

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065253	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER LA Villa Grande Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Little Bookcliff Dr Grand Junction, CO 81501	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314</p> <p>Based on observation, interviews, and record review, the facility failed to ensure services provided met professional standards of practice for two (#3 and #9) of seven residents out of 5 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #9's fluid intake was monitored and managed effectively, which resulted in the resident being sent to the hospital for fluid overload; -Provide Resident #3, who chose not to consistently follow her recommended diabetic diet, with education related to the specific risks associated with not following her dietary recommendations; and, -Ensure Resident #3's diabetic care plan was updated to include documentation of the resident's refusals to comply with her recommended diabetic diet. <p>Findings include:</p> <p>I. Professional standards</p> <p>According to the National Institutes of Health Library of Medicine: Interventions For Improving Adherence To Dietary Salt and Fluid Restrictions In People With Chronic Kidney Disease Stage 4 and 5, retrieved on 10/9/24 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9620929,</p> <p>When prescribed, fluid restrictions are typically 1000 to 1500 milliliters (ml) per day.</p> <p>According to the National Institutes of Health Library of Medicine: Cardiology Explained chapter 4, retrieved on 10/9/24 from https://www.ncbi.nlm.nih.gov/books/NBK2215,</p> <p>LV (left ventricular) systolic dysfunction (heart failure on the left side of the heart) is assessed using the ejection fraction (the percentage of the end diastolic volume ejected during systole). In most cases, this is estimated by eye from all the available echocardiogram views. A normal ejection fraction is 50%-80%, but values as low as 5% are compatible with life (end-stage heart failure).</p> <p>II. Facility policy</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Resident Hydration and Prevention of Dehydration policy, revised October 2017, was received from the director of nursing (DON) on 10/8/24 at 3:44 p.m. It documented in pertinent part,</p> <p>Physician orders to limit fluids will take priority over calculated fluid needs.</p> <p>The dietitian and nursing staff will educate the resident and family regarding hydration and preventing dehydration.</p> <p>Nursing will monitor and document fluid intake and the dietitian will be kept informed of status, the interdisciplinary team (IDT) will update the care plan and document resident responses to interventions until the team agrees that fluid intake and relating factors are resolved.</p> <p>The Hydration-Clinical Protocol policy, revised September 2017, was received from the DON on 10/8/24 at 3:44 p.m. It documented in pertinent part, Staff, with physician's input, will identify and report to the physician individuals with signs and symptoms or lab (laboratory) test results that might reflect existing fluid and electrolyte imbalance.</p> <p>The Comprehensive Person-Centered Care Plan policy, revised March 2022, was received from the DON on 10/8/24 at 3:44 p.m. It documented in pertinent part,</p> <p>If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process.</p> <p>The comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided for the above but are not provided due to the resident exercising his of her rights, including the right to refuse treatment.</p> <p>Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision-making.</p> <p>Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.</p> <p>The resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.</p> <p>III. Resident #9</p> <p>A. Resident status</p> <p>Resident #9, age greater than 65, was admitted on [DATE] and discharged to the hospital on 8/14/24. According to the August 2024 computerized physician order (CPO), diagnoses included stage 4 chronic kidney disease, chronic respiratory failure and epileptic seizures.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 8/14/24 minimum data set (MDS) assessment documented the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. The assessment documented the resident was a poor decision-maker and required cueing and supervision. The resident required moderate assistance with toileting and bathing and was independent with eating.</p> <p>The assessment documented the resident did not have a swallowing disorder and was receiving a therapeutic diet.</p> <p>The assessment documented the resident had no rejections of care.