STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the main kitchen.Specifically, the facility failed to ensure ready-to-eat foods were handled in a sanitary manner to prevent cross-contamination. Findings include:I. Professional referenceThe Colorado Retail Food Establishment Regulations, (3/16/24), retrieved on 9/15/25. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. (3-301.11)II. ObservationsDuring a continuous observation of the lunch meal service on 9/10/25, beginning at 10:35 a.m. and ending at 12:22 p.m. the following was observed:At 11:40 a.m. cook (CK) #2 began preparing a cheeseburger. CK #2 removed the lids for each cold container of hamburger toppings and set them aside. CK #2 donned a glove on one hand, grabbed a piece of lettuce and placed it on a plate. CK #2 then removed the glove and placed the glove in a metal bin which held clean tongs. CK #2 repeated this process to add tomato slices, onion, pickles, and cheese to the plate, and continued putting the used gloves in the metal bin. CK #2 did not perform hand hygiene before and after glove usage each time. CK #2 picked up the tongs from the metal bin and used them to apply the top bun to the cheeseburger before sending it out on the tray line. CK #2 placed the tongs back into the metal bin with the used gloves.At 11:47 a.m. CK #1 was plating a resident meal. CK #1 scooped a spoonful of carrots onto a plate. Some of the carrot slices started to fall off of the side of the plate, so CK #1 used her bare thumb to scoot them back onto the plate.At 11:54 a.m. the registered dietitian (RD) began preparing a sliced banana for a resident on a mechanically altered texture diet. The RD peeled the banana and began chopping it on a cutting board. The RD used her bare hand to stabilize the banana as she cut it into slices, and used her bare hand to brush the banana slices off of the knife and into a bowl. The RD asked a staff member if the bananas were the correct size for the resident's diet texture and proceeded to use her bare hand to scoop the banana slices out of the bowl and back onto the cutting board. After slicing the banana finer, the RD used her bare hand to slide the banana slices off of the knife and into the bowl. The RD covered the bowl with plastic wrap and gave it to an unidentified dietary aide to put onto a room tray cart.At 11:55 a.m. CK #2 began preparing two more hamburgers. CK #2 grabbed the hamburger buns and pulled them open using the same tongs from the metal bin. At 12:03 p.m. CK #2 finished preparing the hamburgers by using the same tongs from the metal bin to place the top buns on the hamburgers before sending them out on the tray line.III. Staff interviewThe dietary manager (DM) and the regional dietary consultant were interviewed together on 9/11/25 at 9:30 a.m. The DM and the regional dietary consultant both said ready to eat foods should be handled with gloved hands or utensils. The DM and the regional dietary consultant both said tongs should be stored somewhere clean between uses, such as a plate, a metal bin, or any clean surface. The DM and the regional dietary consultant both said bare hands should not come into contact with ready-to-eat foods.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to provide the necessary services to maintain personal hygiene for one (#53) of nine residents reviewed for services to maintain highest practicable quality of life out of 46 sample residents.Specifically, the facility failed to ensure Resident #53 received timely incontinence care and repositioning. Findings include:I. Facility policy and procedureThe Activities of Daily Living (ADLs) policy and procedure, revised 4/3/25, was received from the nursing home administrator (NHA) on 9/11/25 at 11:51 a.m. It read in pertinent part, Care and services will be provided for the following activities of daily living: transfer and ambulation and toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.II. Resident #53A. Resident statusResident #53, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with agitation and acute respiratory failure.The 6/13/25 minimum data set (MDS) assessment documented the resident was severely cognitively impaired per staff assessment. The resident was dependent on staff for all ADLs. The resident was dependent on staff for rolling left to right in bed and for transfers.The assessment documented the resident was always incontinent of bowel and bladder.B. ObservationsDuring a continuous observation on 9/9/25, beginning at 9:40 a.m. and ending at 1:44 p.m., the following was observed:At 9:40 a.m. Resident #53 was asleep in her Broda chair (a specialized type of wheelchair) at the nurses' station. Resident #53 was reclined to a 40-degree angle in her wheelchair.At 10:05 a.m. certified nurse aide (CNA) #7 pulled Resident #53 up toward the head of her wheelchair as she had slid down in her seat.At 10:35 a.m. Resident #53 was lying in her Broda chair, groaning and kicking her legs intermittently. Resident #53 stopped and fell asleep again.At 10:50 a.m. Resident #53 was lying in her wheelchair groaning, kicking her legs and grimacing.At 11:10 a.m. Resident #53 was groaning and kicking her legs. Resident #53 was also holding her forehead in her hand and grimacing.At 11:31 a.m. Resident #53 was scratching her head and groaning.At 11:44 a.m. Resident #53 was asleep in