel and water. Resident #8 was transferred to the emergency department (ED) where it was determined she had first and second degree burns. Upon investigation and a care conference with the family, it was determined that, during a family visit, a family member had left a lighter with the resident. The facility failed to implement safety procedures to prevent a family member from providing a lighter to a supervised smoker.</p> <p>Findings include:</p> <p>Record review and interviews confirmed the facility corrected the deficient practice prior to the onsite investigation on 4/15/24 to 4/18/24, resulting in the deficiency being cited as past noncompliance with a correction date of 4/2/24.</p> <p>I. Incident on 3/29/24</p> <p>The facility failed to ensure Resident #13, who had been assessed and determined to be a supervised smoker who's smoking supplies were to be kept locked up by the facility, did not have a lighter in her personal possession. This resulted in Resident #13 attempting to use a lighter she had obtained from her family to burn a dangling thread off of a bandage on her leg in her room on 3/29/24.</p> <p>Due to the facility's failures, the bandage on Resident #13's leg caught on fire. CNA #8 was able to smother the bandage fire with a towel, however, Resident #13 was transferred to the hospital on 3/29/24 where she was discovered to have first and second degree burns to her leg.</p> <p>Record review and interviews during the complaint investigation confirmed the deficient practice had been corrected and the facility was in substantial compliance at the time of the survey from 4/16/24 to 4/17/24.</p> <p>II. Facility correction</p> <p>A. Immediate action</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The corrective action plan the facility implemented in response to Resident #13's lighter accident on 3/29/24 was provided by the director of nursing (DON) on 4/17/24 at 12:00 p.m.</p> <p>On 3/29/24 a sweep of the supervised smokers for lighters was completed. No lighters were found.</p> <p>On 3/29/24 staff were re-educated on safe smoking practices, ensuring supervised smokers did not have lighters and the facility smoking policy.</p> <p>B. Systemic changes</p> <p>On 3/29/24 the social services assistant (SSA) completed an audit of all the smokers to re-determine if the smoker was supervised or unsupervised. The facility implemented smoking aprons for all smokers regardless of smoking status.</p> <p>On 3/29/24 the facility reached out to families to provide education on the importance of not providing smoking supplies to the smoking residents. Families were educated to give the smoking supplies to the nurses.</p> <p>On 3/29/24 the one unsupervised smoker in the facility was re-educated on the importance of keeping control of his lighter and not giving it to supervised smokers. The unsupervised smoker was receptive to the re-education understanding the severity of the situation and agreed not to share his lighter with supervised smokers.</p> <p>On 3/29/24 housekeeping staff were educated to be more critical and observant for lighters when in a smoker's room. Education included, if a lighter was found, it was to be given to the nurse on duty immediately.</p> <p>On 3/29/24 nursing staff were educated if staff turned in a lighter from a supervised smoker to notify the DON.</p> <p>On 3/30/24 Resident #13 was moved to a different hall with more staff monitoring. Resident #13 was provided with a vape pen in lieu of cigarettes and the vape pen supplies were kept locked up by the facility.</p> <p>On 4/2/24 the facility completed a care conference with the family. During the conference, the family admitted they had given Resident #13 the lighter. The resident's family was educated on the importance of not providing the resident with a lighter.</p> <p>C. Monitoring</p> <p>On 3/29/24 audits of smokers were started and continued weekly to ensure lighters were not in the possession of supervised smokers and if found, family education was conducted.</p> <p>All audits and education were to be reviewed during weekly interdisciplinary team (IDT) meetings and during monthly quality assurance and performance improvement (QAPI) meetings.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interviews and record reviews during the recertification survey revealed corrective actions to identify the resident and other residents having the potential to be affected by the deficient practice, systemic changes to prevent its recurrence and monitoring to ensure sustained correction were in place.</p> <p>III. Resident status</p> <p>Resident #8, age younger than 65, was admitted on [DATE] and readmitted on [DATE]. According to the April 2024 computerized physician's order (CPO), diagnoses included hemiplegia on the right side, cerebral infarction (stroke) on the right side and need for assistance with personal care.</p> <p>The 3/1/24 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 10 out of 15.