STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065265	A. Building B. Wing	06/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berthoud Care and Rehabilitation	855 Franklin Ave Berthoud, CO 80513

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for two (#2 and #5) of five residents reviewed for edema care out of 30 sample residents. Specifically, the facility failed to: -Ensure physician orders were followed for the application and removal of elastic hose stockings (used to increase circulation, to prevent blood clots and reduce swelling) for Resident #2; and, -Ensure complete documentation of Resident #5's edema was completed accurately per physician order for Resident #5. Findings include: I. Facility policy The Edema Monitoring policy, undated, was provided by the nursing home administrator (NHA) on 6/10/24 at 9:00 a.m. It read in pertinent part Put on elastic hose as ordered, apply while in bed. II. Resident #2 A. Resident status Resident #2, age 75, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included respiratory failure, diabetes, heart failure, chronic ulcer (sore) of left thigh. The 2/29/24 minimum data set (MDS) assessment revealed Resident #2 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. She required substantial assistance with showering and was dependent on staff for transferring, dressing upper and lower body and putting on and taking off footwear. B. Resident interviews (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 was interviewed on 6/5/24 at 12:05 p.m. She said her left foot often swelled due to her diagnosis of diabetes. She said the nursing staff were supposed to put her socks (elastic hose stockings) on in the morning and take off at bedtime. Resident #2 said nursing staff had not yet put them on 6/5/24. Resident #2 was interviewed on 6/6/24 at 9:30 a.m. Resident #2 said nursing staff did not apply elastic hose stockings on 6/5/24 and had not yet applied elastic hose stockings on 6/6/24. Resident #2 was interviewed on 6/6/24 at 1:00 p.m., Resident #2 said nursing staff had not yet applied elastic hose stockings. Resident #2 was interviewed on 6/10/24 at 9:20 a.m. She said her elastic hose stockings had been on since the morning of 6/7/24. Resident #2 said a certified nurse aide (CNA) applied the stockings on 6/6/24 in the afternoon. She said the stockings were removed that night and then reapplied in the morning of 6/7/24. She said the stockings should have been removed at night on 6/7/24 and applied in the morning and removed at night on 6/8/24 and 6/9/24. C. Observations On 6/6/24 at 1:00 p.m. Resident #2's lower extremities were observed with CNA #1 which revealed there were no elastic hose stockings on the resident (see resident interview above). On 6/6/24 at 1:12 p.m. CNA #1 applied elastic hose stockings to Resident #2's lower legs. On 6/10/24 at 9:30 a.m. Resident #2 was observed with registered nurse (RN) #1 and revealed elastic hose stockings in place on Resident #2's lower legs. -According to Resident #2's interview, the elastic hose stockings had been in place since 6/7/24. D. Record review On 4/21/24 at 7:00 a.m., a physician order was initiated for Tubigrips or TED (thrombo-embolic-deterrent) hose (elastic hose stockings) for bilateral lower extremity edema management with directions to be placed in the mornings, removed at bedtime and left in place for no less than 12 hours and no more than 24 hours. A review of the task documentation (5/28/24 to 6/9/24) for application and removal of elastic hose stockings revealed nursing staff documented the application and removal of elastic hose stockings on 6/5/24, 6/6/24, 6/7/24, 6/8/24 and 6/9/24. -However, according to Resident #2's interview on 6/10/24, the elastic hose stockings were applied on the morning of 6/7/24 and had not been removed since they were applied. E. Staff interviews CNA #1 was interviewed on 6/6/24 at 1:03 p.m. CNA #1 said she was not sure if the elastic hose stockings were being used anymore because she had not seen them on Resident #2 in a few days. She said she should check with the nurse to see if they were needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 6/6/24 at 1:10 p.m. LPN #1 said she asked Resident #2 earlier if her stockings were placed and Resident #2 shook her head no. She said she misunderstood Resident #2 and thought the resident did not want them applied. The director of nursing (DON) was interviewed on 6/6/24 at 1:20 p.m. The DON said Resident #2's elastic hose stockings should have been placed and removed per the physician orders. She said staff should not document the stockings were placed and removed if the stockings were not put on. The DON said the elastic hose stockings helped to decrease Resident #2's edema. RN #1 was interviewed on 6/10/24 at 9:35 a.m. RN #1 said nursing staff documented Resident #2's elastic hose stockings were removed 6/7/24, 6/8/24 and 6/9/24. She said the incorrect documentation could have been due to agency staff working during the weekend. -According to Resident #2, the stockings were not removed 6/7/24, 6/8/24 and 6/9/24. The DON was interviewed again on 6/10/24 at 9:40 a.m. The DON said it was important to take off the stockings at night for circulation and comfort. She said she provided staff education to ensure elastic hose stockings were placed as ordered. She said based on the information provided, she planned additional staff education regarding documentation, application and removal of the elastic hose stockings. 47818 II. Resident status A. Resident #5 Resident #5, age 70, was admitted on [DATE]. According to the June 2023 CPO, the diagnoses included lymphedema (condition causing swelling in the body due to a buildup of fluid) and obesity (excessive fat deposits). The 5/29/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score of seven out of 15. She required maximum assistance with transferring and used a wheelchair for mobility. B. Observation During a continuous observation on 6/5/24 beginning at 10:00 a.m. and ending at 2:00 p.m., Resident #5 remained sitting up in her wheelchair engaging in independent and group activities. Resident #5's bilateral (both legs) edema was visible. Resident #5's legs appeared swollen, stretched and shiny. C. Record review The June 2024 CPO revealed a physician's order for staff to encourage Resident #5 to elevate her legs and observing for adverse signs and symptoms of edema, such as; increased swelling redness and complaints of pain or shortness of breath. Minus sign equaled no and positive sign equaled yes, ordered 6/2/24. (-=No +=Yes). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-However, staff were not indicating - or + on the medication and treatment administration records (MAR/TAR). Staff were only documenting with a check mark which indicated something was administered. The fluid imbalance care plan, initiated on 9/22/22 and revised on 1/3/23, indicated Resident #5 had a potential for fluid imbalance related to edema with diuretic use. It indicated Resident #5 would remain free from symptoms including good skin turgor (skin's ability to change back to shape quickly after being pulled or pinched). Pertinent interventions included monitoring for worsening edema. D. Staff interviews and facility follow up CNA #2 and CNA #3 were interviewed on 6/6/24 at 1:44 p.m. CNA #2 and CNA #3 both said they were responsible for assisting Resident #5 to elevate her legs every shift and if Resident #5 declined the licensed nurses were notified. CNA #3 said Resident #5 declined to elevate her legs on a regular basis. RN #2 was interviewed on 6/6/24 at 2:00 p.m. RN #2 said Resident #5 was encouraged to elevate her legs every shift but Resident #5 declined on a regular basis. RN #2 said Resident #5 was encouraged to elevate her legs every shift because she had edema. RN #2 said it was important to monitor the swelling and redness to edema sites and report changes to the physician. RN #2 said monitoring for edema changes was documented in the MAR/TAR. RN #2 was unable to locate documentation for monitoring changes. RN #2 said the nursing staff should include supplemental documentation for monitoring Resident #5's edema and were not. The DON was interviewed on 6/6/24 at 3:00 p.m. The DON said she was informed by RN #2 of the supplemental monitoring not being documented correctly in the MAR/TAR for Resident #5 and the order was being rewritten so that all components of the order were visible when nursing was charting.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48458 Based on observations, record review and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. Specifically, the facility failed to: -Ensure the laundry area was free from multiple environmental and sanitary concerns; and, -Ensure clean and dirty storage were maintained in separate locations. Findings include: I. Facility policy and procedure The Infection Control for Housekeeping Services policy, revised January 2009, was provided by the nursing home administrator (NHA) on 6/11/24 at 9:10 a.m. It read in pertinent part, It is the policy of this facility to require effective environmental sanitation to lessen the hazards of exposure to contaminated air, dust, furnishings, equipment and other fomites. Equipment shall be maintained in a safe, sanitary condition. Periodic inspection of the facility will be made by the housekeeping supervisor or as a joint exercise with the infection control team. II. Laundry observations and interviews On 6/10/24 at 1:30 p.m. the facility's laundry area was observed with the maintenance supervisor (MS). The following was observed: -The exhaust fan in the soiled linen room was not on. The MS turned the switch and then said it was broken. The MS said he was not aware the fan was broken. The MS said he thought it must have not worked for some time because there was a significant amount of dust on the fan blades. -There was a hole in the ceiling approximately 12 inches by 20 inches located above a dryer; -There was a hole in the wall approximately three inches by 12 inches located directly below clean hanging clothes which were to be delivered to residents; and, -There was unfinished sheetrock and holes approximately six inches by eight inches each on either side of the door to the clean laundry area. A rodent trap was located near the door. The MS said he had not had time to repair the holes. III. Storage observations and interviews (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/24 at 1:50 p.m., the Spartan unit soiled utility room was observed with the MS and the NHA. The following was observed: -A hopper toilet (a toilet/sink used to flush contaminants) in the corner of the room contained dark brown fluid with a hole in the ceiling directly above the toilet which dripped fluid. The NHA touched the ceiling and said it was wet and needed immediate repair. -A storage rack contained approximately 15 clean packaged gowns and 10 boxes of unopened gloves which were located next to four dirty linen and trash containers which contained soiled items. -Approximately six large trash bags were on the floor next to the dirty linen and trash containers. The MS said the bags contained clean isolation cart supplies. The NHA said the supplies should be stored in a different clean location. He said the clean supplies would be removed and disinfected. The MS was interviewed on 6/10/24 at 2:30 p.m. The MS said there were multiple areas which needed attention and he had not had time to assess or repair the ceiling in the soiled utility room. The infection preventionist (IP) was interviewed on 6/10/24 at 3:10 p.m. The IP said a soiled utility room should not contain clean items. She said she would not expect gowns and gloves to be stored in the soiled utility room. The IP said the isolation supplies should be stored in a clean area. B. Facility follow-up The Quality Improvement Action Sheet for Soiled Room Storage was provided by the NHA on 6/10/24 at 3:26 p.m. It read in pertinent part: All non-soiled items have been removed from the soiled storage room and either disinfected or discarded. Roof repair from the water leak has been temporarily fixed. Final drywall repair to be completed by 6/11/24.