

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Sierra Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1432 Depew St Lakewood, CO 80214	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure two (#21 and #32) of five residents reviewed were kept free from abuse out of 34 sample residents. Specifically, the facility failed to protect Resident #21 from physical abuse by Resident #32. Findings include: I. Facility policy and procedure The Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy, dated April 2021, was provided by the nursing home administrator (NHA) on 1/26/26 at 2:10 p.m. It read in pertinent part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. II. Incident of physical abuse by Resident #32 towards Resident #21 on 1/5/26A. Facility investigation The facility investigation was provided by the NHA on 1/27/26 at 3:44 p.m. The investigation documented on 1/5/26, two residents (Resident #21 and Resident #32) experienced an unwitnessed altercation inside their room. According to the investigation at approximately 1:45 p.m., Resident #32 exited his room and reported to a certified nurse assistant (CNA) that he hit his roommate (Resident #21) in the head because he was told to by voices. The investigation documented the CNA was able to separate the two residents to prevent further escalation and an additional CNA notified the nurse on duty. The investigation documented Resident #21 sustained no injuries after the altercation on 1/5/26. The investigation documented interventions to prevent additional occurrences included placing the residents on frequent checks, social services following up with the residents and a room change. The investigation documented Resident #21 was interviewed on 1/5/26 at 3:02 p.m. and said Resident #32 went crazy. It documented Resident #21 denied feeling fearful or distressed. The investigation documented Resident #32 was interviewed on 1/5/26 at 2:54 p.m. It documented Resident #32 stated the voices were in his head. It documented Resident #32 was provided with and declined the crisis line phone number. It documented no psychosocial concerns. The facility interviewed additional residents who could not identify what happened between Resident #21 and Resident #32 on 1/5/26, and no other residents expressed concern about their safety. According to the investigation, the altercation was substantiated as both residents confirmed the incident took place. According to the investigation, the incident did not cause injury or psychosocial stress to either resident, and interventions were successful in preventing additional incidents. III. Resident #32 (assailant) A. Resident status Resident #32, age less than 65, was readmitted on [DATE]. According to the January 2026 computerized physician orders (CPO), the diagnoses included unspecified schizoaffective disorder, unspecified affective mood disorder, type 2 diabetes mellitus, generalized muscle weakness and nicotine dependence. The 1/17/26 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. The MDS assessment indicated the resident had hallucinations and exhibited behavioral</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 065272
		If continuation sheet Page 1 of 11

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>symptoms. The resident was independent with bed mobility, transfer, and locomotion. The resident was taking antipsychotic and anticonvulsant medication. B. Resident interviewResident #32 was interviewed on 1/26/26 at 12:34 p.m. Resident #32 said he was involved in a resident-to-resident altercation with his roommate. Resident #32 said he suddenly started flipping out and punched his roommate in the face while he was lying in bed. Resident #32 said he felt safe and was happy with his room change. C. Record reviewThe behavior care plan, revised 1/6/26, documented Resident #32 exhibited, or had potential for verbally/physically aggressive or violent behaviors towards staff, peers, or self that placed himself and others at risk for harm or distress related to his schizoaffective disorder. Interventions included administering medications as ordered (initiated 11/7/25), applying de-escalation protocols (initiated 11/7/25), moving the resident into a private room on 1/14/26 and providing a calming area for redirection when agitated as the resident permits (initiated 11/7/25). The schizoaffective disorder care plan, revised 8/4/25, documented Resident #32 had schizoaffective disorders and targeted behavior symptoms, including: internal stimuli, auditory hallucinations, delusions, and physical/verbal aggression. Interventions included obtaining authorization for sitter services as needed (initiated 6/13/25), providing mental health services (initiated 8/4/25), encouraging the resident to express his feelings appropriately (revised 8/7/24), and providing a program of activities of interest to the resident (revised 8/7/24).