</p> <p>B. Resident representative interview</p> <p>Resident #9's legal representative was interviewed on 10/8/24 at 11:13 a.m. The representative said Resident #9 could not make decisions for herself and she had been her legally-appointed guardian for several years. The representative said she usually visited Resident #9 weekly. The representative said she became sick in late July 2024 to early August 2024 and did not visit Resident #9 for about two weeks. The representative said when she returned to visit after recovering from her illness, Resident #9's feet and legs had become so swollen with fluid that the skin was red and taut on both legs, up to the level of the hip.</p> <p>The resident's representative said she had asked Resident #9's physician for a 2,000 ml fluid restriction per day in April 2024 or May 2024 because it was recommended by Resident #9's kidney doctor. She said she was surprised when the physician ordered a 3,000 ml fluid restriction because that did not seem like a fluid restriction to her. The representative said the fluid restriction was later reduced to 2,500 ml. The representative said she felt the facility gave Resident #9 too much water when the resident requested it.</p> <p>The resident's representative said she was not aware of any interventions the facility had in place to help Resident #9 adhere to her fluid restrictions. The representative said she could not recall if she or Resident #9 were given education regarding techniques to help Resident #9 adhere to her fluid restrictions.</p> <p>The resident's representative said when Resident #9 was hospitalized on [DATE], she was told by the emergency room physicians that Resident #9 was given too much water at the facility which caused fluid to build up in Resident #9's lungs and required significant medication and oxygen, for more than two weeks in the hospital, to improve.</p> <p>C. Record review</p> <p>Resident #9's kidney disease plan of care was initiated on 7/2/24 and revised on 8/22/24. The plan of care documented a goal for Resident #9 to have no signs or symptoms of complications related to fluid overload. Interventions included elevating the resident's feet when she was sitting in a chair, monitoring vital signs as ordered, monitoring changes in the resident's mental status and obtaining weights as ordered.</p> <p>Review of Resident #9's weights documented in the electronic medical record (EMR) revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-On 5/15/24, the resident weighed 241.4 pounds (lbs);</p> <p>-On 5/17/24, the resident weighed 240.8 lbs;</p> <p>-On 5/18/24, the resident weighed 240.4 lbs;</p> <p>-On 5/29/24, the resident weighed 243 lbs;</p> <p>-On 6/7/24, the resident weighed 257.8 lbs;</p> <p>-On 7/3/24, the resident weighed 261.8 lbs; and,</p> <p>-On 8/6/24, the resident weighed 275.4 lbs.</p> <p>The resident gained 35 lbs from 5/18/24 to 8/6/24, a period of three months.</p> <p>-Despite Resident #9's continued weight gain, there was no documentation to indicate the resident's physician was notified or that the facility put interventions in place to more closely monitor the resident and identify the cause of the resident's significant weight gain after 6/7/24.</p> <p>Review of Resident #9's August 2024 CPO revealed the following physician orders:</p> <p>Consistent Carbohydrate (CCHO) diet with regular texture and thin liquids. No soda or dark colored [NAME]. 2500 ml fluid restriction, ordered on 5/28/24.</p> <p>3,000 ml fluid restriction every shift for nutrition, ordered on 5/16/24 and discontinued on 6/6/24.</p> <p>-The physician's order indicated the resident's fluid restrictions were per shift instead of per day.</p> <p>2,500 ml fluid restriction every shift for nutrition, ordered on 6/6/24.</p> <p>-The physician's order indicated the resident's fluid restrictions were per shift instead of per day.</p> <p>Resident #9's medication administration record (MAR) fluid intakes were reviewed from 6/6/24 to 8/14/24. The 69 days of 2,500 ml fluid intake/restriction documentation revealed the following:</p> <p>-The resident received more than 2,500 ml of fluid in a 24-hour period of time on nine of those days;</p> <p>-The resident received more than 3,000 ml of fluid in a 24-hour period on seven of those days; and,</p> <p>-The resident received more than 4,000 ml of fluid in a 24-hour period on two of those days.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A skilled evaluation nursing note dated 6/25/24 documented Resident #9 was compliant with her fluid restrictions.</p> <p>A skilled evaluation nursing note dated 8/6/24 documented Resident #9 was compliant with her fluid restrictions.</p> <p>-However, according to review of Resident #9's fluid intake documentation on the MARs, the resident had more fluids than was physician ordered on several days (see above).