</p> <p>The assessment identified the resident had impairment on one side (right) and she utilized a wheelchair for mobility. She required one to two staff members for transfers.</p> <p>IV. Record review</p> <p>The care plan, initiated on 3/1/24, identified Resident #8 had impaired cognitive function. Interventions included to keep her routine consistent.</p> <p>The care plan, initiated on 3/12/24, identified Resident #8 was a supervised smoker. Interventions included notifying the charge nurse if the resident violated the facility smoking policy, observing the resident's clothing and skin for signs of cigarette burns, conducting a smoking assessment quarterly and as needed and smoking materials were to be kept by staff.</p> <p>The smoking safety screen assessment dated [DATE], documented the resident needed supervision for smoking which included supervised smoking with the staff, a smoking apron and the facility holding her smoking materials.</p> <p>The progress note dated 3/29/24 at 2:21 a.m. documented CNA #8 heard screams coming from Resident #8's room at 12:30 a.m. When she ran into the room she saw the dressing on Resident #8's leg was in flames. CNA #8 smothered the flame with a towel then doused the area with water. The dressing was removed. The provider was notified at 12:40 a.m. The assistant director of nursing (ADON) was notified at 12:45 a.m. The resident was transported by ambulance to the hospital at 1:16 a.m.</p> <p>The progress note written by registered nurse (RN) #4 on 3/29/24 at 5:01 a.m. documented the discharge report was taken from the ED nurse and the resident returned back to the facility with a kerlix (gauze) wrap intact to her lower left leg and it was clean and dry.</p> <p>The hospital records dated 3/29/24 documented Resident #8 was reportedly trying to burn a string hanging from her previous dressing when she lit her entire bandage on fire. The hospital identified the injuries as first and second degree burns.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The hospital visit note dated 3/29/24 documented the nursing home staff said the resident had a lighter. The facility was unsure how she had one. The resident was reportedly trying to possibly burn a string on her previous dressing when she lit her entire dressing on fire. CNA (#8) was able to use a towel to put out the flames and the resident's wounds were soaked in cool water. On arrival to the ED, the resident had mid lower extremity circumferential first degree burns with a few second degree burns.</p> <p>The progress note written by RN #3 on 3/29/24 at 3:46 p.m. documented the wound to her lower left leg was 13.0 centimeters (cm) by 20 cm around the circumference of her ankle. The affected area appeared to be blistered to the medial (inner) aspect. Silvadene was applied as the ordered treatment regimen. She had been receiving ibuprofen 600 milligrams (mg) and had not complained of breakthrough pain.</p> <p>The progress note written by the wound care nurse (WCN) dated 3/29/24 at 8:24 p.m. documented the wound on the resident's shin was 13.2 cm by 10.8 cm by 0 cm. There was scant serous (pale yellow or transparent) drainage without odor.</p> <p>The provider note date 4/1/24 documented Resident #13 burned the bandage on her leg which apparently then erupted in flames. From the description given by staff, there seemed to be a loose thread hanging from the bandage and due to her extremely poor judgment and executive dysfunction, she decided to burn the dangling thread. Resident #13 was not able to foresee that the burning thread would soon burn the bulk of the bandage. She was sent to the emergency room where she was treated physically, as this did not appear to be a suicide attempt or a serious attempt at self harm.</p> <p>V. Interviews</p> <p>The nursing home administrator (NHA) was interviewed on 4/16/24 at 5:27 p.m. The NHA said after the resident was transported to the hospital, the staff completed a sweep of all the supervised smokers to ensure they did not have a lighter. He said immediately the facility decided all smokers would have to wear a smoking apron. He said the facility called the family and after a conversation about the resident burning herself, the family had admitted to leaving the lighter with the resident. The facility, along with the family, had decided to make all visits with the family supervised, and moved the resident to another hall. He said the family was educated on the importance of not providing supervised smokers with a lighter to ensure the safety of everyone.</p> <p>CNA #6 was interviewed on 4/16/24 at 5:29 p.m. She said when she was the staff member to go out with the supervised smokers, she walked around them during the break ensuring all the aprons were on correctly. She said all the supervised smokers used an apron. She said she did not know if during family visits if Resident #13's family would take her out for a cigarette without staff. She said the management were the people who determined if someone was a supervised smoker. She said the smoking supplies, including the lighter, were locked up at the nurses station. She said only the nurses had a key to the cigarettes.