-Review of the schizoaffective disorder care plan revealed documentation the resident was recently involved in two separate resident to resident altercations.A nurse note, dated 1/5/26 at 2:20 p.m. documented at approximately 1:45 p.m., the resident left his room and reported to a CNA he hit his roommate, Resident #21, in the head approximately two to three times because he heard voices tell him to. It documented that the CNA separated the residents, and another CNA reported the incident to the nurse. It documented Resident #32 was placed on frequent checks and sat in a different area away from Resident #21. It documented Resident #32's provider and mental health case worker were notified. A facility provider note, dated 1/6/26 at 5:36 p.m., documented Resident #32 was evaluated after an altercation with his roommate. It documented Resident #32 punched Resident #21 in the face three times. It documented Resident #32 stated he was angry when asked why he did it, and the resident refused to elaborate due to embarrassment. It documented the treatment plan included management by outpatient psychiatric and mental health services, repeat lab work and medication review and adjustment.III. Resident #21 (victim)A. Resident statusResident #21, age over 65, was admitted on [DATE], and readmitted [DATE]. According to the January 2026 CPO diagnoses included intracranial injury, dementia, post-traumatic stress disorder, and major depressive disorder.The 12/17/25 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. He required supervision/touch assistance with toileting hygiene, oral hygiene, bathing/showering and personal hygiene. He required set up/clean up assistance with eating, upper and lower body dressing and rolling right and left. He was independent with walking and sitting to stand transfers.The MDS assessment indicated the resident did not display behavioral symptoms or rejection of care. B. Resident interviewResident #21 was interviewed on 1/26/26 at 1:00 p.m. Resident #21 said that his old roommate had hit him in the head while he was sleeping. Resident #21 said he moved to another room and had a different roommate now. Resident #21 said he was okay after he was hit and was not hurt or afraid. Resident #21 said his old roommate just hit him and he did not know why. Resident #21 said he was not concerned about the incident or hurt about it and was happy with his new room.C. Record reviewThe trauma-informed care plan, revised 6/25/25, revealed the resident was at-risk for decreased psychosocial well-being and adjustment issues, emotional distress and ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>spiritual wellbeing related to transportation accident. Interventions included allowing him time to make choices in care and encourage active decision making, approaching the resident in a calm, reassuring manner, encouraging the resident to verbalize his feelings, encouraging the resident to participate in activities of choice, monitoring for signs/symptoms of decreased psychosocial well-being, adjustment issues, emotional distress, ineffective coping skills, poor impulse control, adverse effects on function, mental, physical, social, or spiritual wellbeing and report abnormal findings to physician. A nurses note, dated 1/5/25 at 2:37 p.m., documented the nurse was notified by a CNA that Resident #32 admitted to hitting Resident #21 two to three times in the head while he was sleeping in bed. The CNAs separated the residents and put them on frequent checks. When the nurse assessed Resident #21 he denied any pain or loss of consciousness. Resident #21 was asked if he was in fear and he stated no and said his roommate just went crazy. The doctor was notified of the incident and Resident #21's guardian attempted to be notified but his voicemail was full and was unable to leave a message at the time. IV. Staff interviewsCNA #9 was interviewed on 1/28/26 at approximately 10:05 a.m. CNA #9 said Resident #32 was easily agitated. CNA #9 said Resident #32 was involved in a resident-to-resident altercation two to three weeks ago, when he punched his roommate. CNA #9 said the altercation was not observed. She said Resident #32 reported it himself. CNA #9 said Resident #21 was moved into a different room after the 1/5/26 altercation occurred. CNA #9 said Resident #32 was moved into a different room approximately one week prior, however he was unsure why. Registered nurse (RN) #2 was interviewed on 1/28/26 at 2:01 p.m. RN #2 said Resident #32 was initially placed on one-to-one observations after the altercation occurred. RN #2 said the resident was recently moved into a separate room as an intervention for the altercation. RN #2 said she was unsure why there was a delay in the room change occurring. RN #2 said Resident #32's triggers included hearing voices related to his medical condition. RN #2 said facility management would come onto the unit and alert staff of any changed care plan interventions. RN #2 said care interventions could be found in the resident's care plan or on the 24 hour nurse report sheets. RN #2 said updating the resident's care plan timely was important for resident safety and continuity of care. The social services director (SSD) was interviewed on 1/29/26 at 1:49 p.m. The SSD said Resident #32 stated he hit Resident #21 due to uncontrollable anger that came up. The SSD said Resident #32 did have a history of resident-to-resident altercations. She said in the past, the reported root cause was his auditory hallucinations. The SSD said moving Resident #32 to a different room was delayed due to a different resident occupying it, and the facility needed to provide a five day room change notification. The SSD said the social services team was responsible for managing the resident's behavior care plans. The NHA was interviewed on 1/29/26 at 3:09 p.m. The NHA said Resident #32 participated in facility activities and received frequent visits from social services. The NHA said he was unable to state what interventions were put in place to manage Resident #32's anger related outbursts after the resident-to-resident altercation on 1/5/26.