her chair and occasionally groaning.At 11:50 a.m. CNA #7 unlocked the wheels of Resident #53's Broda chair, adjusted the blanket over her legs and escorted her to the dining room.At 12:02 p.m. Resident #53 was lying in her Broda chair perpendicular to the dining table, kicking her feet and grimacing with her eyes closed.At 12:17 p.m. an unidentified CNA placed a clothing protector onto Resident #53.At 12:31 p.m. the unidentified CNA sanitized her hands, pulled Resident #53 closer to her and adjusted her Broda chair so she was sitting up a few degrees more and began assisting her with eating. At 1:04 p.m. the unidentified CNA wiped Resident #53's mouth with a paper napkin, folded and replaced the blanket on the resident's lap,and assisted her back to a spot in front of the nurses' station.At 1:18 p.m. Resident #53 was crying out and saying no and please, and groaning.At 1:30 p.m. CNA #7 told one of the facility's physicians he was going to put Resident #53 to bed and the physician requested to assess the resident before he did so. CNA #7 assisted Resident #53 to her room and the physician came in shortly thereafter.At 1:42 p.m. CNA #7 closed the door to Resident #53's room to provide incontinence care and put the resident to bed (see interviews below).-The facility failed to provide incontinence care for Resident #53 for four hours during the observation period.-The facility did not turn or offload weight for Resident #53 in her Broda chair for four hours during the observation period.C. Record reviewThe ADL care plan, revised 3/11/24, revealed Resident #53 had an ADL self-care performance deficit due to her dementia and Alzheimer's disease. Pertinent interventions revealed Resident #53 required one to two staff members to reposition and turn in bed and for toileting hygiene.The incontinence care plan, revised 3/5/24, revealed Resident #53 was incontinent of both bowel and bladder due to her Alzheimer's. Pertinent interventions included checking Resident #53 as required for incontinence.The pressure ulcer care plan, revised 3/11/24, revealed Resident #53 was at risk of pressure ulcer development due to her (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease process and immobility. Pertinent interventions included following the facility's policies and protocols for the prevention and treatment of skin breakdown.A hospice nursing note, dated 8/6/25, revealed Resident #53 had developed blanchable redness to her coccyx. The hospice nurse encouraged the facility nursing staff to turn and reposition Resident #53 every two hours and keep her skin clean and dry to prevent skin breakdown.A nursing summary, dated 8/27/25, revealed Resident #53 was dependent on staff for transferring, bed mobility and toileting. The summary documented Resident #53 was incontinent and needed toileting every two hours. Resident #53's skin was free of any open areas at that time.D. Staff interviewsCNA #7 was interviewed on 9/9/25 at 1:48 p.m. CNA #7 said he had transferred Resident #53 from her chair to her bed and changed her incontinence brief (see observations above). CNA #7 said Resident #53's incontinence brief had urine in it. CNA #7 said he usually checked Resident #53 every two hours to make sure she was dry and not soiled. CNA #53 said Resident #53 previously used to go over two hours and would remain dry when he checked her brief, but since she had some cognitive decline that happened less frequently.CNA #8 and CNA #9 were interviewed together on 9/10/25 at 4:26 p.m. Both CNAs said they checked Resident #53 for incontinence care every two hours and adjusted her position in her chair. CNA #9 said Resident #53 was incontinent and had bowel movements throughout the day.The medical director (MD) was interviewed on 9/11/25 at 10:46 a.m. The MD said he would have expected the staff to reposition Resident #53 and check her for incontinence care at least every two hours, especially if she was only a few feet away from the nurse's station. The MD said these cares should have been in Resident #53's care plan. The MD said incontinence cares and repositioning were done by the staff to help the residents avoid developing any skin breakdown or pressure ulcers. The MD said sometimes when residents cried out often it became like background noise to the nursing staff and led to Resident #53 getting forgotten about.Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 11:31 a.m. LPN #2 said incontinent residents were checked at least every two hours for toileting, but he tried to check them more frequently. LPN #2 said repositioning was done every two hours, as some residents were more susceptible to developing bed sores. LPN #2 said Resident #53 was incontinent of bowel and bladder. LPN #2 said Resident #53 was on two hour checks for toileting and adjusted her in her Broda chair. LPN #2 said Resident #53 needed repositioning. LPN #2 said Resident #53 was in her Broda chair a lot, so the nursing staff tried to move her around often. LPN #2 said Resident #53 did not have any skin breakdown at the time. LPN #2 said Resident #53 was not able to make her needs known at all. LPN #2 said Resident #53 was not able to turn independently and stayed in the same position.The director of nursing (DON) was interviewed on 9/11/25 at 12:40 p.m. The DON said residents who were dependent on staff should be offered repositioning every two hours. The DON said staff should check and change incontinent residents every two hours. The DON said she would follow up with the nursing staff and provide them with education on toileting and repositioning.