STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065276	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Evergreen	2987 Bergen Peak Dr Evergreen, CO 80439

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151 Based on observations, record review and interviews, the facility failed to ensure residents with indwelling catheters received the appropriate care and services according to professional standards for one (#57) of two residents reviewed for catheter care out of 32 sample residents. Specifically, the facility failed to: -Obtain physician's orders for the use and care of Resident #57's catheter; and, -Maintain documentation for Resident #57's catheter care and maintenance. Findings include: I. Facility policy and procedure The Indwelling Urinary Catheter (Foley) Management policy, revised 6/27/23, was provided by the nursing home administrator (NHA) on 5/15/25 at 6:18 p.m. It read in pertinent part, The facility will ensure that residents admitted with a urinary catheter, or determined to need a urinary catheter for medication indication will have the following areas addressed: timely and appropriate assessments related to the indication for use of an indwelling catheter; identification and documentation of clinical indications for the use of a catheter, as well as criteria for the discontinuance of the catheter when the indication for use is no longer present; insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; response of the resident during the use of the catheter, and ongoing monitoring for changes in condition related to potential catheter associated urinary tract infection (CAUTI), recognizing, reporting and addressing such changes. II. Resident #57 A. Resident status Resident #57, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included protein-calorie malnutrition, sepsis (infection of the blood), acute respiratory failure, chronic obstructive pulmonary disease (COPD), obstructive and reflux uropathy (blockage of the urinary tract) and stage 2 pressure ulcer. (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/7/25 minimum data set (MDS) assessment indicated the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 11 out of 15. The resident needed substantial assistance from staff for most activities of daily living. The MDS assessment documented the resident had an indwelling urinary catheter. B. Observations On 5/12/25 at 11:31 a.m. Resident #57 was lying in bed with his urinary catheter bag clipped to his bed. C. Record review Resident #57's comprehensive care plan documented he had a foley catheter, initiated 4/3/25. Pertinent interventions, initiated on 4/3/25, included providing catheter care every shift and educating the resident and/or family regarding indwelling catheter and care. Pertinent interventions, initiated on 4/4/25, included checking the tubing for kinks each shift, following enhanced barrier precautions and observing the resident for and document pain/discomfort due to the catheter. A 4/4/25 physician note written at 9:37 a.m. documented Resident #57 was admitted to the facility with obstructive uropathy and was to continue indwelling uropathy. A review of Resident #57's May 2025 CPO revealed the following physician orders: -Trial of void (assessment for catheter removal): discontinue the foley catheter post void (emptying the bladder) residual (PVR) and notify the provider if the result was greater than 300 millimeters (ml). If the resident cannot void after six hours, then perform a bladder scan and notify the provider of results regardless of the result, ordered 4/9/25 to 4/12/25. -Insert indwelling foley catheter and catheter care order set, ordered 4/11/25. A 4/12/25 administration note documented at 1:03a.m. that Resident #57 had a foley catheter in place after two of two void attempts resulted in retention. A 4/12/25 administration note documented at 10:51 a.m. that Resident #57 had an indwelling foley catheter placed. -The facility failed to obtain physician's orders for the flushing and maintenance of Resident #57's indwelling urinary catheter, and there was no documentation of urinary catheter care or maintenance on the May 2025 treatment administration record (TAR). A 5/12/25 skilled progress note written at 12:22 p.m. documented Resident #57 had a foley catheter draining clear yellow urine, catheter care was given each shift and with every incontinent episode. -However, a review of Resident #57's progress notes from 5/2/25 through 5/12/25 revealed between 5/2/25 and 5/10/25 there was no documentation of catheter care for Resident #57. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Staff interviews The NHA was interviewed on 5/15/25 at 3:45 p.m. The NHA said the facility utilized a checklist when a resident admitted to the facility that included the resident's diagnoses. The NHA said Resident #57's checklist documented he had a catheter but the facility did not have a physician's order for the catheter and catheter care but should obtain an order. The DON was interviewed on 5/15/25 at 5:00 p.m. The DON said the facility did perform catheter care for the resident and catheter care was documented in the resident's progress notes. -However, review of Resident #57's electronic medical record (EMR) did not include documentation that indicated catheter care was consistently provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on observations, record review and interviews, the facility failed to act upon the pharmacist's recommendations in a timely manner for two (#27 and #20) of five residents out of 32 sample residents. Specifically the facility failed to: -Ensure two medications which potentially contributed to falls for Resident #27 were discontinued, per the pharmacist and physician's recommendations; and, -Ensure Resident #20's serum sodium levels were obtained timely after the pharmacist recommended the laboratory work to be completed. Findings include: I. Facility policy and procedure The Pharmacy Recommendations policy and procedure, revised 11/19/24, was provided by the nursing home administrator (NHA) on 5/13/25 at 6:46 p.m. It revealed in pertinent part, Medication regimen review (MRR) is a thorough evaluation of minimizing adverse consequences and potential risks associated with medication. MRRs are done for residents who experience an acute change of condition and for whom an immediate MRR is requested after appropriate staff have notified the resident's physician, the medical director (MD) and the director of nursing (DON) about the acute change. II. Resident #27 A. Resident status Resident #27, age 72, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included displaced fracture of the greater trochanter of the left femur (left hip fracture), age-related osteoporosis with current pathological fracture, chronic obstructive pulmonary disease (chronic lung disease) and hyperlipidemia (high cholesterol). The 3/18/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. He was independent with rolling in bed, eating, oral hygiene and moving from lying to sitting in bed position. He required partial assistance for sitting to standing, toilet transfers and shower transfers. Walking 10 feet was not attempted due to medical conditions or safety concerns. The MDS assessment indicated Resident #27 had fallen since the prior assessment. It indicated one fall was with a minor injury and one fall was without injury. B. Record review (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's May 2025 CPO revealed the following physician's orders: Tizanidine (muscle relaxer) 2 milligrams (mg) one tablet three times a day for muscle relaxant related to fracture of the superior rim of left pubis, ordered 1/20/25. Atorvastatin calcium (cholesterol lowering medication) 80 mg one tablet by mouth at bedtime for hyperlipidemia, ordered 11/15/23. Review of Resident #27's May 2025 medication administration record (MAR) revealed Resident #27 received all of his scheduled doses of Tizanidine and atorvastatin calcium. The 2/8/25 medication regimen review (MRR), conducted by the pharmacist, for Resident #27 was received from the NHA on 5/13/25 at 6:46 p.m. The pharmacist had recommended to the physician to discontinue one or more medications that could have been a contributing factor to Resident #27's recent falls. The medications included tizanidine, pregabalin, buprenorphine, escitalopram, trazodone, oxycodone and atorvastatin. The physician reviewed the pharmacist's recommendations on 2/11/25 and recommended discontinuing Resident #27's atorvastatin and tizanidine. -However, tizanidine and atorvastatin were not discontinued and Resident #27 continued to receive the medications (see physician's orders above). III. Resident #20 A. Resident status Resident #20, age 88, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included delusional disorder, depression, pain and dementia with mood disturbances. The 3/17/25 MDS assessment revealed Resident #20 was cognitively intact with a BIMS score of 14 out of 15. She was independent with transfers, toileting, bed mobility and walking and required set-up assistance with dressing. The MDS assessment revealed the resident received antipsychotic, antidepressant and opioid pain medications. B. Record review Review of Resident #20's May 2025 CPO revealed the following physician's orders: Sertraline hydrochloride (hcl) (antidepressant medication) 100 milligram (mg) tablets. Give 200 mg by mouth one time a day for depression, ordered 8/15/24. Olanzapine (antipsychotic medication) 5 mg. Give half a tablet by mouth one time a day related to delusional disorder and unspecified dementia with mood disturbances, ordered 5/21/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Olanzapine 5 mg tablet. Give one tablet by mouth at bedtime related to delusional disorder and unspecified dementia with mood disturbances, ordered 5/21/24. Tramadol HCl (opioid pain medication) 50 mg tablets. Give half a tablet by mouth three times a day for chronic pain syndrome, ordered 