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations record review and interviews the facility failed to ensure that the resident environments remained free from accidents hazards as was possible and that each resident had adequate supervision to prevent accidents for for one resident (#10) of three residents reviewed for falls out of sample 34 residents. Resident #10 was admitted on [DATE] for long term care with diagnoses of emphysema (shortness of breath), dementia (impaired memory and thinking), paranoid personality disorder (mental health condition), epilepsy (neurological disorder) and repeated falls. Resident #10 was identified as a high fall risk. Resident #10 sustained eight falls in three months (October 2025 to January 2026). On 10/25/25, Resident #10 sustained a fall where he hit his head. He was sent to the hospital and was diagnosed with a closed head injury. Observations during the survey revealed the facility failed to consistently implement person-centered fall interventions. Specifically, the facility failed to ensure fall precautions were consistently in place for Resident #10. Findings include: I. Facility policy and procedure The Falls and Fall Risk, Managing Policy, revised December 2007, was received from the Nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It revealed in pertinent part, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. II. Resident #10A. Resident status Resident #10, age greater than 65, was admitted on [DATE]. According to the January 2026 computerized physician orders (CPO) diagnoses included emphysema, dementia, paranoid personality disorder, epilepsy and repeated falls. The 12/5/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of seven out of 15. He required staff supervision for toileting, dressing and ambulation. He needed setup assistance with meals and personal hygiene. He was independent with bed mobility. The MDS indicated resident had sustained falls. B. Record review The 7/12/24 comprehensive care plan documented Resident #10 was at risk for falls with and without injury related to dementia with agitation, cognitive impairment, difficulty in walking, wandering, vision and hearing impairment. Interventions put in place by the facility were: -Call light with in reach (initiated 2/2/25); -Personal items within reach (initiated 2/2/25); -Traction strips and signs posted in the room/bathroom to remind Resident #10 to use call light and wait for assistance (initiated 8/27/25); -Bed in low position (initiated 9/13/25); -Keep the resident's personal belongings within inreach (initiated 9/15/25); -Moving the resident's room closer to nurses' station (initiated 9/25/25); -Hipsters as tolerated (initiated 10/2/25); -Low profile fall mat (initiated 10/13/25); and, -Offer scrum cap when out of bed initiated on 10/15/25. The January 2026 CPO documented the following physician's orders: -Low profile fall mat, ordered on 10/13/25; -Offer scrum cap (protective helmet) when out of bed, ordered on 10/15/25; and, -Apply hipsters in the morning, ordered on 10/2/25. Resident #10's electronic medical record (EMR) revealed the resident sustained falls on: -On 10/1/25 the resident fell while pulling his wheelchair backwards. -On 10/7/25 the resident was found on the floor near his wheelchair. -On 10/11/25 the resident was found on the floor near his bed and wheelchair. -On 10/15/25 the resident had a witnessed fall when he turned too fast, lost his balance and struck his head. -On 10/25/25 the resident had a suspected fall resulting in hematoma to right eye and head. -On 1/12/26 the resident was found on the floor next to the toilet in the bathroom with a call light on in his</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>room.-On 1/17/26 the resident was found on the floor next to his bed.-On 1/19/26 the resident was found on the floor in another resident's room. The 10/11/25 post fall reviews documented the resident was a moderate risk for falls.The 10/25/25 post fall review documented the resident was moderate risk for falls. A progress note on 10/25/25 at 10:45 a.m. documented the resident had a change in condition related to a fall. All parties were notified. The resident was sent to the emergency room for evaluation.A progress note on 10:25/25 at 10:49 a.m. documented Resident #10 was assessed by a registered nurse (RN) at 10:30 a.m. due to a report from a licensed practical nurse (LPN) on the memory care unit. The LPN reported a hematoma (raised bruise) to the resident's lateral upper right eye. Per the LPNs report the resident may have fallen during the previous shift but there was no report or injury on file. Resident #10 endorsed he fell in the dining room or his bedroom. Resident #10 reported he was dizzy when he fell but