</p> <p>Hospital documentation for Resident #9's hospital stay indicated Resident #9 was admitted for shortness of breath on 8/14/24 and was discharged from the hospital on 9/3/24.</p> <p>An emergency department physician note dated 8/14/24 documented Resident #9's fluid retention was caused by poor fluid intake management of the facility.</p> <p>A hospital physician note dated 8/15/24 documented Resident #9 required 5 liters per minute (LPM) of oxygen to maintain oxygen saturations, which was an increase from her baseline oxygen setting of 1.5 LPM. The note documented Resident #9 was placed on a fluid restriction of 2,000 ml per day in the hospital. The note documented Resident #9 was being admitted to the hospital for heart failure caused by increased fluid intake. The note documented Resident #9 had an ejection fraction of 55% on her echocardiogram performed on 2/18/2020, but it had now worsened to a 40% ejection fraction on the echocardiogram performed 8/15/24. The note documented Resident #9's left ventricle systolic performance was less vigorous and the posterior wall of the heart appeared hypokinetic (less activity).</p> <p>IV. Resident #3</p> <p>A. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), type two diabetes with long term use of insulin, gastroesophageal reflux disease (GERD) and diabetic retinopathy of the eye (damage to the eye from high blood sugar levels).</p> <p>The 8/16/24 MDS assessment documented the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required setup or clean-up assistance with eating.</p> <p>The assessment documented the resident did not have a swallowing disorder and was receiving a therapeutic diet.</p> <p>The assessment documented the resident had no rejections of care.</p> <p>B. Resident observation and interview</p> <p>Resident #3 was observed in her room on 10/8/24 at 10:22 a.m. On the resident's nightstand was a full size box of cinnamon toast crunch, two boxes of chocolate teddy grahams, two apples and a banana. The resident was eating a separate individual container of cinnamon toast crunch with whole milk and drinking a 7-up soda.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #3 said she had been diabetic since 1996. Resident #3 said she did not plan to adhere to her diabetic diet because she never had. She said she knew she was on a consistent carbohydrate (CCHO) diet, but she did not agree with many parts of that diet. Resident #3 said she would not allow anyone to take away her favorite foods or soda for any reason. She said she had four full size candy bars inside her nightstand as well so she could snack whenever she wanted to. Resident #3 said the facility provided her with the individually wrapped cinnamon toast crunch and whole milk for breakfast, but not the 7-up soda she consumed or the other food items on her nightstand.</p> <p>Resident #3 said she had not received education from a dietician or a nurse regarding adherence to her CCHO diet. She said she was not aware she was always supposed to adhere to her CCHO diet.</p> <p>C. Record review</p> <p>Review of Resident #3's medical diagnoses plan of care, initiated 6/19/24, documented the resident was on a regular CCHO diet. Interventions included providing and serving Resident #3's CCHO diet as ordered.</p> <p>The type 2 diabetes plan of care was initiated on 9/26/24. Interventions included a dietary consult for nutritional regimen and ongoing monitoring, providing the resident with diabetes education, encouraging the resident to comply with dietary restrictions, monitor compliance with diet and documenting any problems and monitoring and documenting the resident's current level of understanding of the disease process and treatment regimen.</p> <p>-The care plan did not document Resident #3 frequently refused to comply with her recommended diabetic diet.</p> <p>-Despite the care plan documenting the resident was to be provided with education related to her diabetic diet and compliance with the diet, there was no documentation in the resident's EMR to indicate education had been provided to the resident.</p> <p>The GERD plan of care was initiated on 9/26/24. Interventions included avoiding overeating, encouraging a bland diet and avoiding foods and beverages that irritated the esophageal lining, such as alcohol, chocolate, caffeine, acidic or spicy foods and fried or fatty foods.</p> <p>Review of Resident #3's October 2024 CPO revealed a physician's order for a consistent carbohydrate diet, ordered on 8/3/23.</p> <p>An IDT note dated 5/8/24 documented Resident #3 was on a CCHO diet and had variable intakes and refusals.</p> <p>-However, there was no documentation in the resident's EMR regarding the resident's refusals of her recommended diet.