5/29/24. The 3/7/25 pharmacisit's MMR report revealed that Resident #20 received Sertraline, Olanzapine,and Tramadol, which could cause or worsen hyponatremia (low sodium) or syndrome of inappropriate antidiuretic hormone secretion (SIADH), which could cause water retention and low sodium levels. Resident #20's most recent serum sodium level was 134 milli-equivalents per liter (mEq/L) on 2/10/25 (normal sodium levels are 135 mEq/L to 145 mEq/L). The pharmacist recommended obtaining a serum sodium level on the next convenient lab day, four weeks after dose changes,and periodically thereafter. The primary care provider (PCP) agreed with the recommendation and signed the form on 3/14/25. -However, review of Resident #20's electronic medical record (EMR) did not reveal documentation that the serum sodium level was ordered or obtained. IV. Staff interviews The DON was interviewed on 5/15/25 at 11:00 a.m. The DON said the MRR completed by the pharmacist on 2/8/25 for Resident #27 was an intervention in response to one of his falls. She said it was the responsibility of the physician to respond to the pharmacist's recommendations and return their response to the facility. She said it was the physician's responsibility to enter physician's orders into the residents' electronic medical records (EMR) following a pharmacy review. She said nursing staff generally followed up to ensure the pharmacist's recommendations and physician's orders in response to the recommendations were completed. The DON said Resident #27's physician was new to the facility in February 2025 and the facility had since provided education with the physicians and medical director about ensuring they entered physician's orders in the residents' EMRs following a medication change due to a pharmacy review. The DON said the primary care physician (PCP) entered the physician's orders into the residents' EMRs for the specific lab test that was to be drawn, but the nurse entered the physician's orders for the actual physical lab draw. The DON said she did not find an order for a serum sodium level for Resident #20 in the resident's EMR. She said the facility could obtain blood work any day of the week, so it should not have taken several weeks to obtain. She said the blood work normally would be drawn within a day or two of the physician's order being placed. The PCP was interviewed on 5/15/25 at 12:45 p.m. The PCP said he received the recommendations from the pharmacy and had 30 days to get back to the facility with answers to the pharmacist's recommendations. He said he normally got back to the facility within a week. He said it was a team approach to get the physician's orders he recommended based on the pharmacist's recommendations entered into the EMR. The PCP said sometimes he entered the orders and other times it was the nurses. He said sometimes things were missed in regards to the communication of whether the physician or the nurses were entering the physician's orders into the EMR. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The PCP said he recommended discontinuing Resident #27's tizanidine and atorvastatin calcium in February 2025 but the medications somehow got missed being discontinued. The PCP said he could re-check Resident #20's sodium level at any time. He said he thought Resident #20 had her annual wellness visit soon, at which time a sodium level would be drawn anyway. 50690

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50690 Based on interviews and record review, the facility failed to ensure one (#45) of one residents reviewed for radiology and diagnostic services, received timely care out of 32 sample residents. Specifically, the facility failed to schedule and obtain magnetic resonance imaging (MRI - diagnostic imaging) in a timely manner for Resident #45. Findings include: I. Facility policy and procedure The Diagnostic Services policy, revised on 9/24/24, was provided by the nursing home administrator (NHA) on 5/15/25 at 6:15 p.m. It revealed in pertinent part, The facility will ensure that diagnostics services meet the needs of residents. The facility is responsible for the quality and timeliness of services whether services are provided by the facility or an outside resource. II. Resident #45 A. Resident status Resident #45, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician's orders (CPO), diagnoses included a history of displaced fracture of right acetabulum (a break in the ball-and-socket portion of the hip joint) and infection of a surgical site. The 3/14/25 minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 13 out of 15. The 3/14/25 MDS assessment revealed his most recent physical therapy regimen was started 3/13/25. He had received physical therapy two days during the seven day look-back period. The 11/25/24 MDS assessment revealed he used a manual wheelchair, required substantial assistance for most transfers and toileting, was dependent on assistance for bathing and required set-up assistance with eating. B. Resident