denied at the time of assessment. The hematoma measured 5 centimeters (cm) by 2.5 cm.A progress note on 10/25/25 at 4:31 p.m. documented the resident returned to the facility. A computed tomography (CT imaging test) scan was performed. The results indicated the resident sustained a periorbital (eye) and left parietal (top rear area of the skull) hematoma.A progress note on 10/27/25 at 4:22 a.m. documented the nurse was told Resident #10 had sustained a fall on her previous shift on 10/25/25. The nurse documented resident remained asleep throughout the night as per his usual pattern, no abnormal sound or activity was noted. The emergency room notes from 10/25/25 documented the resident was seen for a fall with a closed head injury. A resident reported a right sided headache. Imaging showed right periorbital and left parietal scalp hematomas. A physician progress note dated 11/14/25 at 8:18 a.m. documented the physician was requested to see the resident for MRI results of the brain which showed late subacute versus chronic subdural hematoma 11 millimeters (mm). The facility reported that the patient remained neurologically stable without any focal deficits or symptoms. C. Observations and interviewsOn 1/27/26 at 8:40 a.m Resident #10 was lying in bed A (resident was assigned bed B) of the residents room with no fall mat in place. The call light was not in reach of the resident (see care plan interventions and CPOs orders above).On 1/27/26 at 9:27 a.m. the resident's bathroom was observed to have no traction strips on the floor (see care plan interventions above).On 1/27/26 at 4:10 p.m. Resident # 10 was lying in bed A with no fall mat on the floor next to the bed.On 1/28/26 at 8:15 a.m. Resident #10 was rolling around in his bed with no fall mat or callight within reach. III. Staff interviewsCertified nurse aide (CNA) #3 was interviewed on 1/28/26 at 1:44 p.m. She said she had only been on the unit a few times but she utilized the computer records for resident care needs. CNA #3 said Resident #10 was not a fall risk and had not had falls. -However, Resident #10 had sustained eight falls in three months (see record review above).CNA #3 said he could wear pads to his hips (hipsters) but she could not find them. CNA #3 said residents with falls sometimes had their bed mid level. CNA #3 said the resident did not need his bed low to the ground. LPN #3 was interviewed on 1/28/26 at 1:57 p.m. LPN #3 said Resident #10 was a high fall risk resident. LPN #3 said the resident should have a fall mat next to his bed, hipsters and scrum cap on as fall interventions. Resident #10's room was observed with LPN #3. Resident #10's fall mat was laying next to bed B in the room. However the resident had been observed sleeping in bed A during the survey.LPN #3 said the mat should be on the side the resident got out of bed on so if he was sleeping in bed A the mat was not in the best position to protect the resident if he were to fall out of bed. LPN #3 said she was unable to locate Resident#10's hipsters or scrum cap in resident's current room. LPN #3 then went to another room, which was Resident #10's old room to look for other interventions ordered for fall prevention. LPN #1 said the resident was moved to his current room over a week ago and maybe his things had not been moved over yet. LPN #3 said she was unsure if the</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	room move was permanent or why his personal belongings were still in his old room. LPN #3 said she located the resident's scrub cap on the dresser and his hipsters in the drawer along with his personal belongings in his old room. -The facility failed to ensure fall interventions were consistently in place. The director of nursing (DON) was interviewed on 1/29/26 at 12:23 p.m. She said the staff could review the resident's care plan or Kardex (staff directive tool) for care needs and interventions needed for keeping residents safe. The DON said if they had any new interventions, there was a binder at each nurses' station to help the staff learn about new interventions put in place for residents. The DON went to the memory care unit and observed Resident #10's current room. She said the resident's room move was permanent and was not sure why his personal belongings were not moved to his new room since it had been over a week since the move. The DON said fall interventions should be used at all times in order to keep residents safe.		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases on two out of three units. Specifically, the facility failed to: -Ensure housekeepers cleaned and disinfected the residents' rooms in a hygienic manner; -Ensure housekeepers performed hand hygiene while cleaning resident rooms; -Ensure housekeepers cleaned high touch areas; -Ensure dwell times were followed during resident room cleaning; and, -Ensure hand hygiene was conducted appropriately during wound care. I. Housekeeping failures</p> <p>A. Professional reference</p> <p>Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 2/2/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part,</p> <p>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.</p> <p>The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 2/2/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part,</p> <p>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.