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to implement an activities program that met the interests of and supported the physical, mental, and psychosocial well-being of each resident for one (#53) of one resident out of 46 sample residents.Specifically, the facility failed to: Provide a meaningful activities program for Resident #53; and, -Ensure Resident #53's activity participation was accurately documented.Findings include:I. Facility policy and procedureThe Delivery of Activity Services policy and procedure, revised March 2025, was received from the nursing home administrator (NHA) on 9/11/25 at 11:16 a.m. It read in pertinent part, Should a resident be considered medically or mentally incompetent, or physically unable to participate in such programs, an entry will be made in the resident's medical record (chart) stating fully the reason(s) for the restriction(s). Such an entry will be signed and dated by the person recording such data. Some activities can be adapted to accommodate the resident's change in functioning due to physical or cognitive limitations: Cognitive impairment (task segmentation, settings that recreate past experiences, smaller groups without interruption, one-to-one); Terminally ill (life review, spiritual support, touch, massage, music, reading to the resident)II. Resident #53A. Resident statusResident #53, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia with agitation and acute respiratory failure.The 6/13/25 minimum data set (MDS) assessment documented the resident was severely cognitively impaired per staff assessment. The resident was dependent on staff for all ADLs. B. Resident representative interviewResident #53's representative was interviewed on 9/11/25 at 10:33 a.m. The representative said Resident #53 had end-stage Alzheimer's disease and was receiving hospice care. The representative said Resident #53 used to be a people person and liked to talk with people. The representative said Resident #53 never really liked to read books or watch television, but always liked to talk.C. ObservationsOn 9/8/25 at 9:43 a.m., Resident #53 was lying in her wheelchair in her room alone, facing the wall. Resident #53 was saying no repeatedly, groaning and kicking her legs. There was no music playing in the resident's room and no meaningful activity was occurring. At 12:52 p.m. Resident #53 was lying in her wheelchair near the nurses' station. Resident #53 was kicking her legs and groaning. Three nursing staff members were sitting at the nurses' station talking about their personal lives. The nursing staff members did not attempt to engage Resident #53 in a meaningful activity.During a continuous observation on 9/9/25, beginning at 9:40 a.m. and ending at 1:44 p.m., the following was observed:At 9:40 a.m. Resident #53 was lying in her wheelchair at the nurses' station. At 9:51 a.m. activity assistant (AA) #1 walked through the hallway and interacted with another resident. At 9:53 a.m. AA #1 walked back through the hallway and continued interacting with another resident. AA #1 invited a resident to the daily devotional activity at 10:00 a.m. that morning.-AA #1 did not interact with Resident #53 or invite her to the activity.At 1:13 p.m. an unidentified activity assistant invited several residents near the nurses' station to go to bingo that afternoon.-The activity assistant did not talk to or acknowledge Resident #53.On 9/10/25 at 9:43 a.m. Resident #53 was in her room alone, lying in her wheelchair and talking to herself. An unidentified activity assistant was walking down the hallway looking for residents to invite to the morning activity. The activity assistant peered into Resident #53's room from the hallway but did not enter the room or speak with Resident #53.At 10:02 a.m. Resident #53 was lying in her wheelchair in her room alone, facing a wall. Resident #53 was crying out, kicking her legs and saying unintelligible words. There was no music playing in the resident's room and no meaningful activity was occurring.D. Record reviewThe activity care plan, revised 12/24/24, revealed Resident #53 enjoyed passively participating in independent, structured and one-to-one leisure activities. Resident #53 enjoyed listening to music and spending time in the common areas watching and socializing with peers and staff members. Resident #53 practiced the Christian faith. Resident #53 became overstimulated when in large groups and had a history of yelling (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out. Pertinent interventions included staff assisting Resident #53 to potential groups of interest, monitoring her activity participation for any change or decline and providing therapeutic one-to-one visits three times per week.A quarterly activity assessment for Resident #53 was conducted on 8/25/25 at 10:58 a.m. The assessment documented Resident #53 preferred to be independent in her leisure activities and preferred small groups or one-to-one settings. Resident #53 engaged in structured leisure activities four to six times per week, mostly passively. Resident #53 enjoyed spending time in her room resting or in the television room on the unit watching television programs. Resident #53 enjoyed programs with bright colors and animation. Resident #53 had been observed to enjoy listening to music and spiritual visits, such as reading the daily devotions and daily chronicles. Review of Resident #53's religious activity task log, from 8/12/25 through 9/10/25, revealed Resident #53 refused to participate in activities each day, including on 9/9/25 at 10:06 a.m. and 9/10/25 at 10:00 a.m.