STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065273	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Post Acute	6270 W 38th Ave Wheat Ridge, CO 80033

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, record review and interviews, the facility failed to ensure one (#8) of one resident reviewed out of 32 sample residents was provided personal privacy in her room. Specifically, the facility staff failed to knock before entering Resident #8's room while the resident was being provided with personal care. Findings include: I. Facility policy and procedure The Resident Rights policy, revised August 2009, was provided by the nursing home administrator (NHA) on 7/4/24 at 9:46 a.m. It read in pertinent part, Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to privacy and confidentiality and voice grievances and have the facility respond to those grievances. II. Resident status Resident #8, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure, chronic pain syndrome, bipolar disorder, major depressive disorder, and diabetes mellitus. The 4/15/24 minimum data set (MDS) assessment revealed Resident #8 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #8 required moderate assistance of one person with bed mobility, toileting and maximum assistance with lower body dressing. The assessment documented Resident #8 had no behaviors. III. Resident interview and observations Resident #8 was interviewed on 6/26/24 at 3:19 p.m. Resident #8 said most of the facility staff did not respect her privacy. Resident #8 said staff would frequently enter her room when she was receiving personal care which bothered her. (continued on next page)

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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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/24 at 1:51 p.m. Resident #8 was lying in her bed waiting for staff assistance to get ready for an outside appointment. At 1:55 p.m. certified nurse aide (CNA) #2 arrived to assist the resident. CNA #2 knocked on the door and entered the resident's room. CNA #2 closed the resident's door before she started providing personal care. At 2:02 p.m. activities assistant (AA) #1 arrived at Resident #8's room. AA #1 proceeded to enter Resident #8's room without knocking. -AA #1 exited the room quickly after realizing Resident #8 was being provided with personal care, however, AA #1 failed to initially knock before entering the room At 2:10 p.m. Resident #8 came out of her room in a power wheelchair and said there was no privacy in the facility. IV. Staff interviews CNA #2 was interviewed on 6/27/24 at 2:15 p.m. CNA #2 said she always knocked before entering a resident's room. She said AA #1 did not knock before she opened Resident #8's bedroom door. CNA #2 said she was providing personal care to Resident #8 when AA #1 entered the room without knocking. She said Resident #8 was upset about the incident. CNA #2 said she asked AA #1 to knock and wait for a response before entering a resident's room because residents' private areas were often exposed when they were receiving personal care. AA #1 was interviewed on 6/27/24 at 2:45 p.m. AA #1 said she was trained to run special activities groups, one-on-one activities and outings. AA #1 said she had been in her current position for two months and had no prior experience with the activity department. AA #1 said Resident #8 had previously complained that her knocking was too loud, which disturbed her afternoon sleep, therefore she tried to knock gently. AA #1 said she did not document or report the resident's concern about her knocking too loudly to disturb the resident's afternoon sleep to anyone. AA #1 said she would be mindful of knocking. -However, despite AA #1 saying she knocked gently on Resident #8's door, AA #1 was observed entering the resident's room without knocking (see observation above). The NHA was interviewed on 7/1/24 at 1:00 p.m. The NHA said it was the facility's policy for every resident to be treated with respect and dignity. The NHA said every staff member should knock before entering a resident's room. The NHA said resident's rights should be respected and followed. The NHA said she had initiated education on 7/1/24 for AA#1 and would continue to educate all the facility's staff regarding knocking on resident's doors before entering their rooms.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on record review and interviews, the facility failed to develop and revise the comprehensive care plans that included the instructions needed to provide effective and person-centered care for one (#8) of four residents reviewed out of 32 sample residents. Specifically, the facility failed to ensure Resident #8's care plan was revised to address the resident's confrontational behaviors. Findings include: I. Facility policy and procedure The Care Plans, Comprehensive Person-Centered policy, revised March 2022, was provided by the nursing home administrator (NHA) on 7/1/24 at 3:35 p.m. It read in pertinent part, A comprehensive, person-centered care plan should include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The interdisciplinary team should review and update the care plan when there has been a significant change in the resident's condition, when the resident has been readmitted to the facility from a hospital stay, and at least quarterly, in conjunction with the required quarterly MDS (minimum data set) assessment. The care plan interventions should be derived from information obtained from the resident and his/her family/responsible party, with possible discretionary modifications resulting from the comprehensive assessment. II. Resident status Resident #8, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included chronic respiratory failure, chronic pain syndrome, bipolar disorder, major depressive disorder and diabetes mellitus. The 4/15/24 minimum data set (MDS) assessment revealed Resident #8 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #8 required moderate assistance of one person with bed mobility, toileting and maximum assistance with lower body dressing. The assessment revealed Resident #8 had no behaviors. III. Resident interview Resident #8 was interviewed on 6/27/24 at 9:30 a.m. Resident #8 said she was threatened by another resident at the facility. She said the issue was reported and the facility initiated an investigation and reported the incident to law enforcement. The resident said the police came and interviewed her. Resident #8 said the facility did not complete any further follow up. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	IV. Record review The 3/26/24 nursing progress note documented at 9:38 p.m. revealed Resident #8 was in another resident's space yelling and was using foul language towards the other resident and the unit nurse. The incident escalated to an extent where law enforcement were called to the facility. The progress note documented after the police were gone, an unidentified CNA found Resident #8 in another resident's room. Resident #8 said she was retrieving books that the resident had borrowed from the facility's library. The behavior care plan, initiated on 2/22/23 and revised on 2/27/23, revealed Resident #8 was on antidepressant medication for depression. The interventions included ensuring all care needs were met and reviewing the resident if new behaviors were exhibited. -A review of Resident #8's comprehensive care plan revealed the comprehensive care plan failed to identify and include person-centered interventions to redirect Resident #8 when she got into others' space and initiated confrontations. V. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 6/27/24 at 3:55 p.m. LPN #2 said Resident #8 had the tendency to get too close to other residents and she would initiate confrontations. She said sometimes Resident #8 would use foul words and accusatory language toward the staff. LPN #2 said it was difficult to calm the resident down when she was upset. The director of nursing (DON) and the NHA were interviewed together on 7/1/24 at 1:00 p.m. The DON said Resident #8 had a history of initiating confrontations with others. The DON said two staff members witnessed the incident on 3/26/24 and stated Resident #8 initiated the altercation by going into the other resident's space and yelling at him. She said the resident's care plan should have been updated following the incident to include intervention for facility staff to manage the resident's escalating behaviors. The NHA said there should have been a care plan with person-centered approaches for Resident #8's confrontational behaviors. She said she would collaborate with the social services director to update the resident's care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on observations, interviews and record review, the facility failed to ensure one (#19) of two residents reviewed for accident/hazards out of 32 sample residents remained as free from accident hazards as possible. Specifically, the facility failed to ensure Resident #19, who was an unsupervised smoker, smoked in an appropriate area designated for smoking. Findings include: I. Facility policies and procedure The Smoking policy, revised October 2023, was provided by the nursing home administrator (NHA) on 7/1/24 at 10:15 a.m. The policy revealed in pertinent part: The facility has established and maintained safe resident smoking practices. Before, and upon admission, residents are informed of the facility's smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Smoking is not allowed inside the facility under any circumstances. Metal containers, with self-closing cover devices, are available in smoking areas. Ashtrays are emptied only into designated receptacles. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic cigarettes, pipes, tobacco, and other smoking items in their possession. Only disposable safety lighters are permitted. II. Resident Status Resident #19, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician's orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), paranoid schizophrenia, anxiety disorder, need for assistance with personal care and problems related to unspecified psychosocial circumstances. The 3/18/24 minimum data set (MDS) assessment revealed Resident #19 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #19 required moderate assistance from one person with showers, toileting and mobility. III. Resident observation and interview On 6/26/24 at 12:48 p.m.Resident #19 was observed in an area that was not a designated smoking area smoking a cigarette. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident extinguished her cigarette on the ground and then threw the butt in a space between the concrete slab at the end of the porch where she sat and a wooden fence located next to the concrete slab. There were multiple extinguished cigarette butts lying on the ground in between the slab and the wooden fence. On 6/27/24 at 11:10 a.m. Resident #19 was observed smoking a cigarette in the same area that was not a designated smoking area. On 6/27/24 at 11:58 p.m. after Resident #19 left the undesignated smoking area, a burn hole was observed in the seat cushion of the chair where the resident had been smoking her cigarette. On 6/27/24 at 2:48 p.m. Resident #19 was again observed smoking a cigarette in the same area that was not a designated smoking area. On 7/1/24 at 10:30 a.m. Resident #19 was observed smoking a cigarette in the same area that was not a designated smoking area. On 7/1/24 at 1:07 p.m. Resident #19 was observed smoking a cigarette in the same area that was not a designated smoking area. Resident #19 was interviewed on 7/1/24 at 10:45 a.m. Resident #19 said she was an independent smoker and did not require supervision when smoking. She said she did not like smoking in the designated smoking area with other residents. The resident said she smoked at the front of the facility, which was not a designated smoking area. IV. Staff interviews Certified nurse aide (CNA) #2 was interviewed on 7/1/24 at 10:05 a.m. CNA #2 said Resident #19 was an independent smoker and did not require supervision. She said the resident usually sat at the undesignated area for her smoke breaks. CNA #2 said she was unsure who permitted the resident to smoke in the area that was not a designated smoking area. Registered nurse (RN) #2 was interviewed on 7/1/24 at 10:15 a.m. RN #2 said Resident #19 always sat at the front of the facility on the concrete slab to smoke. RN #2 said she did not believe there was an ashtray for the resident to extinguish her cigarette after smoking. She said since there was a wooden fence next to the concrete slab where Resident #19 sat to smoke, there could be a potential fire hazard. RN #2 said she was unsure who permitted the resident to smoke in that area. The NHA was interviewed on 7/1/24 at 10:30 a.m. The NHA said she planned to designate the front location where Resident #19 sat to smoke to be a designated smoking area but had not officially done so. The NHA said she was aware of the resident smoking at the front of the facility because she permitted her to smoke there. The NHA said she understood the potential fire hazard in the area due to the wooden fence and not having an ashtray for the resident to extinguish her cigarette appropriately. The NHA said she would immediately ensure the appropriate measures were put in place to ensure the area was safe for smoking.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#16) of one resident reviewed for dialysis care out of 32 sample residents received dialysis services consistent with professional standards of practice. Specifically, the facility failed to consistently complete the pre-dialysis facility assessment section on dialysis communication forms for Resident #16. Findings include: I. Facility policy and procedure The Care of the Dialysis Resident policy and procedure, undated, was received from the nursing home administrator (NHA) on 7/4/24 at 9:46 a.m. It revealed in pertinent part, Dialysis residents will be provided care and service in a manner that promotes the residents quality of life and to attain or maintain the residents highest possible physical, mental and psychosocial well being. The nursing staff will follow established protocol for all dialysis residents. The nursing staff will send a dialysis communication to the dialysis center every time a resident is scheduled for dialysis. II. Resident #16 Resident #16, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included end stage renal disease (decreased kidney function), dependence on renal dialysis, type 2 diabetes mellitus (abnormal glucose control) and cirrhosis of liver (decreased liver function). The 5/1/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He had no behaviors and did not reject care. He received dialysis care. III. Resident interview Resident #16 was interviewed on 6/27/24 at 10:45 a.m. Resident #16 said his dialysis communication folder had important papers the facility and dialysis center sent back and forth in order to communicate with each other. Resident #16 said sometimes the communication form did not get filled out by the facility staff. IV. Record review (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #16's July 2024 CPO revealed a physician's order for Resident #16 to receive dialysis on Mondays, Wednesdays and Fridays, ordered 3/21/24. Review of Resident #16's pre- and post-dialysis communication forms, located in the resident's electronic medical record (EMR), revealed the communication forms had three sections which were to be filled out on dialysis days. The general information section on the dialysis communication form was to be completed by the facility with the date, resident's name, facility contact person and facility phone number. The pre-dialysis section on the dialysis communication form was to be completed by the facility with the resident's vital signs, including temperature, pulse, respirations and blood pressure. The section included comments to identify any assessment concerns or medication changes which the facility wished to be communicated with the dialysis center. A signature/title/date and time the assessment was completed were to be filled in by the facility staff. The third section on the dialysis communication form was to be completed by the dialysis center after the resident completed their dialysis session. The section included vital signs, pre-weight, post-weight, whether any lab work was completed, whether any medications were given at the dialysis center and any recommendations or follow up from the dialysis center. A signature and date were to be filled in by the dialysis center nurse. Review of Resident #16's dialysis communication forms from May 2024 to July 2024 revealed the communication form was not completed appropriately on the following dates: -On 5/24/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 5/31/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 6/14/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 6/22/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 6/28/24 the facility did not complete the pre-dialysis section of the dialysis communication form. -On 7/1/24 the facility did not complete the pre-dialysis section of the dialysis communication form. V. Staff interviews (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed practical nurse (LPN) #1 was interviewed on 7/1/24 at 9:12 a.m. LPN #1 said facility nurses were supposed to fill out the dialysis communication forms prior to residents leaving for dialysis. She said nurses needed to review the communication form upon the resident's return from dialysis for any complications or changes recommended by the dialysis facility. LPN #1 was interviewed again on 7/1/24 at 4:49 p.m., after Resident #16 had returned from dialysis. LPN #1 reviewed Resident #16's dialysis communication form for 7/1/24. LPN #1 said she had not filled out the pre-dialysis section of the form prior to Resident #16 leaving for dialysis that morning. LPN #1 said it was the responsibility of the night shift nurse to prepare the forms and place the forms, in the resident's dialysis communication folder, into the resident's wheelchair bag. LPN #1 said she did not fill out the communication form unless the resident came to her prior to leaving for dialysis with their folder. The director of nursing (DON) was interviewed on 7/1/24 at 4:56 p.m. The DON said the nurse on duty at the time the resident left for dialysis was responsible for completing the pre-dialysis section of the dialysis communication form. The DON said dialysis communication forms were important in order to communicate a resident's status or needs before or after dialysis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47150 Based on interviews and record review, the facility failed to ensure residents were free from significant medication errors for two (#4 and #38) of seven residents reviewed for medication errors out of 32 sample residents. Resident #4, who had diagnoses of schizoaffective disorder (mental health condition that causes people to experience symptoms of schizophrenia and mood disorders) and bipolar, had a physician'sorder for clozapine (an antipsychotic medication). The medication required a complete blood count (CBC) laboratory result to be sent on a monthly basis to the pharmacy in order for the pharmacy to refill the medication. On 6/11/24, Resident #4 was administered her last available dose of clozapine, however, the results of the monthly CBC had not been obtained from the laboratory and faxed to the pharmacy in order for the pharmacy to refill the medication. Due to the facility's failure to send the CBC laboratory results to the pharmacy, Resident #4 did not receive her clozapine on 6/12/24 and 6/13/24. The facility failed to contact the resident's physician in order to inform the physician the medication was unavailable and obtain further orders. Due to the facility's failures to obtain the antipsychotic medication timely, Resident #4 missed two doses of the medication and self harmed herself on 6/13/24 by burning her left forearm with a cigarette, causing a cluster of five blisters. Additionally, the facility failed to: -Ensure Resident #38 received antibiotic medication according to the physician's orders; and, -Complete a medication review and reconciliation of medications prescribed for Resident #38. Findings include: I. Professional reference According to [NAME], P.A., [NAME], A.G., et.al., Fundamentals of Nursing, 10 ed. (2020), E.[NAME], St. Louis Missouri, pp. 606-607, retrieved on 7/15/24, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment. Professional standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. II. Antipsychotic medication error A. Facility policy and procedure The Adverse Consequences and Medication Errors policy, revised April 2014, was provided by the nursing home administrator (NHA) on 7/1/24 at 9:46 a.m. It read in pertinent part, A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of professionals providing services. Examples of medication errors include the omission of drugs (medication not administered). The Medication Shortages/Unavailable Medication policy, revised 1/1/22, was provided by the director of nursing (DON) on 7/1/24 at 10:25 a.m. It read in pertinent part, This policy set forth procedures relating to medication shortages and unavailable medications. Upon discovery that the facility has an inadequate supply of medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from the pharmacy. If a medication is unavailable during normal pharmacy hours, the facility nurse should call the pharmacy to determine the status of the order. If the next available delivery causes a delay or a missed dose in the resident'smedication schedule, the facility nurse should obtain the medication from the emergency medication supply kit to administer the dose. If the medication is not available in the facility'semergency supply kit, the licensed facility nurse should call the pharmacy emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. If emergency delivery is unavailable, the facility nurse should contact the attending physician to obtain orders and directions. If the facility nurse is unable to obtain a response from the attending physician in a timely manner, the facility nurse should notify the nursing supervisor and contact the facility's medical director for orders and directions, making sure to explain the circumstances of the medication shortage. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	When the missed dose is unavoidable, the facility nurse should document the missed dose and the explanation for such missed dose on the MAR and TAR and in the nursing progress notes. The documentation should include a description of the circumstances of the medication shortage, a description of the pharmacy response upon notification, and actions taken. B. Resident #4 1. Resident status Resident #4, age less than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included schizoaffective disorder, bipolar, chronic obstructive pulmonary disease (COPD), depression and muscle weakness. The 5/16/24 minimum data set (MDS) assessment documented the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. The assessment revealed the resident was on routine antipsychotic medications and it had been documented by a physician that a gradual dose reduction (GDR) was contraindicated. 2. Resident interview Resident #4 was interviewed on 6/26/24 at 10:33 a.m. Resident #4 said the facility told her they ran out of her clozapine. She said she became anxious and was feeling distressed about not receiving her routine clozapine medication for two consecutive days. Resident #4 said on 6/13/24, due to the anxiety she was feeling about not receiving the medication, she used a cigarette to burn her left forearm which caused five blisters on her arm that required medical attention 3. Record review A review of Resident #4's behavior care plan revealed the resident was on an antipsychotic medication for schizoaffective disorder related to unprovoked verbal aggressive behavior. Interventions included monitoring behavior episodes and attempting to determine the underlying cause. -The care plan did not include an intervention for ensuring CBC laboratory results were faxed to the pharmacy in order to obtain refills of the medication. Review of Resident #4's June 2024 CPO, revealed the following physician's orders: Clozapine oral tablet 100 milligrams (mg). Give three tablets by mouth at bedtime related to schizoaffective and bipolar disorder, ordered 6/15/23. Monthly CBC for clozapine monitoring every day shift every month for clozapine use. Fax results to pharmacy for refill on medication clozapine, ordered 8/28/23. Review of Resident #4's June 2024 medication administration record (MAR) revealed the resident received her last dose of clozapine on 6/11/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	-Further review of the June 2024 MAR revealed the resident's clozapine was not administered on 6/12/24 and 6/13/24. -A review of the resident's progress notes on 6/12/24 revealed no documentation to indicate why Resident #4 did not receive her clozapine. On 6/13/24 at 11:39 p.m. registered nurse (RN) #2 documented the medication was unavailable. RN #2 documented the pharmacy required an updated CBC laboratory result in order to refill the medication. -The facility failed to send Resident #4's CBC laboratory results to the pharmacy prior to the resident's last dose of the medication on 6/11/24 in order to receive the next refill of the medication in a timely manner (see progress note above and interviews below). A 6/14/24 progress note documented Resident #4 reported to an occupational therapist that, due to feelings of distress and not receiving her medication, she self harmed by burning herself with a cigarette on the evening of 6/13/24. A wound care progress note dated 6/24/24 revealed Resident #4's blisters on her left forearm had developed into wounds and had received a status of not healed. The initial wound encounter measurements were 3.2 centimeters (cm) length by 3.7 cm width. An education for medication unavailability and shortages, dated 6/18/24, was provided by the NHA on 7/2/24 at 12:13 p.m. It read in pertinent part, Education completed with the primary nurse (RN #4) regarding how to access needed laboratory information for follow up, notifying the provider and the need to document steps taken to resolve issues as they arise. Licensed practical nurse supervisor educated on the need to follow up on information reported from floor staff. All nursing administration was educated regarding the above. C. Staff interviews RN #4 was interviewed on 7/2/24 at 11:02 a.m. RN #4 said she discovered, during medication administration on her shift on 6/12/24, that Resident #4 did not have clozapine available for administration. RN #4 said she contacted the pharmacy and was told the medication would be delivered with the next delivery. RN #4 said she did not administer the medication on her shift because the clozapine was unavailable and therefore Resident #4 missed a dose of the medication on 6/12/24. RN #4 said she passed the information on to the next shift's nurse but did not inform the charge nurse or the nurse manager about the missed dose due to the unavailability of Resident #4's clozapine. RN #4 said she failed to document her actions in the nurse progress notes. RN #4 said missing the doses of clozapine could have caused Resident #4 to inflict the injuries to her forearm with a cigarette on 6/13/24. RN # 4 said she had been educated by the director of nursing (DON) on the proper procedures to follow when medications were unavailable. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	RN #2 was interviewed on 7/2/24 at 11:40 a.m. RN #2 said she contacted the pharmacy on 6/13/24 during her nighttime medication administration when she discovered Resident #4's clozapine was not available. RN #2 said the pharmacy requested an updated CBC laboratory result before the medication could be refilled. RN #2 said she faxed the most current CBC laboratory test result to the pharmacy, however, she said she still did not receive the clozapine. RN #2 said she contacted the pharmacy again and was informed that the clozapine was not filled because the CBC laboratory test result was not current and, as a result, Resident #4 missed a second dose of the medication on 6/13/24. RN #2 said she informed the oncoming nurse about the unavailable medication, however, she said she did not notify the attending physician to obtain further orders and/or directions. RN #2 said she was unable to obtain the updated CBC laboratory test result for the pharmacy because the laboratory's website did not communicate with the facility's electronic medical record system RN #2 said Resident #4 received clozapine for her diagnosis of schizoaffective and bipolar disorder and missing two consecutive days of her medication could result in extreme behaviors, such as self-harm. RN #2 said she did not recall why she did not inform the nursing supervisor and the attending physician about the missed doses of the medication. RN #2 said she had received education on the proper procedures to follow when there were instances of medication shortage/unavailability and to document her actions per the facility's protocol. The DON was interviewed on 7/2/24 at 12:10 p.m. The DON said the staff should have followed the facility's protocol for medication shortages and unavailability by notifying the nurse supervisor and the attending physician about the circumstances of the medication and the missed doses. The DON said she believed the lack of awareness of staff led to the significant medication error and she had completed training for all nursing staff about the facility's policy regarding medication unavailability and medication errors. -A voicemail was left for the pharmacist during the survey, however, the phone call was not returned by the survey exit on 7/2/24. 47536 III. Antibiotic medication error A. Professional reference [NAME] A, Triantafylidis L, O ' [NAME] N, et al. Improving Medication Reconciliation With Comprehensive Evaluation At A Veterans Affairs Skilled Nursing Facility: The Joint Commision Journal on Quality and Patient Safety (2021), was retrieved on 7/1/24 from https://www.jointcommissionjournal.com/article/S1553-7250(21)00153-7/fulltext. It read in pertinent part, (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Unintentional medication discrepancies due to inadequate medication reconciliation pose a threat to patient safety. Skilled nursing facilities (SNFs) are an important care setting where patients are vulnerable to unintentional medication discrepancies due to increased medical complexity and care transitions. SNFs represent a critical setting for medication reconciliation efforts due to challenges completing the reconciliation process and the concomitant high risk of adverse drug events in this population. Ineffective medication reconciliation continues to threaten patient safety across health care systems around the world. Best-practice guidelines outline the need for high-quality medication reconciliation in all care settings, including skilled nursing facilities (SNFs). Patients in SNFs are at heightened risk for medication reconciliation errors due to increased care transitions (for example, home to hospital to SNF to home) and medical complexity. Improving medication reconciliation in the SNF setting is challenging due to resource constraints, complex workflows, and variation in the capabilities of electronic medical records (EMRs). B. Facility policy The Documentation of Medication Administration policy, revised November 2022, was received from the nursing home administrator (NHA) on 7/1/24 at 3:35 p.m. The policy read in pertinent part, A medication administration record is used to document all medications administered. A nurse documents all medication administered to each resident on the resident's medication administration record (MAR). Administration of medication is documented immediately after it is given. Documentation of medication administration includes, at a minimum, the resident's name, name and strength of the drug, dosage, route of administration, date and time of administration, initials, signature and title of the person administering the medication, and the resident response to the medication. C. Resident #38 1. Resident status Resident #38, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included neuromuscular bladder dysfunction and history of methicillin-susceptible staphylococcus aureus (MSSA) bacteremia staphylococcus infection (MSSA BSI). The 5/15/24 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent with his activities of daily living. 2. Resident interview Resident #38 was interviewed on 7/1/24 at 1:14 p.m. Resident #38 said he took antibiotic medications three times a day. He said he took the medication to prevent an infection from returning to his spine. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	3. Record review Review of Resident #38's July 2024 CPO revealed the following physician's order: Cephalexin 500 milligram (mg) tablets, give 500 mg orally (by mouth) three times a day, ordered 5/25/22. A 8/1/23 infectious disease (ID) physician note revealed Resident #38 was evaluated by the ID physician. The ID physician ordered a decrease in the resident's Cephalexin. The new order was for Cephalexin 500 mg tablets, two times a day. A 4/2/24 ID physician note revealed Resident #38 was evaluated by the ID physician. The note documented the resident had a history of MSSA BSI from an infection in his spine in 2020. The note documented the resident was to continue on Cephalexin 500 mg twice a day for infection prevention. The facility failed to change Resident #38's Cephalexin order on 8/1/23. From 8/1/23 to 7/2/24, the resident was administered the Cephalexin medication three times a day instead of two times a day. -There was no documentation in Resident #38's electronic medical record (EMR) to indicate a medication review and reconciliation had occurred following the resident's appointment with the ID physician in order to ensure the resident was receiving the correct dose of the Cephalexin antibiotic -Review of Resident #38's comprehensive care plan revealed the facility failed to develop an individualized care plan focus for Resident #38 for antibiotic stewardship and infection monitoring. D. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/1/24 at 1:05 p.m. LPN #1 said when any resident returned from outside appointments, the facility nurse should review the clinical documentation from the outside provider, which included a review and reconciliation of medication. She said when the nurse completed her review, it was the nurse's responsibility to contact the physician to discuss new or changed treatment orders. The DON was interviewed on 7/2/24 at 8:50 a.m. The DON said when residents returned to the facility from outside appointments, the nurse should review the clinical documentation from the outside provider. The DON said when changes to care were identified, the nurse should contact the physician for clarification and new facility orders if indicated. The DON said she was unable to locate documentation in Resident #38's EMR to indicate the nurse, the interdisciplinary team or the facility physician had completed a review of the ID physician's treatment plan. The DON said the facility had an antibiotic stewardship program. She said the antibiotic stewardship program was responsible for reviewing all antibiotic orders to ensure antibiotics were used effectively. The DON said she was unable to locate documentation to indicate the facility reviewed Resident 38's prescribed antibiotic medication. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	The DON said she would contact the ID physician and ensure Resident #38 received the prescribed dose of Cephalexin going forward.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations, record review and interviews, the facility failed to ensure one (#10) of three residents reviewed for ancillary services out of 32 sample residents received routine dental care and 24-hour emergency dental care. Specifically, the facility failed to ensure Resident #10 was provided dental services for new dentures timely. Findings include: I. Facility policy and procedure The Dental Services policy and procedure, undated, was received from the nursing home administrator (NHA) on 7/4/24 at 9:46 a.m. It revealed in pertinent part, It is the policy of this facility to assist residents in obtaining routine and emergency dental care. Routine dental services annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full dentures adjustments, smoothing of broken teeth and limited prosthodontic procedures (taking impressions for dentures and fitting dentures). For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days. Direct care staff are responsible for notifying supervisors or social service director of the loss or damage of dentures during the shift that the loss or damage was noticed. The social service director or designee, shall make appointments and arrange transportation. The resident and/or resident representative shall be kept informed of all arrangements. All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the residents medical record. II. Resident #10 Resident #10, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included cellulitis of the right lower limb (infections of the skin), peripheral vascular disease (abnormal blood circulation), chronic kidney disease (abnormal kidney function) and chronic obstructive pulmonary disease (abnormal oxygen exchange). The 6/5/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. The resident was independent for oral hygiene and eating. The assessment documented Resident #10 did not use dentures. III. Resident interview (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10 was interviewed on 6/ 26/24 at 10:49 a.m. Resident #10 said his dentures went missing, along with the container, a few months ago and he told the staff. Resident #10 said he struggled with eating. He said if he was served something he could not chew with his gums he just would not eat it. Resident #10 said he was unable to replace the dentures himself due to the cost. IV. Record review A dental visit note from 10/24/23 documented Resident #10 had poorly fitting dentures and he was unable to wear them. The dentist recommended new dentures for Resident #10. -Review of the resident's electronic medical record (EMR) did not reveal documentation that the facility had scheduled any follow up appointments for the dentist recommendations. A progress note written by the social worker, dated 10/24/23, documented Resident #10 was seen by the dentist and the dentist recommended new dentures. The 2/25/24 weekly progress note documented the resident had upper and lower dentures but refused to wear them. The 4/10/24 weekly progress note documented Resident #10 was unable to find his dentures. The 4/24/24 weekly progress note documented Resident #10 lost his dentures. The 5/1/24 weekly progress note documented Resident #10 dentures were still missing. The 5/8/24 weekly progress note documented Resident #10 needed new dentures. The 6/5/24 weekly progress note documented Resident #10 had no dentures. The comprehensive care plan, initiated on 2/5/19 and revised on 5/27/20, revealed Resident #10 no longer had any natural teeth and was edentulous (missing all teeth). Interventions were to coordinate arrangements for dental care and transportation as needed. -However, a review of the resident's EMR did not reveal documentation indicating the facility had coordinated care for the resident's dental care needs. V. Staff interviews Licensed practical nurse (LPN) #1 was interviewed on 7/2/24 at 12:31 p.m. LPN #1 said Resident #10 lost his dentures at the hospital in April 2024. LPN #1 said the social service director (SSD) was aware of the missing dentures and she thought the facility was waiting on insurance to cover the cost of dentures. -There was no progress note to document where the dentures were lost or if the insurance was contacted for approval of new dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NHA was interviewed on 7/2/24 at 12:36 p.m. The NHA said the SSD was not available for an interview. The NHA said Resident #10's dentures were lost at the hospital. She said the facility reached out to the hospital regarding the resident's missing dentures, however, there had been no resolution after talking to the hospital liaison. The NHA said she did not know where the facility was in regards to the process of getting new dentures for Resident #10. The NHA was interviewed again on 7/2/24 at 1:00 p.m. The NHA said Resident #10 had not been on the dental schedule at the time of the earlier interview (on 7/2/24). The NHA said Resident #10 had since been scheduled to see the dentist on 7/22/24. The NHA said she was unable to find documentation that indicated if the facility had taken steps to get Resident #10 new dentures. The NHA said she reviewed the dental visit note from 10/24/23 (see record review above) and she said Resident #10 was recommended to get new dentures eight months ago prior to the dentures being lost. The NHA said it was the facility's responsibility to get Resident #10 new dentures after such a long period of time since the initial dentist recommendation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47150 Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in a sanitary manner in the facility's main kitchen and two out of four unit refrigerators. Specifically, the facility failed to: -Ensure beverages in the unit refrigerators were dated and labeled; -Ensure stacked pans were dried appropriately; -Ensure dented food cans were not used; and, -Ensure an appropriate test strip was used for the sanitizing bucket. Findings include: I. Ensure beverages in the unit refrigerators were dated and labeled A. Professional reference The Colorado Department of Public Health and Environment (3/16/24) The Colorado Retail Food Establishment Rules and Regulations, were retrieved on 7/10/24 from https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_RFE_Reg_6 CCR 1010-2_2024_EN.pdf. It read in pertinent part, Time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations. A date marking system may include using a method approved by the regulatory authority for refrigerated, ready-to-eat time/temperature control for safety food that is frequently rewrapped, such as lunch meat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine, marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded and/or marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded. The Hormel Code Date and Handling Information 2022, retrieved on 7/15/24 from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.hormelhealthlabs.com/wp-content/uploaDM/HHL-Code-Date_Handling-Sheet-04_2024.pdf It revealed in pertinent part, Hormel Thick & Easy Clear Thickened Beverages shelf life: refrigerated up to ten days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Observation On 6/26/24 at 10:22 a.m., the following was observed in the east nursing station nourishment refrigerator: -There was one opened gallon of milk with no open date . On 6/27/24 at 3:14 p.m., the following was observed in the west nursing station nourishment refrigerator: -There were two bottles of juice, an opened bottle of sparkling water and an opened container of thickened beverage with no labels or dates on them. C. Staff interviews The dietary manager (DM) was interviewed on 6/27/24 at 3:45 p.m. The DM said nursing staff were responsible for ensuring all opened items in the unit refrigerator were properly labeled and dated. He said all opened and undated items should be discarded since no one knows how long they have been opened. He said undated beverages could cause food-borne illness. Licensed practical nurse (LPN) #2 was interviewed on 6/27/24 at 4:00 p.m. LPN #2 said opened beverages needed to be dated and labeled to ensure every staff member knew when the drink should be discarded. She said the gallon of milk in the refrigerator had no open date and needed to be thrown away. LPN #2 said residents could become sick from drinking milk products that were past the date they should be discarded. LPN #2 said all unlabeled and undated items in the refrigerator would be discarded. The NHA was interviewed on 7/1/24 at 1:00 p.m. She said the unit refrigerators should be monitored by nursing staff to ensure items were dated and labeled when opened. II. Ensure stacked pans were dried appropriately A. Professional reference The Colorado Department of Public Health and Environment (3/16/24) The Colorado Retail Food Establishment Rules and Regulations, was retrieved on 7/10/24 from https://www.colorado.gov/pacific/sites/default/files/DEHS_RetailFd_RFE_Reg_6 CCR 1010-2_2024_EN.pdf. It read in pertinent part, Equipment and Utensils, Air-drying required. After cleaning and sanitizing, equipment and utensils shall be air-dried or used after adequate draining before contact with food and may not be cloth dried. B. Facility policy The Kitchen Sanitation policy, revised November 2022, was provided by the nursing home administrator (NHA) on 7/2/24 at 6:25 p.m. It read in pertinent part, The food service area is maintained in a clean and sanitary manner. Food preparation equipment is allowed to be air dried. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	C. Observations On 7/1/24 at 10:40 a.m. there were metal pans that were stacked on a storage shelf in the main kitchen. The metal pans had moisture between them. D. Staff interviews Dietary aide (DA) #2 was interviewed on 7/1/24 at 11:00 a.m. DA #2 said cooking utensils and pans needed to be air-dried before they were stacked together to prevent moisture buildup. DA #2 said sometimes they stacked the pans together to make room for additional dishes. The DM was interviewed on 7/1/24 at 11:10 a.m. The DM said the pans should not have moisture between them and should be air-dried. The DM said the excess moisture could attract harmful bacteria and had higher chances of cross contamination. The DM separated the pans and placed them individually to be air-dried. He said he would provide education to all of the kitchen staff on the proper process of drying kitchen pans before they were stacked together. III. Ensure dented cans were discarded A. Professional reference According to the United States Department of Agriculture (USDA), retrieved on 7/10/24 from https://ask.usda.gov/s/article/Is-food-in-damaged-cans-dangerous, Never use food from cans that are leaking, bulging, or badly dented, cracked jars or jars with loose or bulging liDM, canned food with a foul odor or any container that spurts liquid when opening. Such cans could contain clostridium botulinum. A deep dent is one that you can lay your finger into. Deep dents often have sharp points. A sharp dent on either the top or side seam can damage the seam and allow bacteria to enter the can. Discard any can with a deep dent on any seam. While extremely rare, a toxin produced by it is the worst danger in canned gooDM. Don' t taste such fooDM. Even a minuscule amount of botulinum toxin can be deadly. B. Observations On 6/26/24 at 10:14 a.m., during the initial kitchen tour, there was one dented can of ready-to-use roasted chicken gravy, one dented can of mandarin oranges and one dented can of apples that were on the rack for storing canned fooDM in the kitchen. C. Staff interviews The DM was interviewed on 6/27/24 at 4:30 p.m. The DM said dented canned food needed to be stored separated from the other cans and should not be used. The DM said dented canned food could grow bacteria that could cause food-borne illness to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DM said he believed a lack of awareness from the kitchen staff resulted in having dented canned fooDM on the kitchen rack. He said all of the kitchen staff received training and were aware not to place dented food cans on the rack to be used. The DM said he had removed the dented cans and would provide education to the kitchen staff immediately to avoid staff using any dented food cans. The nursing home administrator (NHA) was interviewed on 7/1/24 at 1:00 p.m. The NHA said dented canned fooDM should be separated and were not to be used. IV. Ensure the correct sanitizing stripes were used for sanitizing buckets A. Professional reference The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 7/10/24 from: https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view read in pertinent part, Chemical sanitizers that are used to sanitize equipment and utensils shall be provided and available for use during all hours of operation. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times and be used in accordance with the EPA registered label use instructions. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. B. Observations and interviews On 6/26/24 at 10:11 a.m., DA #1 went to the dishwashing area and filled a red bucket with a broad range quaternary sanitizer solution and headed to the dining room. DA #1 said the solution was used to clean equipment and surfaces in the food preparation area. She said she did not check the chemical concentration of the sanitizer when she filled the bucket with the sanitizer solution. The DM said the kitchen had an automatic solution dispenser that mixed the solution with water. The DM said the staff used the machine to fill the red sanitizer buckets. He said the staff needed to test the solution each time they filled the bucket to ensure the strength of the solution was correct by testing the parts per million (PPM). He said the kitchen staff needed to document that they tested the solution on a log. He said the solution should also be tested in the morning and in the evening to ensure it was the correct strength. The solution was tested with a test strip by the DM. The solution registered 10 ppm on the strip. -The DM dumped out the solution and tested another bucket of sanitizer solution with a new test strip. The new test strip read 10 ppm. The DM told DA #1 to stop using the solution until the proper sanitizing solution was attained. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/27/24 at 8:50 a.m. the DM tested the sanitizer with a new test strip and tested the chemical solution and it measured 200 ppm. C. Record review A review of the June 2024 (6/1/24 to 6/27/24) sanitizing test strip log on 6/27/24 at 9:50 a.m. revealed the log was missing documentation for nine days out of 27 days. -The test logs for 6/1/ 24 to 6/18/24 documented the quat solution tested at 200 ppm each shift (see interview below). C. Staff interviews The DM was interviewed on 6/27/24 at 2:25 p.m. The DM said the facility had been using the wrong test strips to test the ppm of sanitizing solution. The DM said the correct test strips had been obtained and the quat solution was now testing at 200 ppm, which was the proper ppm. The DM said the test logs could not be accurate given the facility had the wrong test strips (see record review above). The DM said he would educate the kitchen staff on how to test the quat solution correctly. The DM said he did not know how long the facility had been using the wrong test strips. He said all the old test strips had been discarded. The nursing home administrator (NHA) was interviewed on 7/1/24 at 1:00 p.m. The NHA said the kitchen staff should ensure the sanitizing solution measures 200 ppm before using it on equipment and surfaces in the food preparation area and in the dining room where residents eat. The NHA said she was unsure why the policies and procedures were not being followed by facility staff. She said she would provide education immediately and monitor for compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infection on two of four units. Specifically, the facility failed to: -Ensure housekeeping staff followed proper cleaning techniques for cleaning and disinfecting resident rooms and high frequency touch areas (call lights, bed controls and light switches); -Ensure infection control protocols were followed during and after wound care provided to a resident in the facility's shower room; and, -Ensure staff performed hand hygiene appropriately during wound care. Findings include: I. Housekeeping failures A. Professional reference 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 7/10/24 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part, 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. The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 7/10/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html?CDC_AAref_Val=https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#cdc_generic_section_2-4-1-general-environmental-cleaning-techniques. It read in pertinent part, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Common high-touch surfaces include bed rails, IV (intravenous) poles, sink knobs, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs. 