</p> <p>A care conference note dated 8/20/24 documented the resident was an insulin dependent diabetic. The care conference documented nursing was managing Resident #3's diabetes and blood sugars.</p> <p>-The care conference note did not indicate the resident's CCHO dietary recommendations were discussed.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A performance improvement plan (PIP), dated 8/15/24, was received from the DON on 10/8/24 at 3:19 p.m. The PIP documented the facility's IDT committee would complete an audit of current residents in the facility who may have fluid restrictions and/or dietary recommendations in order to identify those residents who choose not to follow dietary recommendations. It documented the IDT team would complete education with identified residents to inform them of specific risks associated with not following recommendations and update resident care plans if needed.</p> <p>-However, Resident #3's care plan had not been updated to include her refusals to follow her recommended diet and there was no documentation in the resident's EMR to indicate she had been educated about the specific risks associated with not following her dietary recommendations (see above).</p> <p>V. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 10/8/24 at 1:28 p.m. CNA #1 said if something had been ordered per shift, it meant it was done twice per day. CNA #1 said Resident #3 only occasionally adhered to her diet order. CNA #1 said Resident #3's family had brought her food items that were typically not given to residents on a CCHO diet. CNA #1 said she did not know if diet education had been provided to Resident #3 or her family.</p> <p>Licensed practical nurse (LPN) # 2 was interviewed on 10/8/24 at 1:32 p.m. LPN #2 said if a resident was non-adherent to their diet order, it would be communicated to the physician and the dietitian and documented in progress notes. LPN #2 said refusals of dietary recommendations would normally be documented in progress notes and discussed with the dietitian. LPN #2 said if something was ordered each shift it could mean either two or three times per day, depending on how many staff shifts the facility had.</p> <p>Registered nurse (RN) #2 was interviewed on 10/8/24 at 1:37 p.m. RN #2 said if a resident did not want to adhere to their diet, the nursing staff would try and educate the resident of the importance of diet adherence. RN #2 said nursing staff would try to involve the dietitian in this process. RN #2 said she was unfamiliar with the process of changing a resident's diet order and would need to ask her peers for assistance in that process.</p> <p>LPN #1 was interviewed on 10/8/24 at 1:44 p.m. LPN #1 said when a resident refused to follow the physician-prescribed diet order, the physician would be notified. LPN #1 said the physician notification should be documented in the progress notes. LPN #1 said nursing staff provided residents with education about the importance of adhering to the physician-prescribed diet and that education should be documented in the progress notes section of the resident's EMR.</p> <p>The registered dietitian (RD) was interviewed on 10/8/24 at 2:28 p.m. The RD said she was present in the facility one day per week on Wednesdays. The RD said it was important that residents with diabetes on a CCHO diet received appropriate servings with meals to ensure resident blood sugars were not erratic. The RD said the facility did not count carbohydrates for diabetic residents on a CCHO diet, but rather, the facility would simply halve the portion of the dessert option. The RD said if the dessert option was cake, the diabetic resident on a CCHO diet would receive a half of a piece of that cake instead of a whole piece.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The RD said anyone present in the resident's vicinity while eating was responsible for ensuring the resident was adherent to the physician-prescribed diet order. The RD said nurses could provide education to residents on the importance of diet adherence. The RD said if she were notified, she could provide education to the residents on the importance of diet adherence for diabetes management as well.</p> <p>The RD said if a resident was not interested in diet adherence, she would communicate the resident's preference to the nursing management team. The RD said she would discuss the resident's preference with the physician and the resident's family to identify additional interventions to assist with diet adherence. The RD said the care plan should be updated to reflect the current plan of care.