</p> <p>Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs.</p> <p>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the Hydrogen Peroxide Cleaner Disinfectants, dated 2026. Retrieved from: https://www.cloroxpro.com/products/clorox-healthcare/hydrogen-peroxide-cleaner-disinfectants/?UTM_Camp=on+2/2/26 it was revealed in pertinent part. Wipe the surface until completely wet. To disinfect, keep surface wet for the contact time (1 minute for most bacteria and viruses; 2 minutes for C. auris).</p> <p>According to the Technical Bulletin: Concentrated SPIC and SPAN Disinfecting All-Purpose Spay and Glass Cleaner, updated 7/23/21, was retrieved on 2/2/26 from https://assets.ctfassets.net/xsotn7jngs35/6ql41K6mC3OnnZQcx32AeU/e0c1c6588d8efe3daf05cd1a676226ff/ It revealed in pertinent part, To Sanitize/Disinfect: For visibly soiled areas, a precleaning is required. Spray hard, non-porous surfaces until thoroughly wet. To Sanitize: Treated surfaces must remain visibly wet for 15 seconds before wiping. To Disinfect: Treated surfaces must remain visibly wet for the time indicated for each organism listed under the efficacy section. A rinse is required for surfaces in direct contact with food.</p> <p>According to the Comet Disinfecting-Sanitizing Bathroom Cleaner, updated 9/13/18, was retrieved on 2/2/26 from http://assets.ctfassets.net/xsotn7jngs35/5xJmZUMq9KOiw27ZTOf5rl/3e9635a410c1491ab8da7d19612c390/c It revealed in pertinent part, TOILET BOWLS AND URINALS: Empty water from the toilet bowl or urinal. Hold 6-8 from the surface. Spray exposed surfaces. Brush thoroughly. Let stand for 5 minutes, then flush.</p> <p>B. Facility policy and procedure</p> <p>The Cleaning and Disinfecting Resident Rooms policy, revised August 2013, was received from the nursing home administrator (NHA) on 1/30/26 at 12:21 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidelines for cleaning and disinfecting residents' rooms. Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily, three times per week) and when surfaces are visibly soiled.</p> <p>The environmental services director and administrator, in conjunction with the infection preventionist, will select appropriate facility disinfectants.</p> <p>Steps in the Procedure for Resident Room Cleaning: 1. Gather supplies as needed. 2. Prepare disinfectant according to manufacturer's commendations. 3. Discard disinfectant/detergent solutions that become soiled or clouded with dirt and grime and prepare fresh solutions. 4. Change mop solution water at least every three (3) rooms, or as necessary. 5. Change cleaning cloth when they become soiled. Wash cleaning cloth daily and allow cloth to dry before reuse. 6. Clean horizontal surfaces (e.g., bedside tables, overbed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters. 7. Clean personal use items e.g., lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly.</p> <p>The Handwashing/hand Hygiene policy, revised October 2023, was received from the NHA on 1/30/26 at 12:21 p.m. It revealed in pertinent part, This facility considers hand hygiene the primary means to</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065272	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER Sierra Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1432 Depew St Lakewood, CO 80214	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>prevent the spread of healthcare -associated infections.All personnel are trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>Environmental measures are taken to reduce contamination associated with sinks and sink drainage, including:the use of disinfectants that are EPA-registered for biofilm removal to clean sinks and faucets daily.</p> <p>Indications for Hand Hygiene:. Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (for example, placing an indwelling device or handling an invasive medical device); c. after contact with blood, body fluids, or contaminated surfaces; d. after touching a resident; e. after touching the resident's environment; f. before moving from work on a soiled body site to a clean body site on the same resident; and g. immediately after glove removal.</p> <p>Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations.</p> <p>II. Observations</p> <p>On 1/28/26 at 9:16 a.m. housekeeper (HK) #1 was cleaning room [ROOM NUMBER], a double occupancy room on the Prasada unit. She [NAME] by sweeping the A side of the room then collected a Spic N Span all purpose disinfectant and a glass spray entered the residents' bathroom and sprayed the toilet down with the Spic N Span. HK #1 returned to her cleaning cart at the entrance of the door, collected two Clorox Hydrogen Peroxide wipes, went to A side of the room, wiped down the night stand then went to bed B side of room and wiped down the bed side table wiping around the resident personal items. She then wiped the legs of the table down to the floor.</p> <p>-HK #1 failed to use a different wipe for each side of the room. The surfaces wiped with the Clorox wipes did not remain wet for the one minute dwell time (see professional reference above).