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. B. Facility policy and procedure The Cleaning and Disinfecting Residents' Rooms policy and procedure, revised August 2013, was received from the nursing home administrator (NHA) on 7/1/24 at 2:49 p.m. It revealed in pertinent part, The purpose of this procedure is to provide guidance for cleaning and disinfecting residents' rooms. Clean horizontal surfaces (for example, bedside tables, over bed tables, and chairs) daily with a cloth moistened with disinfectant solution. Do not use feather dusters. Clean all high touch furniture items with disinfectant solution. Clean all high touch personal use items (for example, lights, phones, call bells and bed rails) with disinfecting solutions. C. Observations On 6/27/24 at 8:52 a.m. housekeeper (HSKP) #1 was observed cleaning resident room [ROOM NUMBER], a double occupancy room. HSKP #1 used a Swiffer duster to dust the B side of the room, including the lamp, ceiling, walls, television, bedside table, night stand, headboard/footboard of the bed, dresser and the window sill. After dusting, HSKP #1 removed her gloves, performed hand hygiene and applied new clean gloves. HSKP #1 proceeded to take the same Swiffer duster to the A side of the room and dust the lamp, ceiling, television, door frame, closet doors and the light above the sink. -HSKP #1 failed to wipe any high touch surfaces in the residents' room with a disinfectant. On 6/27/24 at 9:12 a.m. HSKP #1 was observed cleaning resident room [ROOM NUMBER], a double occupancy room. HSKP #1 collected the Swiffer duster and dusted the B side of the room, including the light over the sink, blinds, television, the light over the bed, headboard, footboard and the walls. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Use an alcohol-based hand rub containing at least 62% alcohol, or alternatively, soap (antimicrobial or non antimicrobial) and water for the following situations: before and after direct contact with residents,before performing any mom-surgical invasive procedures, before handling clean or soiled dressings and gauze pads, before moving from a contaminated body site to a clean body site during resident care, after contact with blood or bodily fluids, after contact with objects in the immediate vicinity of the resident and after removing gloves. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. Applying and removing gloves perform hand hygiene before applying non sterile gloves. Perform hand hygiene after removing gloves. The Dressing-Clean Technique policy and procedure, undated, was received from the NHA on 7/4/24 at 9:46 a.m . It revealed in pertinent part, A clean dressing technique is used to provide a conduit to wound healing. All dressings are performed using clean technique, unless otherwise specified by the physician. Wash hands before and after the procedure and wear gloves. Remove gloves. Open packages and remove dressing, observing aseptic technique. C. Observations On 7/1/24 at 12:43 p.m. licensed practical nurse (LPN) #1 was observed providing wound care to Resident #10. Wound care was provided in the shower room. LPN #1 set all of the clean wound care supplies directly on the counter around the sink. Resident #10 remained sitting in a wheelchair for treatment with the resident's right foot resting on the foot pedal with no barrier pad between the surface of the foot pedal and the bottom of the resident's foot. -LPN #1 failed to provide a clean working area for the clean wound care supplies and the treatment of the wound. LPN #1 applied gloves and removed the old dressing from the resident's right foot. LPN #1 had to moisten the bandage with normal saline to remove the dressing. After removing the old dressing from the wound, LPN #1 removed her soiled gloves and applied new gloves. -LPN #1 failed to perform hand hygiene after removing her soiled gloves and before putting on new gloves. LPN #1 applied normal saline to two pieces of gauze. Taking one piece of gauze at a time, she pressed the wound twice with the gauze and then wiped the wound four times. Wound drainage and saline solution was observed to be dripping down the resident's leg onto his foot pedals and onto the shower room floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 opened sterile gauze pad packets and then opened a bottle of iodine and poured it over the gauze. LPN #1 proceeded to wring out the excess iodine over the trash can and placed the iodine soaked gauze pads on the resident's wound. LPN #1 secured gauze pads to the resident's leg with rolled gauze. Resident #10 left the shower room via wheelchair. -The resident's wheelchair pedals were not cleaned after the wound care was provided. LPN#1 removed her gloves after disposing of the unused supplies. LPN #1 applied one glove to one hand and carried the trash across the hallway from the shower room to the soiled utility room for disposal into a biohazard trash receptacle. LPN #1 returned to the nurses station, collected a computer and placed it onto her medication cart. The shower room door was closed and the floor was not cleaned. -LPN #1 failed to change her gloves after cleaning the wound, prior to opening the sterile packaging and failed to perform hand hygiene after wound care was complete. -LPN #1 failed to place a barrier pad under the resident's leg to contain the wound drainage. -LPN#1 did not clean the shower room floor or the resident's foot pedals after wound care. On 7/1/24 at 3:40 p.m. registered nurse (RN) #1 was observed on 7/1/24 at 3:40 p.m. providing wound care to a Resident #28 in his room. Resident #28 was lying on his right side for treatment and the resident's incontinence brief was pulled away from the site of the wound. The resident was lying on a chucks barrier pad. The incontinence brief and the chucks pad were observed with bloody wound drainage on them prior to RN #1 changing the wound dressing. -RN #1 did not place a clean chucks pad or incontinence brief under the resident prior to changing the wound dressing. Following the wound dressing change, RN #1 changed the resident's incontinence brief, however, she did not replace the soiled chucks barrier pad. -RN #1 failed to provide a clean working area under the resident for wound care. D. Staff interviews LPN #1 was interviewed on 7/1/24 at 12:49 p.m. LPN #1 said she did not sanitize between gloves changes and it was best practice to apply a sanitizer or wash hands with soap and water between glove changes. LPN #1 said the Resident #10 preferred not to complete wound care in his room if his roommate was present, which was why she completed the wound care in the shower room. LPN #1 said the shower room was cleaned by the certified nurse aides (CNA) after each use and once daily by housekeeping. LPN #1 said she did not observe any fluids drip onto the resident's foot pedals or floor during wound care and so she did not clean the shower room floor or the foot pedals (see observations above). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #1 said sometimes a barrier pad could be placed under the wound if a resident was receiving treatment in bed. LPN #1 said a barrier pad could prevent cross contamination or soiling of areas below the wound during treatment. LPN #1 said when cleaning the wound, she should have only wiped the wound once with each piece of gauze to prevent potential contamination of the wound. RN #1 was interviewed on 7/1/24 at 4:58 p.m. RN #1 said placing a new chucks barrier pad under the resident for wound care could help prevent infection. IP #1 was interviewed on 7/2/24 at 11:52 a.m. IP #1 said a wound should be cleaned with what the physician order instructed. IP #1 said the wound should only be wiped once with each piece of gauze to prevent infection. IP #1 said chucks barrier pads should be used under the residents' wounds to absorb drainage and prevent infection. IP #1 said setting up dressing supplies should be done on a clean surface, such as a barrier pad, to prevent infection. IP #1 said the nurse should have cleaned the shower room and foot pedals after wound care was provided. IP #1 said nursing staff should perform hand hygiene when changing gloves to prevent the spread of infection. IP #1 said housekeeping cleaned shower rooms and CNAs also cleaned shower rooms between residents. She said the nursing staff should have cleaned the shower room floor and Resident #10's foot pedals after performing wound care

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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. 41032 Based on observations 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 main entrance walkway was smooth without holes and gaps in the concrete surface; -Ensure the sidewalks and the common space areas were clear of debris, hoses and other equipment; -Ensure the residents had unrestricted access to hallway safety rails; -Ensure the common area recreational spaces were clear of extension cords; -Ensure the residents' hallway flooring was even without open gaps/spaces in the flooring surface; -Ensure the handicapped door opener was functioning and operational; -Ensure broken and damaged medical equipment, discarded resident belongings, folding chairs, large metal drums, hoses and maintenance items were disposed of and not left piled up in the parking lot behind the facility; -Ensure the landscaping was tidy and free from large areas covered with weeds and overgrown grass, empty cardboard boxes and piles of wood; and, -Ensure missing light covers were replaced when missing or broken. Findings include: I. Facility policy and procedure The Maintenance Manual policy, dated 12/31/15, was provided by the nursing home administrator (NHA) on 7/4/24 at 9:46 a.m. It read in pertinent part, Maintenance activities include, providing a functional, sanitary, and comfortable environment, controlling or eliminating nuisances and pollutants within the immediate environment and ensuring that all equipment, buildings, spaces, and fixtures are kept in operable condition. This facility shall properly maintain the exterior of the building, the grounds, and the parking lot to ensure that they are clean, well-kept, and as free as possible of environmental pollutants. This facility shall employ safe and proper methods in maintaining the facility to protect against injury to our residents, staff, or visitors. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065273	A. Building B. Wing	07/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Post Acute	6270 W 38th Ave Wheat Ridge, CO 80033