-However, observations revealed Resident #53 was not invited to or encouraged to participate in the activities on 9/9/25 and 9/10/25 (see observations above).Review of Resident #53's creative activity task log, from 8/12/25 through 9/10/25, revealed on 8/21/25 at 3:32 p.m. Resident #53 refused to participate.-No other activities were documented during this time period for the creative activity task log.Review of Resident #53's independent activity task log, from 8/12/25 through 9/10/25,revealed the following:-Active participation was marked once per day for each day of the time period; -Activities, including television/radio/movies, walking or wheeling, exploring the environment and observing surroundings were marked almost every day for the time period; and,-Visiting with other residents was marked fifteen times, including on 9/9/25 at 12:49 p.m.-However, Resident #53 was unable to speak to or interact with other residents due to her disease progression, and the resident was not observed interacting with staff or any other residents on 9/9/25 (see observations above).Review of Resident #53's social activity task log, from 8/12/25 through 9/10/25, revealed Resident #53 refused to participate each day, including on 9/9/25 at 1:33 p.m. -However, observations revealed Resident #53 was not invited to or encouraged to participate in activities on 9/9/25 (see observations above).Review of Resident #53's mental activity task log, from 8/12/25 through 9/10/25, revealed the following:-Passive participation was documented 20 times;-Resident not available was marked two times;-Resident refused was marked 20 times; and,-Active participation was marked once.Specifically, reading and word/card games were documented almost each day over the review period, resident council was documented once, and a self-esteem workshop was documented once.Review of Resident #53's entertainment activity task log, from 8/12/25 through 9/10/25, revealed the following:-Resident not available was marked once; and,-Resident refused was marked three times.-No other activities of this kind were documented during the review period.Review of Resident #53's one-to-one activity task log, from 8/12/25 through 9/10/25, revealed the resident had actively participated in one-to-one activities 13 times over the review period for 15 minutes each time.III. Staff interviewsCertified nurse aide (CNA) #9 was interviewed on 9/10/25 at 4:18 p.m. CNA #9 said the nursing staff took Resident #53 to group activities because she liked to attend them. CNA #9 said Resident #53 enjoyed going to the daily devotions activity in the mornings.-However, observations throughout the survey period did not reveal Resident #53 attending or being invited to the daily devotions activity (see observations above).Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 11:31 a.m. LPN #2 said he did not know if Resident #53 could read but knew she could see. LPN #2 said the facility's activity assistants invited all of the residents to each activity, and the nursing staff assisted the residents in getting to the activities.-However, the activity assistants were not observed inviting Resident #53 to the activities (see observations above). LPN #2 said Resident #53 did not really do much during the day. LPN #2 said Resident #53 mostly stayed at the nurses' station or went to group activities to listen but not actively participate in the activities. AA #1 was interviewed on 9/11/25 at 11:41 a.m. AA #1 said all of the activity assistants invited residents to activities. AA #1 said the activities staff did not always invite every resident to every activity, but they tried to do so. AA #1 said if a resident (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not religious, the activities staff did not invite them to the daily devotions activity. AA #1 said she was instructed by the previous activity director to mark refused in the activity task if a resident was sleeping. AA #1 said if a resident was sitting in a common area of the facility, she documented it as visiting with other residents in the independent leisure activity task, as the resident was likely talking with others. AA #1 said in the mental activity task, receiving the daily chronicle was documented as reading and word games. AA #1 said if the resident could not read, the activity assistants would document refused. AA #1 said sometimes the activity assistants would read the daily chronicle to the residents, which was considered passive participation.AA #1 said Resident #53 mostly just sat around the facility. AA #1 said the activities staff tried to bring her to group activities but the resident would get overstimulated and start yelling out. AA #1 said Resident #53 was on a one-to-one activity visit program three times per week. AA #1 said the activities staff really struggled with Resident #53 to know what activities they could