</p> <p>The RD said she had not been informed of any concerns with diet adherence for Resident #3. The RD said she was not aware the resident was eating food items in her room that were not on her recommended diet. The RD said if Resident #3 was consistently making the choice to eat cereal and soda for breakfast then she would need to provide education to the resident and her family regarding the importance of diet adherence. The RD said physician's orders should always be followed.</p> <p>The RD said if something were to be ordered per shift, it could mean very different things, depending on the facility. The RD said it could mean every six hours, every eight hours, or every 12 hours. The RD said she was typically more familiar with seeing a fluid restriction ordered per day rather than per shift. The RD said that the 2,500 ml fluid restriction ordered per shift for Resident #9 did not seem to be an appropriate order and should have been clarified.</p> <p>The RD said a 2,500 ml fluid restriction per shift, even for two shifts a day, would equal 5,000 ml of fluid intake per day, which she did not consider to be a fluid restriction. The RD said she was not aware of how Resident #9's fluid restriction order had been written.</p> <p>The DON was interviewed on 10/8/24 at 2:59 p.m. The DON said if a resident did not want to follow a physician-ordered diet, he would expect nursing staff to educate the resident on the importance of adhering to the diet. The DON said if the education was not effective, he would expect nursing staff to inform the IDT team or the registered dietitian. The DON said nursing administration would then discuss the situation on the next day, identify root causes and perform a dietary assessment of risks and benefits to diet adherence. The DON said he was not aware Resident #3 was non-adherent to her diet.</p> <p>The DON said there were two shifts at the facility. The DON said fluid restrictions varied based on the physician's order. The DON reviewed Resident #9's physician orders. The DON said a 2,500 ml fluid restriction per shift did not seem correct. The DON said his staff should know that a 2,500 ml fluid restriction order always means per day and not per shift.</p> <p>-An attempt to interview Resident #9's physician on 10/8/24, during the survey, was unsuccessful.</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>40467</p> <p>Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in one of one kitchen.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure safe and appropriate storage of food items in the refrigerators and pantry; and, -Ensure ready-to-eat foods were handled in a sanitary manner to prevent cross contamination. <p>Findings include:</p> <p>I. Failure to store food items appropriately in the refrigerators and the dry storage area</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 10/16/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part,</p> <p>Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices and sugar shall be identified with the common name of the food.</p> <p>In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit.</p> <p>Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5 degrees celsius (41 degrees fahrenheit (f)) or less for a maximum of seven days. The day of preparation shall be counted as day one.</p> <p>According to the United States Department of Agriculture (USDA) Is Food In Dented Cans Dangerous? (9/18/24) retrieved on 10/16/24 from https://ask.usda.gov/s/article/is-food-in-damaged-cans-dangerous, food from cans that were leaking, bulging, or badly dented should never be eaten. The damaged cans could contain clostridium botulinum (a toxic bacteria).</p> <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>According to the USDA How You Should Handle Food With Mold On It (9/18/24) retrieved on 10/16/24 from https://ask.usda.gov/s/article/How-should-you-handle-food-with-mold-on-it, It documented in pertinent part, Buying small amounts and using food quickly can help prevent mold growth. But when you see moldy food: Don't sniff the moldy item. This can cause respiratory trouble. If food is covered with mold, discard it. Put it into a small paper bag or wrap it in plastic and dispose of it in a covered trash can that children and animals can't get into. Clean the refrigerator or pantry at the spot where the food was stored. Check nearby items the moldy food might have touched. Mold spreads quickly in fruits and vegetables.</p> <p>B. Facility policy and procedure</p> <p>The Food Receiving and Storage policy, revised November 2022, was provided by the dietary manager (DM) on 10/8/24 at 1:58 p.m. The policy read in pertinent part, Foods shall be received and stored in a manner that complies with food handling practices.</p> <p>When food is delivered to the facility it is inspected for safe transport and quality before being accepted.</p> <p>Dry foods and goods are handled and stored in a manner that maintains the integrity of the packaging until they are ready for use.