

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Orchard Park Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6005 S Holly St Littleton, CO 80121	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150</p> <p>Based upon observations, interviews and record review, the facility failed to ensure two (#65 and #69) of five residents reviewed for assistance with activities of daily living (ADL) received fingernail care out of 45 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #65 fingernails were trimmed and clean; and, -Ensure Resident #69 received staff assistance with fingernail care, applying lotion on his dry skin and showering assistance. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Fingernails policy, revised June 2008, was provided by the nursing home administrator (NHA) on 5/9/24 at 5:00 p.m. It revealed in pertinent part, The purpose of this procedure is to promote circulation to the hands and to clean fingernails.</p> <p>Procedure includes, assisting residents into comfortable positions, cleaning under the fingernails with an orange stick if indicated and using nail clippers to cut the fingernails if permitted.</p> <p>II. Resident #65</p> <p>A. Resident status</p> <p>Resident #65, age greater than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia, blindness right and left eye category three, chronic pain, unspecified osteoarthritis, muscle weakness and the need for assistance with personal care.</p> <p>The 3/23/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 10 out of 15. He required set-up assistance with transfers, dressing, eating, toileting and personal hygiene.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Observations and interview</p> <p>Resident #65 was interviewed on 5/6/24 at 9:12 a.m. Resident #65 was sitting on his bed in his room. His fingernails were long, chipped and cracked.</p> <p>Resident #65 said he needed assistance to get his fingernails cut and filed. He said his fingernails were too long and that bothered him. The resident said, although he received showers twice a week, the certified nurse aides (CNA) did not cut and trim his fingernails.</p> <p>At 2:35 p.m. Resident #65 returned to his room from an activity and sat on his bed. His fingernails were long and chipped.</p> <p>On 5/7/24 at 4:15 p.m. Resident #65 sat in his wheelchair in his room with long, chipped and cracked fingernails.</p> <p>On 5/8/24 at 9:40 a.m. Resident #65 was escorted to the shower room by CNA #1 for a shower. The resident returned to his room with CNA #1 following the shower.</p> <p>At 10:00 a.m. CNA #1 left Resident #65' s room after assisting the resident with the shower and escorting him back to his room. Resident #65' s nails remained long, cracked and chipped.</p> <p>-CNA #1 failed to provide fingernail care to the resident even though she assisted the resident with a shower.</p> <p>C. Record review</p> <p>The ADL care plan, initiated on 9/12/23 and revised on 4/1/24, identified Resident #65 had an activities of daily living (ADL) self-care performance deficit related to his diagnosis of dementia.</p> <p>-The care plan did not include interventions for fingernail care.</p> <p>III. Interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 5/8/24 at 10:25 a.m. CNA #1 said Resident #65 required one person extensive assistance with his activities of daily living (ADL), including cutting and trimming his fingernails. She said she noticed during the resident' s shower that his fingernails were long but she did not have fingernail clippers to cut them. CNA #1 said long fingernails could cause injuries such as skin tears and could carry bacteria that could cause infections.</p> <p>Registered nurse (RN) #1 was interviewed on 5/8/24 at 10:35 a.m. RN #1 said Resident #65 was dependent on staff and required extensive assistance with his ADLs. RN #1 said the nurses were responsible for providing fingernail care for all dependent residents. She said she was not sure if CNAs could provide nail care for residents. She said Resident #65' s nails were long and chipped. RN #1 said the resident' s fingernails should be kept cut and trimmed. RN #1 said long fingernails could collect bacteria and result in sickness.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The director of nursing (DON) was interviewed on 5/8/24 at 3:15 p.m. The DON said the nursing staff were responsible for ensuring residents were assisted with fingernail care. The DON said long and chipped fingernails could lead to illness and injuries, such as skin tears. The DON said she would immediately provide education to the nursing staff to ensure staff assisted dependent residents with nail care.</p> <p>41032</p> <p>IV. Resident #69</p> <p>A. Resident status</p> <p>Resident #69, age 69, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the May 2024 CPO, diagnoses included diabetes, need for assistance with personal care and reduced mobility.