do more of for her. AA #1 said Resident #53 could not read and did not talk much, but did enjoy physical touch. AA #1 said Resident #53 did better in small groups and with one-to-one, and she thought the resident might enjoy aromatherapy.The NHA was interviewed on 9/11/25 at 12:54 a.m. The NHA said the activity director left the facility that Monday (9/8/25), so a regional consultant was helping to fill in. The NHA said all residents were to be invited to all activities. The NHA said he thought the activity assistants woke residents up to invite them to activities if they were sleeping, but he was not sure what the facility's policy was. The NHA said the activities program should be resident-centered and residents should be offered one-to-one activities and be encouraged to come to group activities.The NHA said he had not seen any issues with activity documentation.The social services consultant was interviewed on 9/11/25 at 1:22 a.m. The social services consultant said Resident #53 was on a one-to-one activity visit program, which was her main source of activity engagement. The social services consultant said the activities staff had been documenting that the resident had been receiving and using the daily chronicle, but the staff should really have been documenting that the resident was not available, as she could not interact with the daily chronicle on her own and the staff were not reading it to her. The social services consultant said the activities documentation had been divided amongst the activities staff in a way where all of the staff members were doing some segmented bits of documentation. The social services consultant thought this documentation method was possibly where some of the inaccuracies in the documentation had originated.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 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 two of three certified nurse aides (CNA).Specifically, the facility failed to complete annual performance reviews and/or provide regular in-service education based on the outcome of the reviews for CNA #7 and CNA #11. Findings include:I. Record reviewAnnual performance reviews for CNA #7 and CNA #11 were requested on 9/9/25 at 1:34 p.m. The facility was unable to provide annual performance evaluations for CNA #7 (hired on 3/1/24) and CNA #11 (hired on 3/1/24).-The CNAs did not have an annual performance review completed and the CNAs did not have an in-service education plan based on the outcome of the review.The facility provided a document on 9/9/25 at 3:03 p.m. which identified that a performance improvement plan (PIP) had been initiated on 8/22/25 regarding outstanding annual performance reviews. The PIP stated an audit had been completed and identified staff members who had not received an annual review timely. The audit revealed 36 staff members had outstanding annual performance reviews with a goal to complete the performance reviews by 10/31/25.-However, only one CNA annual performance evaluation had been completed since the PIP was initiated on 8/22/25.II. Staff interviewsThe director of nursing (DON) was interviewed on 9/11/25 at 9:02 a.m. The DON said the CNA performance reviews needed to be done annually and the facility had initiated a PIP because she was behind on the reviews. The DON said she was behind because human resources (HR) went on maternity leave and she helped with managing those. The DON said she did all of the reviews and did not utilize the assistance director of nursing (ADON) because she liked to meet face to face with the staff. The DON said the reviews were important so that the staff knew how they were doing in their roles. The DON said she did a CNA review 5/2/25 for CNA #12 but the review did not reveal any concerns so there was no in-service education based on the outcome of that review. The DON said she had completed one CNA review since the PIP was put in place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease.Specifically, the facility failed to:-Ensure staff performed appropriate hand hygiene assisting residents with eating; and,-Ensure staff handled residents' drinkware in a sanitary manner.Findings include:I. Failed to ensure staff performed hand hygiene while assisting residents with eatingA. Professional referenceAccording to The Centers for Disease Control and Prevention's (CDC) Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 9/15/25 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, included the following recommendations for hand hygiene, Hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics. Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings.B. Facility policy and procedureThe Dining and Infection Control policy, revised March 2021, was received from the NHA on 9/11/25 at 11:15 a.m. It read in pertinent part, Staff will perform appropriate hand hygiene. If hands are soiled, have touched their face/hair, have touched a resident or wheelchair, they will wash their hands before passing additional trays.C. ObservationsDuring a continuous observation of the breakfast meal in the main dining room on 9/8/25, beginning at 7:10 a.m. and ending at 8:26 a.m., the following was observed:At 8:05 a.m. licensed practical nurse (LPN) #1 was assisting two unidentified dependent residents with eating. LPN #1 alternated offering each resident a bite of food before offering a bite of food to the other resident. LPN #1 scratched her face and adjusted her face mask several times while alternating between offering bites of food to each resident.