interview (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45 was interviewed on 5/12/25 at 4:39 p.m. Resident #45 said the scheduling coordinator (SC) was working with him to get a MRI that was ordered a month ago. He said she had not been much help. He said she just kept telling him she would look into it. He said the MRI was ordered because he had increased pain in his right hip and leg. He said he could not lift his right leg anymore. He said it hurt the most when he tried to straighten it. He said he could ride the bicycle in the gym, but standing and walking were very painful. He said after trying to walk in physical therapy, he would have increased pain for the next two days. C. Record review Review of Resident #45's May 2025 CPO revealed a physician's order for a MRI without contrast of the lumbar spine and right hip, ordered 4/14/25 at 12:01 p.m. by the nurse practitioner (NP). On 5/13/25 at 9:24 a.m. the MRI order was marked as complete and discontinued by the MDS coordinator (MDSC). -However, the appointment for the MRI was never scheduled by the facility (see interviews below). A review of Resident #45's electronic medical record (EMR) revealed the following progress notes: An NP noted, dated 11/9/24, revealed Resident #45 had returned to the facility after an open reduction internal fixation (ORIF) procedure on 11/2/24, to repair a fracture of his right upper leg/hip. A PCP note, dated 3/12/25, revealed that Resident #45 was frustrated with his evaluation by the orthopedic surgeon. He said he was not happy with his visit. The surgeon reviewed his Xrays and told him there was nothing wrong and then left the room. The resident said he was continuing physical therapy but still felt like something was wrong with his right hip. A NP note, dated 4/1/25, revealed that the resident's orthopedic clinic notes were reviewed with the resident. The notes documented the radiograph (Xray) showed routine healing but did reveal areas where it appeared a suture had moved. The orthopedic note documented to continue with physical and occupational therapy and follow up in six weeks for a repeat Xray. An Xray would be repeated as recommended. A NP note, dated 4/14/24, revealed Resident #45 had ongoing right lower extremity weakness and pain. He had trace dorsiflexion (upward movement of the foot towards the shin) but he was apparently able to do some walking. The note documented that given the resident's ongoing issues, the NP recommended obtaining a MRI of the lower back and hip, and initiating a referral for a new orthopedic doctor. The resident agreed and the NP was going to place the new outpatient orders for a MRI. A PCP note, dated 4/16/25, revealed Resident #45's surgical and more recent Xrays were reviewed with the resident. The resident continued to have significant hip pain to the point where he was debilitated and unable to walk. The note documented the NP recommended to obtain a second opinion with a different orthopedic surgeon and the NP had made the referrals. The facility said the resident was no longer participating in physical therapy. A NP note, dated 4/18/25, documented the plan was to continue with the second opinion following the MRI. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note, dated 4/21/25, documented Resident #45 had called his original orthopedic surgeon's office and canceled his follow-up appointment. The resident said he wanted to pursue a second opinion elsewhere. -A review of Resident #45's electronic medical record (EMR) revealed a referral form for the MRI was not completed and sent, until 5/13/25 (see interview below). A PCP note, dated 5/14/25, documented Resident #45 reported he was supposed to have a MRI of his hip this week to assess his continued hip pain. The facility said the resident was using the gym and exercise equipment, but was not receiving formal physical therapy anymore. -Review of Resident #45's EMR did not reveal documentation that the resident had received a MRI since it was recommended on 4/14/25 by the NP. III. Staff interviews The SC was interviewed on 5/14/25 at 9:36 a.m. The SC said after the doctor ordered a test, the nurse verified it and then the order went directly to her or as a transportation request form filled out by the nurse. She said she usually received the orders right away but she did not receive Resident #45's transportation form from nursing until this month (May 2025). She said the MRI order was dated 4/14/25. She said she sent a fax on Tuesday (5/13/25) at 1:10 p.m. to the resident's new doctor for a MRI of the lumbar spine and right pelvis. The SC said the office required a referral. She said she filled out the referral form for the MRI and appointment, and the NP signed it on 5/12/25 (during the survey). She said she did not know why the order did not get to her until May 2025, but it was possible that the order had disappeared from their electronic charting system. She said once the appointment was scheduled, the resident received a