</p> <p>Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen or discarded.</p> <p>The hand hygiene policy, revised November 2022, was provided by the dietary manager (DM) on 10/8/24 at 1:59 p.m. The policy read in pertinent part, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.</p> <p>C. Observations</p> <p>On 10/8/24 at 9:35 a.m. a can of corn was stocked on the first row of the can goods rack in the dry storage room of the kitchen. The can of corn had a large and deep dent on the side of the can.</p> <p>At 9:40 a.m. the following items were observed in the kitchen's walk-in refrigerator:</p> <ul style="list-style-type: none"> -Multiple containers of undated strawberries were sitting on a shelf. Four of the containers had moldy strawberries in them; -There were pre-bowled berries in a pan covered with parchment paper. The bowls of berries contained strawberries, blueberries and blackberries. The bowls were not labeled or dated; -A plastic lidded tub of lettuce that was not labeled or dated; and, -A plastic tub of white cheese covered in aluminum foil was not labeled or dated. <p>At 11:52 a.m. the moldy containers of strawberries remained on the shelf in the walk-in refrigerator. The cheese and lettuce tubs remained undated.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER LA Villa Grande Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 Little Bookcliff Dr Grand Junction, CO 81501	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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>-During the lunch meal service, beginning at 11:50 a.m. and ending at 1:10 p.m., seven bowls of the undated pre-bowled berries were served.</p> <p>At 12:45 p.m. The DM entered the walk-in refrigerator and removed the moldy strawberry containers.</p> <p>II. Failure to ensure ready-to-eat foods were handled in a sanitary manner</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Establishment Regulations, (3/16/24), were retrieved on 10/16/24 from https://cdphe.colorado.gov/environment/food-regulations. 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.</p> <p>If used, single-use gloves shall be used for only one task such as working with ready-to-eat food or with raw animal food, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation.</p> <p>The Center for Disease Control and Prevention (CDC) About Hand Hygiene For Patients in Healthcare Settings (2/27/24), retrieved on 10/16/24 from https://www.cdc.gov/clean-hands/about/hand-hygiene-for-healthcare.html, read in pertinent part, Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients.</p> <p>According to the CDC, hand washing should occur before preparing or eating food, before touching the eyes, nose or mouth, and after touching potential contaminated surfaces.</p> <p>B. Observations</p> <p>During a continuous observation of the lunch meal service in the kitchen on 10/8/24, beginning at 11:50 a.m. and ending at 1:10 p.m., the following was observed:</p> <p>Cook (CK) #1 was observed plating ready-to-eat food for the lunch meal service.</p> <p>At 12:02 p.m. CK #1 touched the side of her head with her left hand and then continued to plate resident meals.</p> <p>-CK #1 did not perform hand hygiene after touching her head.</p> <p>At 12:35 p.m. CK #2 placed a glove on one hand.</p> <p>-CK #2 did not perform hand hygiene before donning the glove.</p> <p>CK #2 picked up a stack of meal tickets, flipped through the tickets with the gloved hand and separated the tickets in two piles.</p> <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>-CK #2 did not remove the glove or perform hand hygiene after handling the meal tickets.</p> <p>CK #2 placed four premade hamburger patties on to a skillet with the same gloved hand he had used to handle the meal tickets.</p> <p>III. Staff interviews</p> <p>The DM was interviewed on 10/8/24 at 12:12 p.m. The DM said all cans of food should be checked for any dents and/or missing labels. She said all the cans should be checked for dents when delivered and stocked. She said damaged cans should be removed from the supply for use and set aside to return to the delivery driver on the next shipment.</p> <p>The DM said a can with a dent could have a small hole in it. She said a hole could allow air to get into the can and cause contamination. She said dents in canned food posed a risk of foodborne illnesses, such as botulism. The DM said all dented cans should be removed because staff would not know if there were small puncture holes that they could not see in the can or if the food inside had gone bad.</p> <p>The DM observed the dented can of corn on the can supply rack. She said the can should not have been placed on the rack with other cans ready for use. She said she would remove the can from the supply and set it in the delivery pick up pile from return.