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Exterior general maintenance: Inspect the exterior of the building weekly for needed repair. Check the exterior of doors and windows, including handles, knobs and locks, sills. Grounds, sidewalks, patios, and parking lot: Cut all lawns on a regular basis (weekly during summer). Keep shrubs neatly trimmed. Sweep sidewalks and patios daily during warm months when they are in constant use and weekly during cool months. Clean up any debris, especially broken glass, on sidewalks and patios immediately. All debris is a potential hazard to our residents. Maintain the facility, its fixtures, and equipment in safe and good repair. Repair, or have repaired, any defect in the facility's structure, fixtures, or equipment as soon as possible. By periodic inspection (at least weekly), he/she shall check the condition of special equipment and fixtures for the blind and otherwise physically handicapped residents, and all other required safety equipment and fixtures. Should any of the above be inoperable, defective, or not securely installed, the administrator will have them immediately repaired by the maintenance supervisor or appropriate servicing company. Inspect all areas in the building and grounds under the control of the license that are used to provide the care and services required to obtain and retain a license, including storage areas. Determine that no condition exists that presents a potential hazard to residents, clients, employees, or visitors. Check bulb guards around exposed light bulbs to make sure they are securely fastened. Install new fluorescent lights as necessary. Replace light covers and glass when broken or cracked. II. Observations Two environmental tours of the facility were conducted on 6/26/24 at 10:10 a.m. and on 7/2/24 at 12:22 p.m. Observations revealed the following: -The front concrete sidewalk at the bottom of the ramp leading to the front door was cracked and had a large hole the width of the sidewalk at the point where two pieces of the sidewalk met. The gap in the sidewalk spanned the entire width of the sidewalk and was four to five inches wide and a couple of inches deep. -Visitors and residents were observed having to make a deliberate step over the hole in the sidewalk or step or roll around to an area of the sidewalk that was not as badly gouged. A couple of visitors got stuck in the hole and one vendor bringing in supplies struggled to get the cart full of supplies over the gouged sidewalk. The facility had several patios for resident use. The patio off the activities room had raised garden beds where residents assisted in the gardening process. -The sidewalks on the activities room patio had gardening supplies, a cardboard box and a garden hose on the surface, which were likely to cause a trip hazard for residents using the patio. -Additionally, there were pieces of a disassembled plastic shed leaning up against the building. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The smoking patio had uneven sidewalks and several gouged areas on the surface of the walkway at the entrance to the patio area. -The unit hallways were cluttered with unused resident beds, wheelchairs, a recliner chair and mechanical lifts that were blocking resident access to the hallway safety rails. -The hallway lights outside the resident rooms were missing their covers and the bulbs were exposed. The facility recreation room had a large pool table, television and several bookshelves containing books and other recreation items for the residents. -The televisions and bookshelves in the room were inaccessible to residents because the walkway was blocked by a large coiled-up extension cord used to power a swamp cooler, which was a potential tripping hazard. -The hallway floor outside the rehabilitation gym was in a state of disrepair. The tiles were missing and a new plywood floor was placed. The floor, however, had a large gap where the flooring did not meet, causing an uneven surface that a resident with unsteady balance or using a walker assistive device could get stuck in causing a likely trip hazard. -There was a large pile of trash in the back parking lot visible from inside the facility. The unorganized pile of trash spanned several parking spaces and consisted of three hospital beds, several folding chairs, hoses, a large metal drums, a weed eater, a grass spreader, open and filled cardboard boxes, folding tables, metal buckets, walkers, wheelchairs, discarded resident belongings and other miscellaneous items. The pile was dumped in place in a disorganized manner and the items left in the elements were starting to rust. -The outside landscaping was overgrown with weeds. III. Resident interviews Resident #25 was interviewed on 6/26/24 at 9:33 a.m. Resident #25 said the front entrance sidewalk was a problem that had been in its current state of disrepair for at least the past two years. He said it needed to be fixed because he and the other residents and visitors would be caught up in the hole. He said he saw several residents in manual wheelchairs struggle to get past the hole and up the ramp. Resident #25 said the handicapped door opener at the front door when exiting the building had also been broken for at least two years. He said it caused an accessibility issue and was a problem because residents who used wheelchairs had to position themselves correctly to be able to push the door with their footrests and if they did not have proper shoes on it could be problematic to the person. Resident #25 said he was bothered by the pile of trash in the back parking lot. He said the trash was building up and the facility was not taking care of it. He said the weeds were growing around the trash and it could possibly attract rodents. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A resident group interview was conducted on 7/1/24 at 10:30 a.m. with four alert and oriented residents (#65, #20, #42 and #46). The residents said they thought the area in the back parking lot was a storage area for broken equipment that needed to be repaired. The residents said the area was a space for staff parking and they had occasional cookouts for residents and staff in the back during warm weather. The residents said the handicapped door opener had been broken for at least three years and they just got used to it. One resident said it needed to be fixed. The residents said the cracked sidewalk at the bottom of the front entrance ramp had been that way forever. One resident said he hated that crack and they all said staff had to help them up the ramp because of the crack and hole in the surface of the sidewalk. IV. Staff interviews The maintenance director (MTD) was interviewed on 7/2/24 at 3:35 p.m. The MTD said there was a lot to keep up with in the building. He said the facility had contractors in the building doing structural repairs and it took his time away from his regular duties. He said the floor outside of the rehabilitation gym was sagging and he was having a hard time repairing it. He said he would replace more of the flooring to eliminate the gap in the floor. The MTD said the facility had a routine schedule for landscaping the grounds every Friday but got delayed when the building had plumbing issues that needed to be addressed. The MTD said the junk out back had been there for some time and they just needed to get a dumpster to get rid of all of the unused items. The MTD said the facility had plans to remodel the building and would begin that work as soon as they cleared the list of urgent repairs. The MTD said the handicapped door opener needed to be fixed. He said he had a door technician scheduled and would have him look at the handicapped door opener to see if he could repair it during the repair visit. The NHA was interviewed on 7/2/24 at 3:48 p.m. The NHA said the MTD had a lot of projects but she would talk to him about the issues discussed.