-LPN #1 did not perform hand hygiene after touching her face or mask and between offering bites of food to each resident.At 8:07 a.m. the regional dietary consultant delivered a bottle of hand sanitizer to the table where LPN #1 was sitting and told her to perform hand hygiene after adjusting her mask.At 8:08 a.m. LPN #1 finished assisting one of the unidentified residents with eating and began assisting another unidentified resident. -LPN #1 did not perform hand hygiene before assisting the other resident with eating.On 9/10/25 at 12:39 p.m. certified nurse aide (CNA) #9 was sitting in the dining room at a table assisting two unidentified dependent residents with eating. CNA #9 was alternating offering each resident a bite of food.-CNA #9 did not perform hand hygiene between assisting the two residents. -Additionally, there was no hand sanitizer visibly available at the dining room table.D. Staff interviewThe director of nursing (DON), who was also the facility's infection preventionist (IP), was interviewed on 9/11/25 at 12:40 p.m. The DON said the staff should perform hand hygiene in between feeding different residents.II. Failed to handle residents' drinkware in a sanitary mannerA. ObservationsDuring a continuous observation of the breakfast meal in the main dining room on 9/8/25, beginning at 7:10 a.m. and ending at 8:26 a.m., the following was observed:At 7:42 a.m. CNA #10 carried four glasses of orange juice through the dining room to deliver to residents. CNA #10 had the glasses stacked one on top of the other so the rims of two of the glasses were touching the bottom of the other two glasses. CNA #10 was holding the stacked glasses in the middle of the stack and her hand was touching two of the glasses by the rim of the glass. At 7:45 a.m. CNA #10 delivered two more glasses of orange juice to residents in the dining room. CNA #10 held one of the glasses by the rim of the glass. At 7:46 a.m. CNA #10 delivered a mug of coffee to a resident in the dining room. CNA #10 held the coffee mug by the rim of the mug.B. Staff interviewThe DON was interviewed on 9/11/25 at 12:40 p.m. The DON said the staff should hold residents' drinking glasses by the bottom of the glass. The DON said the staff should not hold the rim of the glass when serving drinks to residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065248	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Care and Rehabilitation	5301 W 1st Ave Lakewood, CO 80226

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)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews, the facility failed to ensure certified nurse aides (CNA) received the required 12 hours of training per year for two out of three CNAs reviewed.Specifically, the facility failed to:-Ensure a system was in place to track the CNAs training to ensure they met the annual training requirements; and,-Ensure CNA #7 and CNA #11 received the required 12 hours of training per year. Findings include:I. Facility policy and procedureThe Nurse Aide Training policy and procedure, revised March 2025, was provided by the nursing home administrator (NHA) on 9/11/25 at 11:50 a.m. It read in pertinent part, This facility maintains an appropriate and effective nurse aide in-service training program for the purpose of ensuring the continuing competence of nurse aides. The staff development coordinator (or designee), with oversight from the director of nursing, shall be responsible for the coordination and/or provision of nurse aide education. Each nurse aide shall be provided at least 12 hours of in-service training annually, based on his/her employment date, not calendar year. The staff development coordinator shall maintain documentation of training in his/her office during the current training year, and shall forward to the HR (human resource) director at the completion of the training year to be maintained in the employee's personnel file. It is the responsibility of the employee to attend/complete mandatory in-service trainings to maintain employment status with the facility. A review of the employee's attendance/completion records shall be performed at least annually, such as at time of performance review.II. Record reviewA review of the CNA training records was completed on 9/10/25 at 10:03 a.m. CNA #7 was hired on 3/1/24. The training records revealed .75 hours of training in the previous year.CNA #11 was hired on 3/1/24. The training records revealed 1.00 hours of training in the previous year. III. Staff interviewThe director of nursing (DON) was interviewed on 9/11/25 at 9:02 a.m. The DON said they did not have a staff development coordinator (SDC). She said they had one for a while but could not find someone appropriate for the job and the job was no longer posted that she was aware of. The DON said the facility staff completed online training and HR was keeping track to ensure they met the annual training requirements. The DON said they had a temporary HR staff member since the regular HR staff member was on maternity leave. The DON said it was important to ensure that the CNAs completed the annual training requirements to ensure that they were doing their job duties adequately.