</p> <p>CK #1 was interviewed on 10/8/24 at 12:20 p.m. CK #1 said she prepped the strawberries, blueberries and blackberries for the lunch meal after the new shipment of strawberries arrived. She said she only used the new stock of strawberries that were delivered on the morning of 10/8/24.</p> <p>-However, the parchment paper covering the prepared bowls of berries was not dated to indicate when the berries should be discarded and mold was observed on the strawberries in the remaining containers in the refrigerator (see observation above).</p> <p>CK #2 was interviewed on 10/8/24 at 12:20 p.m. CK #2 said most of the produce that arrived at the facility arrived fresh. He said if he saw mold on any of the produce, he would throw it away. CK #2 said the kitchen staff did not have a routine schedule to check the produce in the refrigerator. He said the kitchen went through so much produce and the ongoing use created a quick turnover which decreased the need for scheduled checks. He said the produce supply was used faster than it went bad.</p> <p>CK #2 said dented cans could be used if they had a dent on them. He said he would not use the cans of food if the seal of the can was broken, if it was visibly open to air, and/or if there was liquid running out of it.</p> <p>The DM was interviewed a second time on 10/8/24 at 12:45 p.m. as she removed the moldy strawberries from the shelf in the walk-in refrigerator (see observation above). The DM said she found four and a half containers of moldy strawberries in the refrigerator. She said one of the strawberry containers had been opened and used. The DM could not identify when the opened pack of strawberries was last used. She said she needed to remove the moldy strawberries because of the risk of mold spreading to the rest of the produce. She said mold grew quickly on strawberries and if one strawberry had mold on it, the mold would quickly spread onto the other strawberries.</p> <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 DM said all produce in the refrigerator should be labeled and dated. The DM was informed of the undated and labeled tub of cheese covered with an aluminum foil and a covered tub of lettuce. The DM said the cheese and the lettuce should have been dated and labeled. She said the cheese should have been covered with a fitted lid so there was no risk for air entering the cheese. She said a fitted lid for the tub should have been used instead of the aluminum foil.</p> <p>The DM said staff should have been checking the produce daily to make sure there was no mold on the produce and everything was labeled and dated. She said checking the produce daily was an expectation but she did not have it as a set task or a log to sign off that the task had been completed. The DM said she would re-educate staff and create a log to sign off on to ensure the kitchen staff checked all produce in the refrigerator for freshness and made sure all refrigerated items were labeled and dated.</p> <p>Registered nurse (RN) #1 was interviewed on 10/8/24 at 2:26 p.m. RN #1 said she was the facility's infection preventionist. She said all staff received hand hygiene training during the new hire orientation and during the July 2024 skills fair. RN #1 said she did hand hygiene audits throughout the facility to include the kitchen staff. She said she conducted the audit monthly to ensure staff was following safe infection control practices and provide additional training as needed. RN #1 said she reminded the kitchen staff to perform hand hygiene before food preparation and every time they touched a potentially contaminated surface.</p> <p>The registered dietitian (RD) was interviewed on 10/8/24 at 2:31 p.m. The RD said she conducted routine oversight of the kitchen. The RD said, during kitchen walk-throughs, she would make sure the kitchen was clean and in good repair, staff was practicing good hand hygiene and using gloves appropriately. She said she would also make sure food items were labeled and dated.</p> <p>The RD said dented cans should be removed and set aside and not used because of the risk of botulism. She said had not been involved in educating the dietary staff on food borne illnesses.</p> <p>The RD said all produce with mold on it should be removed from the supply stock because of the risk of the mold spreading.</p> <p>The DM was interviewed a third time on 10/8/24 at 2:58 p.m. The DM said she reviewed and re-educated the dietary staff on hand washing, appropriate glove use and making sure the stored food for resident use was routinely inspected for safe consumption and removed from the stock when problems were identified.</p>		