</p> <p>RN #2 was interviewed on 4/16/24 at 5:37 p.m. RN #2 said the residents had set times for smoking. He said the times were posted at the nurses station where the residents could see. He said he would delegate a CNA to assist the residents to the smoking area where they would ensure the oxygen was removed. He said the CNAs assisted the residents to the smoking area, put on the aprons, and handed them a cigarette and lit the cigarette for the resident.</p> <p>(continued on next page)</p>		

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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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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>RN #2 said residents were not allowed to save the cigarette if they did not finish it and they were not given the lighter to light the cigarette themselves. He said Resident #13 was a supervised smoker. He said sometimes it was noted the family would come by and go outside to the smoking area to smoke with her. He said it was during one of those times that the family gave the resident the lighter. He said the smoking assessments were completed by social services. He said the smoking supplies were locked up in the medication room.</p> <p>CNA #3 was interviewed on 4/17/24 at 8:45 a.m. CNA #3 said she was new to the facility. She said she knew Resident #13 had a burn from an accident and knew she was a supervised smoker. She said she used a vape pen, not cigarettes. She said she had received education on smoking safety recently but could not recall the date. She said the smoking supplies were kept locked in the medication room and only the nurse could get them for the designated smoke breaks.</p> <p>CNA #4 was interviewed on 4/17/24 at 8:50 a.m. CNA #4 said she had not seen Resident #13's family visit since her room change. She said she knew there was an accident with a lighter and now she used a vape pen instead of a cigarette. She said right after the accident the facility did training on smoking and the use of lighters with supervised smokers and how the supervised smokers were not allowed to have a lighter. She said all the smoking supplies were locked in the medication room and only the nurse could get the smoking supplies.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 4/17/24 at 8:52 a.m. LPN #2 said since Resident #13 had moved to the new room, the family had not been over for a visit while she was there. She said she knew Resident #13 had an accident and now she used a vape pen instead of a cigarette during the scheduled smoke breaks. She said the facility completed training on smoking safety right after the incident. She said supervised smokers were not allowed to have a lighter, and if one was discovered with a supervised smoker, the charge nurse was to be notified immediately and to ask the individual if they could give it up, but not to fight with them.</p> <p>CNA #7 was interviewed on 4/17/24 at 9:10 a.m. CNA #7 said at the smoking times, the residents all lined up to go out. On their way outside, an apron was put on them. She said she would light the cigarettes and watch all of them to make sure they did not burn themselves. She said if they did not finish the cigarette, it was thrown away and the resident was not allowed to save it for the next break. She said residents were not allowed to light their own cigarettes. She said all the smoking supplies were locked at the nurses station in the medication room and only accessed by the nurse on duty. She said all staff were told if a lighter was found with a supervised smoker, to take it and report immediately to the charge nurse.</p> <p>On 4/17/24 at 10:30 a.m. wound care was completed with the wound care nurse practitioner (WCNP). She said the burn was a partial thickness burn (second degree) and it had improved from first treatment.</p> <p>CNA #1 was interviewed on 4/17/24 at 1:02 p.m. CNA #1 said seven to eight months ago a lighter was discovered with Resident #13. He said he reported it to the charge nurse who was no longer at the facility. He said she went and talked to Resident #13 and was able to retrieve the lighter. He said he did not know if the charge nurse told anyone.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>LPN #1 was interviewed on 4/17/24 at 1:02 p.m. LPN #1 said Resident #13 was found to have a lighter seven to eight months ago. He said he reported it to the charge nurse. He said the charge nurse had a good relationship with Resident #13. He said she talked to Resident #13 and was able to retrieve the lighter and educate the resident. He said he did not know if it was reported to the DON or not.