blue appointment reminder sign, which was usually a week before. The MDSC was interviewed on 5/14/25 at 3:33 p.m. The MDSC said the standard practice was when the date of an order had passed, it was deleted from the system under the assumption that it had been completed already. She said that appointments and orders that were over a month old got deleted so that the system did not get cluttered. She said that the director of nursing (DON) and the SC were the ones who dealt with the follow-through of the orders. The NP was interviewed on 5/14/25 at 3:45 p.m. The NP said that an Xray obtained by the facility (2/19/25) revealed that Resident #45 had some medial displacement. The NP said the resident returned to his surgeon, who said there was nothing wrong with Resident #45's hip despite the Xray findings. He said that prompted him and the resident to obtain a second opinion in April 2025. The NP said typically, a resident should be able to get an appointment confirmation sooner than a month. He said when a resident needed an appointment outside of the facility, he entered an order and then the nurse filled out a form and gave it to the SC. He said the SC made the appointments. The NP said he made a lot of outpatient referrals, so there might have been a backlog. He said the SC often complained about not hearing back from the offices she called. He said he frequently updated Resident #45 on the status of his MRI. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON was interviewed on 5/15/25 at 11:59 a.m. The DON said that outpatient MRI appointments could take a month or two to schedule, unless it was emergent. She said that the SC obtained the MRI order just recently. She said Resident #45 had had a lot of imaging done, and had changed doctors several times, which made it confusing. She said the SC was very efficient in ensuring the schedule was done and appointments were scheduled. The DON said that when Resident #45 canceled his appointment in March, 2025 they thought that that was the appointment associated with the MRI. She said the MRI did appear in more recent notes though and she had heard that he wanted to change orthopedic doctors again. She said that for the past several months, even though the resident had been cleared by orthopedics to do weight bearing, he had not been wanting to bear weight. She said the resident was more compliant now, but for a few months he did not like what the orthopedic doctor was saying or what the imaging found. The PCP was interviewed on 5/15/25 at 12:47 p.m. He said that because of the facility's population and location, they did sometimes run into problems related to logistics and getting referrals and tests completed timely. IV. Facility follow-up On 5/16/22 at 2:27 p.m. (after the survey) the NHA provided additional documentation that indicated Resident #45 was scheduled for a MRI on 5/22/25 at 12:20 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47151 Based on observations, record review and interviews, the facility failed to store, prepare and distribute food in a sanitary manner in the main kitchen. Specifically, the facility failed to: -Ensure employees performed hand hygiene appropriately during meal service; and, -Ensure food was labeled, dated and disposed of timely. Findings include: I. Ensure employees performed hand hygiene appropriately during meal service A. Professional reference The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20/25 read in pertinent part, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation, including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts other than clean hands and clean, exposed portions of arms; after using the toilet room; after coughing, sneezing, using a handkerchief or disposable tissue; using tobacco products, eating, or drinking; after handling soiled equipment or utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; before donning gloves to initiate a task that involves working with food; and after engaging in other activities that contaminate the hands. (2-301.15) B. Facility policy and procedure The Safe Food Handling policy, revised 4/26/23, was provided by the nursing home administrator (NHA) on 5/15/25 at 6:18 p.m. The policy read in pertinent part, Associates shall wash their hands in accordance with the hand hygiene policy and current food code guidelines, before handling or consuming food including working with clean equipment and utensils, and: After coughing sneezing or blowing nose, after touching the hair, mouth or touching tobacco products, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, before donning gloves to initiate a task that involves working with food and after engaging in any other activities that contaminate the hands. C. Observations During a continuous observation on 5/14/25, beginning at 11:15 a.m. and ending at 12:17 p.m., the following was observed during the meal preparation and service in the main kitchen: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065276	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Evergreen	2987 Bergen Peak Dr Evergreen, CO 80439