</p> <p>According to the 3/26/24 MDS assessment, the resident was cognitively intact with a BIMS score of 15 out of 15. The resident required extensive assistance with bed mobility, transfers, bathing and with dressing and grooming.</p> <p>B. Resident interview and observations</p> <p>Resident #69 was interviewed on 5/6/24 at 10:06 a.m. Resident #69 said he preferred to shower over a bed bath but the staff would not get him up for the shower. He said, instead, the staff just gave him a bed bath. The resident said he had not had a bed bath in several days and he at least wanted a bed bath if they could not provide him a shower.</p> <p>Resident #69 said when staff did assist him with a bed bath there was only one certified nurse aide (CNA) who assisted him to apply lotion to his dry skin and apply deodorant. He said the other CNAs would not make the effort even when he requested lotion and deodorant. Resident #69 pointed to a box he kept at the foot of his bed and said his lotion and deodorant was in the box. He said the staff would not have to move far to reach his hygiene supplies.</p> <p>Resident #69 said he had been asking the staff to help with a shower for over a week and he had not received one. Resident #69 said he had refused an offer to go to the shower room on one occasion because he was not feeling up to getting out of bed. He said he thought a shower would help relieve his dry itchy skin and the itchiness in his groin area.</p> <p>Resident #69 said he had asked staff to assist him with cutting his fingernails as they were getting long. The resident showed his long curling nails. He said his fingernails needed to be clipped and cleaned, but the CNAs would not assist him with nail care. He said one CNA left a pair of clippers in his room, but they disappeared. He said he was unable to clip his nails on his own. He said he had a bad itching in his groin area and had been scratching the area. Resident #69 said his long nails irritated his skin even more but it itched so much he had to scratch the area. Resident #69 said he had even tried to rip off his nails to shorten them, but he was unsuccessful. He did not know what else to do.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/6/24 at 10:06 a.m., 5/8/24 at 2:11 p.m and 5/9/24 at 3:30 p.m., Resident #69 was observed with long and dirty fingernails. There was a brown substance underneath each nail and the skin on the resident' s arms and back were dry with flakes of dead skin visible.</p> <p>C. Record review</p> <p>The resident' s comprehensive care plan, initiated on 1/12/24, revealed Resident #69 had an ADL self-care performance deficit due to bed confinement and impaired skin integrity. Interventions included referral to podiatrist/foot care, nurse to monitor/document foot care needs and to cut</p> <p>long nails, conduct daily skin inspections and report abnormalities to the nurse.</p> <p>-However, the resident had both legs amputated below the knees and the care plan did not have interventions to maintain fingernails or a treatment for dry skin.</p> <p>According to the resident' s bath schedule for the past 30 days the resident received bathing assistance two times out of eight opportunities. The record documented that the resident had a bed bath on 4/10/24 and 4/19/24 and refused only one showering opportunity on 4/17/24. The schedule documented that showers did not apply to this resident on four occasions and no bathing assistance was provided. The last scheduled bathing date was not documented and none were given.</p> <p>-A review of the resident's electronic medical record did not reveal documentation indicating how much assistance the resident needed for nail care or the last time he received nail care.</p> <p>V. Interview</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 5/8/24. LPN #1 said Resident #69 should get two showers per week. She said there had been a staff shortage and that could be why the resident did not get his scheduled showers. LPN #1 said Resident #69 should receive nail care on his bathing days.</p> <p>Registered nurse (RN) #2 was interviewed on 5/9/24 at 3:06 p.m. RN #2 said Resident #69 recently moved to the unit, so he was not sure why the resident had not received showers or nail care. He said the CNAs were supposed to follow the schedule and provide bathing and nail care for Resident #69. RN #2 checked the shower schedule and verified the resident was on the showering schedule. He said he would make sure the resident received a shower and nail care care that evening.</p> <p>CNA #2 was interviewed on 5/9/24 at 5:30 p.m. CNA #2 said Resident #69 told her he preferred a shower over a bed bath because it made him feel better. CNA #2 did not know why the resident had not been showered.</p> <p>The director of nursing (DON) was interviewed on 5/9/24 at 5:50 p.m. The DON said the resident should receive his showers on his scheduled shower days. She said showers or baths could help with skin issues and keep body odor under control.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150</p> <p>Based on interviews, observations and record review, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures.</p> <p>Specifically, the facility failed to ensure resident food was palatable in taste, temperature and texture.</p> <p>Findings include:</p> <p>I. Resident interviews</p> <p>Resident #108 was interviewed on 5/6/24 at 1:37 a.m. Resident #108 said his meal trays were often missing an ordered item. He said he was served a hamburger for lunch with no lettuce and tomatoes and sugar and creamer and no tea. The resident said warm food was usually cold when it was delivered.</p> <p>Resident #215 was interviewed on 5/6/24 at 2:02 p.m. Resident #215 said the food in the facility was not good. He said he had not had a good meal in so long he could not remember when the last good meal was. He said he told the kitchen not to serve him rice anymore because it was always served with hard pieces in it and the pork and beans that were served recently as a main meal was hardly a meal. He said instead, it was a cup of beans with one small piece of a hotdog [NAME]. Staff served his food with plastic utensils that usually broke off in his food and food that was supposed to be hot was often served cold. The last cheeseburger he was served was not only cold but was hard like it had been sitting around.</p> <p>Resident #22 was interviewed on 5/7/24 at 9:07 a.m. Resident #22 said the food tasted terrible, that it was dry and tasteless, especially the chicken. He said his meal trays were often missing an ordered item and the hot foods were served cold most of the time.</p> <p>Resident #69 was interviewed on 5/8/24 at 12:13 p.m. Resident #69 said he was served salisbury steak, green beans and mashed potatoes for lunch and it was terrible and the temperature was cold. He said he could only eat a few bites of food. He said he tried to get staff to bring him something else but staff did not return until the meal service was over so he just went without. Resident #69 said if you ate in the main dining room there were no good alternative foods offered.</p> <p>II. Observations</p> <p>On 5/8/24 at 12:37 p.m. five surveyors evaluated a test tray for a regular textured diet and a pureed textured diet immediately after the last resident had been served their lunch.</p> <p>The regular textured meal consisted of chicken pot pie, carrots, mashed potatoes and and individual cheesecake pudding pie with a graham cracker crust.</p> <p>-The mashed potatoes had a chicken stock flavor.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The chicken pot pie was present in a messy scooped pile that was unidentifiable as a pot pie and was way too salty.</p> <p>-The carrots were not seasoned but tasted like a cooked carrot.</p> <p>-The cheesecake pudding pie with a graham cracker crust had a strange slightly floral taste and was warm and not cold as you would expect.</p> <p>The pureed consistency meal consisted of chicken pot pie, carrots and an individual crustless cheesecake pudding.</p> <p>-The chicken pot pie was too salty.</p> <p>-The carrots tasted bland and had a gritty slightly chunky texture.</p> <p>-The crustless pie was bland and warm tasting.</p> <p>When the temperature was taken both the cheesecake crusted and crustless pies temperatures were over the acceptable temperature range for safe and palatable food temperature.</p> <p>The test tray crusted cheesecake pie temperature was 52 degrees Fahrenheit (F) and the crustless cheesecake pie temperature was 73 degrees F.</p> <p>-In both cases the cheesecake pudding pies were removed from the refrigerator and placed directly on the meal trays and then taken shortly after to be delivered to the resident and delivered as the test tray.</p> <p>At 1:05 p.m., after testing the meal trays, the temperature was taken of the leftover cheesecake pudding pies that remained in the facility's main kitchen refrigerators. The temperature of the individualized cheesecake pudding pies that remained in the refrigerators was 49 degrees F.</p> <p>On 6/8/24 at 4:30 p.m., dietary manager (DM) #2 provided the cheesecake pie recipe. The recipe revealed the cheesecake pudding pies were made of a milk product containing cream cheese, canned vanilla pudding, and a graham cracker pie shell. The ingredients were to be mixed together and chilled for two to three hours before serving. The pie was to be held and served cold at or below 40 degrees F.</p> <p>III. Staff interviews</p> <p>DM #1 and DM #2 were interviewed on 5/8/24 at 2:50 p.m. DM #1 said the kitchen staff should have obtained the temperature of the cheesecake before serving it to the residents. DM #1 said it was important to ensure food items were kept at a safe temperature to avoid bacteria growth, which could lead to food-borne illnesses. DM #1 said the chicken pot pie might have been salty due to the chicken base the cooks used. DM #1 said he would try a different chicken base the next time pot pie was on the menu.</p> <p>(continued on next page)</p>

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