</p> <p>The DON was interviewed on 4/17/24 at 1:30 p.m. She said Resident #13 was trying to burn off a stray thread and lit the bandage around her leg on fire. She said the staff put out the fire with a towel and then water. She said the RN cut off the bandage and called the provider and an ambulance. She said the resident went out to the hospital and returned with first and second degree burns. She said immediately the staff did a search of the supervised smokers for lighters and none were found. She said that day (3/29/24), the SSA started reinforcing the training on smoking safety with the staff, starting with the staff who were present. She said the facility determined all supervised smokers would use an apron going forward. She said Resident #13 was moved to another unit.</p> <p>She said during the care conference on 4/2/24 with the family, it was the family who said they had provided Resident #13 with the lighter. She said the facility and the family, after a lengthy conversation, mutually agreed to have supervised visits with the family during visits if smoking was involved. The facility provided education to the family about smoking and supervised smoking. The facility and family also agreed to use a vape pen for Resident #13. The facility determined the vape pen would be kept with the smoking materials and given during the smoking breaks and returned at the end of the break.</p> <p>The DON said education was immediately started with the staff and a sweep was completed of all the supervised smokers to ensure no other lighters were found for the safety of all the residents. She said the housekeeping staff were to do visual inspection of supervised smokers rooms keeping a lookout for lighters going forward.</p> <p>The DON said she had never been notified before the accident that the resident had ever had a lighter in her possession.</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** 47150</p> <p>Based on observations, record review and interviews, the facility failed to ensure one (#40) of three residents out of 28 sample residents who required respiratory care were provided such care and services consistent with professional standards of practice.</p> <p>Specifically, the facility failed to ensure Resident #40's supplemental oxygen was on the correct ordered liter flow per the physician's order.</p> <p>Findings include</p> <p>I. Facility policy and procedure</p> <p>The Oxygen administration policy, revised October 2010, was received from the director of nursing (DON) on 4/18/24 at 11:40 a.m. It read in pertinent part, The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify there is a physician order for this procedure.</p> <p>Documentation in medical records includes: rate of oxygen flow, route, frequency, and duration.</p> <p>Notify the supervisor if the resident refuses the procedure. Report other information in accordance with facility policy and professional standards of practice</p> <p>II. Resident #40</p> <p>A. Resident status</p> <p>Resident #40, under the age of 65, was admitted on [DATE]. According to the April 2024 computerized physician orders (CPO), diagnoses included type I diabetes mellitus, low vision, chronic obstructive pulmonary disease (COPD), end stage renal disease, and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues).</p> <p>The 3/13/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15.</p> <p>He required supervision with personal hygiene, dressing, bed mobility, transfers, toilet use, and set-up assistance with eating.</p> <p>The assessment documented the resident required continuous oxygen therapy.</p> <p>B. Observations and resident interview</p> <p>Resident #40 was interviewed on 4/15/24 at 11:13 a.m. He was on 3 liters per minute (LPM) of oxygen. He said the physician had ordered continuous oxygen at all times at 2 LPM.</p> <p>Resident #40 was observed on 4/16/24 at 12:31 p.m. on 3 LPM of oxygen via nasal cannula.</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>The resident was observed on 4/17/24 at 2:05 p.m. on 3 LPM of oxygen via nasal cannula.</p> <p>The resident was observed on 4/18/24 at 9:30 a.m. in his room on 3 LPM via nasal cannula.</p> <p>C. Record review</p> <p>The April 2024 CPO revealed a physician's order dated 3/7/24 for 2 LPM of oxygen via a nasal cannula.</p> <p>The oxygen care plan, revised 5/6/21, revealed the resident had oxygen therapy related to ineffective gas exchange due to chronic obstructive pulmonary disease (COPD). The care plan indicated the resident was on continuous 3 LPM of oxygen.</p> <p>-The resident' s comprehensive care plan did not match the physician' s order of 2 LPM.</p> <p>D. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 4/18/24 at 9:40 a.m. RN #1 said Resident #40 received supplemental oxygen via nasal cannula at 2 LPM. RN #1 reviewed Resident #40's physician orders and said the physician' s order indicated for the resident to receive 2 LPM via nasal cannula RN #1 verified the resident' s oxygen concentrator was at 3 LPM and adjusted the liter flow per minute to 2 LPM as the physician' s order specified. RN #1 took his finger pulse oximetry (a tool used to check the oxygen levels in the blood) to ensure he had an oxygen saturation (oxygen blood level) above 90%. Resident #40's pulse oximetry level was 92% on 2 LPM.</p> <p>The DON was interviewed on 4/18/24 at 10:51 a.m. The DON said residents receiving oxygen should have a physician's order in place. She said the orders should include the rate of oxygen, routes like a nasal cannula or mask and frequency of intermittent or continuous. She said staff should be monitoring the resident's pulse oximetry to ensure they were maintaining oxygen saturation above 90%.</p> <p>The DON said oxygen use should be included on the resident' s comprehensive care plan according to the physician' s order. The DON said failure to follow the physician' s order could result in oxygen toxicity which could cause a variety of health complications leading to death. The DON said she would re-educate the nursing staff to monitor and ensure they were following the physician' s order for oxygen therapy and ensuring the care plan and the physician' s order for oxygen matched.</p> <p>E. Facility Follow-up</p> <p>The DON provided an updated care plan for Resident #40 on 4/18/24 at 1:45 p.m. The care plan update reflected the right amount of oxygen as indicated on the physician' s order. It documented the resident would sometimes titrate his oxygen concentrator and the facility had notified the physician.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>31820</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for five of five staff reviewed.</p> <p>Specifically, the facility had not completed annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #9, CNA #11, CNA #12, CNA #13 and CNA #14.</p> <p>Findings include:</p> <p>I. Record review</p> <p>CNA #9 (hired on 3/13/18), CNA #11 (hired on 7/1/16), CNA #12 (hired on 4/22/22), CNA #13 (hired on 5/7/21) and CNA #14 (hired on 7/1/16) did not have an annual performance review completed. The CNAs did not have an in-service education plan based on the outcome of the review.</p> <p>II. Staff interview</p> <p>The director of nursing (DON) was interviewed on 4/16/24 at 2:23 p.m. The DON said she was not aware the performance reviews needed to include a regular in-service plan based on the outcome of these reviews. She said going forward she would ensure the performance reviews were completed annually to ensure best care was being delivered to the residents.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31820</p> <p>Based on observations, interviews and record review, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with accepted professional standards, in two of two medication carts.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Discard an expired Anoro inhaler; -Date an Anoro inhaler when opened; and, -Date a Lantus insulin pen when opened. <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Anoro inhaler manufacturer's guidelines, retrieved on [DATE] from https://gskpro.com/content/dam/global/hcpportal/en_US/Prescribing_Information/Anoro_Ellipta/pdf/ANORO-ELLIPTA-PI-PIL-IFU.PDF, Discard Anoro Ellipta 6 (six) weeks after opening the foil tray or when the counter reads '0', whichever comes first.</p> <p>According to the Lantus insulin pen manufacturer's guidelines, retrieved on [DATE] from https://products.sanofi.us/lantus/lantus.html#section-15, Storage conditions for the 3 ml (milliliter) single patient use solostar pen in-use (opened) 28 days room temperature only.</p> <p>II. Observations and interviews</p> <p>On [DATE] at 3:30 p.m. the west medication cart was observed with registered nurse (RN) #2.</p> <p>The medication cart contained two Anoro inhalers. One inhaler was expired with an open date of [DATE] and one inhaler was not dated with the date it was opened.</p> <p>RN #2 said he did not know the Anoro inhaler was expired and the second inhaler belonged to a resident who had just moved rooms to his hall. He said it was important to date the inhalers when they were opened to ensure the medication was effective and safe.</p> <p>On [DATE] at 11:10 a.m. the south medication cart was observed with licensed practical nurse (LPN) #2.</p> <p>The medication cart contained an open Lantus solostar pen with no open date labeled on it.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LPN #2 said she was not aware the insulin pen did not have an open date. She said it was important to date the insulin when it was opened to make sure it was safe to administer to the resident.</p> <p>III. Additional interview</p> <p>The director of nursing (DON) was interviewed on [DATE] at 11:40 a.m. The DON said it was important for all medications to be dated when opened and discarded when expired to ensure the medication was safe for the residents who received them.