</p> <p>HK #1 then collected the trash from the trash can near the sink and replaced it with a new bag. She collected the toilet bowl brush and one red rag for the housekeeping cart. She then entered the bathroom, scrubbed the toilet bowl with the brush. She then took the red rag, wiping the toilet bowl rim, then seat and then lid.</p> <p>-HK # failed to clean the toilet from the cleanest area to dirtiest areas.</p> <p>HK #1 returned to her cart, collected a dry mop pad, dunked it into the mop bucket, rang it out then went into the restroom and mopped the bathroom. HK #1 went back to her cart, removed the mop pad and repeated the process of dunking the new mop pad in the mop bucket, then mopped the room from the B side to the A side then to the doorway. HK #1 then removed the mop pad, replaced it with a dry mop pad and mopped the floor with a dry pad to dry the floor.</p> <p>-HK #failed to change her gloves and complete hand hygiene after cleaning the toilet. She then reached into the mop bucket where she contaminated the cleaning solution with soiled gloves twice, while wetting each mop pad.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 9:26 a.m. HK #1 said she was done cleaning room [ROOM NUMBER]. She removed her gloves and moved to the next room.</p> <p>-HK #1 failed to clean high touch areas in the resident room and bathroom like call lights, light switches, bed controls. HK #1 failed to clean the resident sink area.</p> <p>HK#1 moved her cart to room eight, a triple resident room at 9:28 a.m. She applied clean gloves, knocked on the door and announced herself.</p> <p>-HK #1 failed to perform hand hygiene between rooms and prior to applying clean gloves.</p> <p>HK #1 collected the Spic n Span disinfectant and went to the bathroom sprayed the toilet. She collected the trash by the sink and side A and took it to the cart. She replaced the trash bags in trash cans and collected two Clorox hydrogen peroxide wipes. She wiped the bedside table, the night stand on the B side. She then went to the C bed night stand and wiped it down. The surface dried in 30 seconds.</p> <p>-HK #1 did not wipe bed A's night stand or bed side table. H K#1 also used the same Clorox wipe for both B and C beds. HK #1 failed to ensure the surface remained wet for the dwell time for the Clorox (see professional references above)</p> <p>HK #1 collected Spic n Span disinfectant all purpose spray and glass cleaner. She sprayed the sink then the mirror. She wiped the mirror then the sink handles then, then the sink bowl, she then wiped the counter top with the same rag.</p> <p>-HK #1 failed to clean the sink area from cleanest to dirtiest.</p> <p>HK #1 returned to her cart, collected the toilet bowl brush, brought it into the bathroom, scrubbed the toilet bowl then took it back, re entered the room, touched the light switch at the sink then returned to cart collected a roll of toilet paper and placed it into the bathroom.</p> <p>-HK #1 touched areas in the room, items on the cleaning cart with soiled gloves used to clean the toilet bowl.</p> <p>HK #1 collected a new rag from the cart, re entered the bathroom, wiped the toilet and returned to her cart. HK #1 changed gloves.</p> <p>-HK #1 changed her gloves but failed to perform hand hygiene between changes.</p> <p>HK #1 then took a new mop pad, dunked it into the mop water, rang it out then mopped the bat</p> <p>II. Failure to perform hand hygiene per professional standards of practice</p> <p>A. Observation</p> <p>On 1/28/26 at 2:15 p.m. the IP was preparing to provide catheter care to Resident #54. She performed hand hygiene. She left the room to get a Foley catheter bag. She washed her hands and donned (put on) personal protective equipment (PPE). She undid the secure tabs of his adult disposable brief. She took off the old drain sponge, grabbed a clean washcloth and placed it in the warm, soapy water.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>She washed the supra pubic area. She then grabbed a second clean washcloth and cleaned the area a second time. She grabbed a clean washcloth, placed it in the warm water, and rinsed the area. She grabbed a clean washcloth and dried the area. She placed a new drain sponge on the supra pubic catheter site. She reattached the secure tabs of his adult disposable brief. She took off her PPE and disposed of it. She washed her hands, and she put on gloves, and grabbed the garbage bag from the resident's waste basket, along with PPE and an old Foley catheter bag, to take to the garbage disposal area.</p> <p>-The IP failed to change her gloves and perform hand hygiene after removing the soiled drain sponge. And failed to place the old Foley catheter bag in a red bag for bodily fluids.</p> <p>C. Staff interviews</p> <p>The IP was interviewed on 1/28/26 at 2:30 p.m. The IP said she did not normally perform supra pubic catheter care. She said the nurse assigned to the resident was having an issue with the catheter care and asked her to complete the care. She said gloves should be changed after removing the dirty dressing.</p> <p>The DON was interviewed on 1/28/26 at 2:50 p.m. The DON said the nurse should remove the old dressing, remove gloves, wash hands and place clean gloves on to complete the Foley catheter care. She said the nurse should place the dirty Foley catheter bag into a red biohazard bag to discard it.</p>		