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 11:25 a.m. dietary aide (DA) #1 blew his nose into a tissue. DA #1 wiped his nose with the tissue and discarded the tissue in a garbage can. -Without washing his hands, DA #1 picked up a room delivery tray, placed it on the trayline, picked up silverware rolled in a linen napkin and placed it on the tray. At 11:32 a.m. DA #1 touched his face, scratched his neck with his left hand and continued to assemble meal trays for room delivery. At 12:01 p.m. DA #1 touched his face twice with his left hand. Without washing his hands, DA #1 picked up two four ounce bowls of dessert and placed them on a meal tray for delivery. At 12:04 p.m. DA #1 touched his nose with his left hand,and without washing his hands picked up a heated room delivery base and placed it on the counter. DA #1 pulled a meal delivery cart forward, then covered a plated meal with a lid. DA #1 picked up the room delivery base and placed it under the plated meal. DA #1 picked up a can of soda and a drinking glass with the same hand, filled the glass with ice and placed them both on the assembled meal tray for delivery. D. Staff interviews Cook (CK) #1 and DA #2 were interviewed together on 5/15/25 at 2:30 p.m. CK #1 said the staff received hand hygiene training online during their employee onboarding at the facility. CK #1 said the staff should wash their hands if they changed tasks, after removing disposable gloves or putting gloves on. DA #2 said hand hygiene should be conducted after touching a contaminated surface. The divisional registered dietitian (DRD) was interviewed on 5/15/25 at 2:30 p.m. The DRD said hand hygiene should be conducted after coughing, sneezing or after adjusting your glasses with your hands. The NHA was interviewed at 5:00 p.m. The NHA said hand hygiene training was always provided upon hire. The NHA said if an issue with hand hygiene was identified in an observation by any manager there would be follow up education provided to the staff member. The NHA said dietary staff were included in hand hygiene training provided by the infection preventionist (IP) for the facility. II. Ensure time and temperature control food was labeled, dated and disposed of timely A. Professional reference The Colorado Retail Food Regulations, (3/16/24) and retrieved on 5/20//25 read in pertinent part, Commercially processed food: open and hold cold, refrigerated, ready-to-eat 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, the day the original container is opened in the food establishment shall be counted as day one and the day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. (3-501.17) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065276	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Facility policy and procedure The Safe Food Handling policy, revised 4/26/23 was provided by the nursing home administrator (NHA) on 5/15/25 at 6:18 p.m. The policy read in pertinent part, The facility must store, prepare, distribute and serve food in accordance with professional standards for food service safety. Local, state and federal regulations are followed when handling food. Snacks and other food items sent from the foodservice department will be handled safely in regard to temperature, labeling and storage. C. Observations The initial main kitchen tour was conducted on 5/12/25 at 9:30 a.m. The following was observed in the walk in refrigerator: -A clear uncovered plastic container that contained shredded cheese in the walk in refrigerator was not marked with a label or date; -A metal pan covered with plastic wrap that contained cheese and was not marked with a label or date; -A container covered with plastic wrap labeled with green chili and a use by date of 5/8/25; -Turkey pastrami opened and approximately half the product remaining, covered with plastic wrap and written date of 4/17/25; -A container of buttermilk with a printed best by date of 4/29/25; and, -A metal pan with five raw chicken breasts in a clear plastic bag not dated or labeled. During the initial main kitchen tour on 5/12/25 at 9:30 the following was observed in the reach-in refrigerator: Five clear plastic containers with lids and different food in each container. The containers were not labeled or dated. D. Staff interviews CK #1 was interviewed on 5/15/25 at 2:30 p.m. CK #1 said meats used for meals were typically pulled from the freezer the day prior to service and then cooked the next day. The DRD was interviewed on 5/15/25 at 2:30 p.m. The DRD said food items that were not dated should be discarded. The DRD said the kitchen staff did rounds to check product dates in the refrigerators. The NHA was interviewed on 5/15/25 at 5:00 p.m. The NHA said the facility registered dietitian (RD) would do a monthly walk through in the kitchen with a specific focus with sanitation, but would start doing the walk through more frequently in the future.