</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>47150</p> <p>Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure the kitchen was clean and sanitary; and, -Ensure food was held at appropriate temperatures. <p>Findings include:</p> <p>I. Ensure kitchen staff prepared and served food in a sanitary environment in the main kitchen.</p> <p>A. Facility policy and procedure</p> <p>The Sanitation policy, revised November 2022, was provided by the dietary supervisor (DS) on 4/18/24 at 11:45 a.m. It read in pertinent part, The food service area is maintained in a clean and sanitary manner.</p> <p>All kitchens, kitchen areas, and dining areas will be kept clean, free from garbage and debris.</p> <p>All equipment, food contact surfaces, and utensils are cleaned and sanitized using heat or chemical sanitizing solutions.</p> <p>All utensils, counters, shelves, and equipment are kept clean, maintained in good repair, and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use.</p> <p>B. Observations</p> <p>During the initial tour of the kitchen on 4/15/24, beginning at 8:30 a.m. and ending at 9:15 a.m., the following was observed:</p> <ul style="list-style-type: none"> -There was chipped paint and there was dust on the surface on the shelf below the three compartment sink. -There was dust and debris buildup on the exposed plumbing pipes, around the hand-washing sink and on top of the dishwashing machine. -The outside of the kitchen steamer was covered with dark greasy substances. -There was dirt and grime build up on the wall under and around the hand-washing sink located at the left side of the cooking area. <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>On a follow-up visit to the kitchen on 4/17/24 at 11:30 a.m. the following was observed;</p> <ul style="list-style-type: none"> -There was the same chipped paint and the shelf below the three compartment sink with items on it were covered in dust. -There was dust and debris build up on the exposed plumbing pipes, around the hand-washing sink, and on top of the dishwashing machine. -The outside of the kitchen steamer was covered with dark greasy substances. -There was dirt and grime build up under and around the hand-washing sink located at the left side of the cooking area. <p>C. Staff interviews</p> <p>The dietary supervisor (DS) was interviewed on 4/17/24 at 2:34 p.m. The DS said there were areas in the kitchen where the facility could do better cleaning. He said it was important to maintain a clean food preparation area to avoid any foodborne illness.</p> <p>The DS said without a clean and sanitary kitchen environment the facility was at risk for contamination of food and food preparation surfaces.</p> <p>II. Food temperatures of cold and hot food items were not held at the proper temperature</p> <p>A. Tray line observation</p> <p>During a continuous observation on 4/17/9/24, beginning from 12:05 p.m. and ending at 2:00 p.m. the lunch meal service was observed from the tray line on the secured unit. Dietary aide (DA) #1 took the initial holding temperatures of the hot foods on the steam table and the cold foods were in a plastic bowl with ice cubes underneath the bowl in the serving area. DA #1 took food temperatures again at the end of the lunch service. The food holding temperatures did not hold to safe levels throughout the lunch service.</p> <p>The temperatures of the foods at the end of the service revealed:</p> <ul style="list-style-type: none"> -The country fried steak was 116 degrees fahrenheit (F); -The mechanical soft country fry steak was 82 degrees F; -The puree vegetables were 96 degrees F; -The puree steak was of 90 degrees F; -The chocolate pudding was 67 degrees F. -The potato salad was 48 degrees F. <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 temperatures taken at the end of service were outside the correct safe temperature zone to prevent foodborne illness.</p> <p>B. Staff interview</p> <p>DA #1 was interviewed on 4/17/24 at approximately 1:45 p.m. DA #1 said the food should be held on the steam table at 165 degrees F for hot foods and cold foods should be below 41 degrees F. He said he did not think the steam table was functioning properly. DA #1 said it was important to ensure the food items being served remained in the safe temperature zone to avoid contamination and the growth of harmful bacteria which could get the residents sick.</p> <p>The DS was interviewed on 4/17/24 at 2:34 p.m. The DS said he would complete a maintenance work order for maintenance to work on the steam table on the locked unit. He said it was important to ensure food items remained in the safe temperature zone to avoid harmful bacteria growth which could cause illness and serious health issues for the residents. The DS said he would ensure lids were utilized to help keep the food warm.</p>