STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065306	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Rehabilitation and Healthcare Center, The	211 E 3rd Ave Mancos, CO 81328

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47350 Based on observations and interviews, the facility failed to ensure all drugs and biologicals used in the facility were properly stored and labeled on three of five units. Specifically, the facility failed to ensure residents' topical medications were stored and locked in appropriate medication carts or medication storage rooms that were accessed only by authorized licensed personnel. Findings include: I. Facility policy and procedure The Medication Labeling and Storage policy and procedure, reviewed February 2023, was provided by the nursing home administrator (NHA) on 6/26/24 at 2:20 p.m. It read in pertinent part, Compartments (including, but not limited to drawers, cabinets, rooms, refrigerators, carts and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise available to others. Medications are stored in an orderly manner in cabinets, drawers, carts or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer or other holding area to prevent the possibility of mixing medications of several residents. II. Observations On 6/24/24 at 9:15 a.m. the E hallway shower room contained a cart with Triamcinolone cream 0.1% labeled for Resident #26 and an over the counter (OTC) antifungal powder spray, which was not labeled with a specific resident's name, sitting on it. On 6/24/24 at 11:02 a.m. a bottle of Nystatin (an antifungal) 100,000 units per one gram topical powder and an OTC antifungal powder spray, both labeled for Resident #164, were observed on the chest of drawers in Resident #164's room. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065306	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/25/24 at 10:25 a.m. a bottle of Nystatin 100,000 units per one gram topical powder and an OTC antifungal powder spray, both labeled for Resident #164, were observed on the chest of drawers in Resident #164's room. On 6/26/24 at 11:00 a.m. the E hallway shower room contained a cart with an OTC antifungal powder spray, which was not labeled with a specific resident's name, sitting on it. On 6/26/25 at 11:03 a.m. the D hallway shower room contained a cart with an OTC antifungal powder spray, which was not labeled with a specific resident's name, sitting on it. On 6/26/25 at 11:06 a.m. the A hallway shower room contained a cart with an OTC antifungal powder spray, which was not labeled with a specific resident's name, sitting on it. III. Staff interviews Registered nurse (RN) #1 was interviewed on 6/26/24 at 11:00 a.m. RN #1 said all medications, which included OTC medications, should be stored in a medication cart or in the medication storage room. She said medications should not be stored unsecured in shower rooms or in residents' rooms. RN #1 said unlicensed personnel could not administer medications. She said it was a hazard if other residents obtained unsecured medications and self administered them. The director of nursing (DON) and the infection preventionist (IP) were interviewed together on 6/26/24 at 11:30 a.m. The IP said medications needed to be secured in a medication cart or a medication storage room so unlicensed personnel could not administer them. The IP said medications should be properly secured to ensure other residents could not access the medications and self administer them.

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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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50219 Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the kitchen. Specifically, the facility failed to: -Ensure kitchen staff handled ready-to-eat foods in an appropriate sanitary manner to prevent cross contamination; and, -Ensure safe holding temperatures for food items were maintained. Findings include: I. Inappropriate handling of ready-to-eat foods A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 7/1/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Food employees may not contact exposed, ready-to-eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. B. Facility policy The Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices policy, revised 11/2022, was provided by the nursing home administrator (NHA) on 6/26/24 at 2:20 p.m. It read in pertinent part, Gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced between handling soiled and clean dishes. Food service employees are trained in the proper use of utensils such as tongs, gloves, deli paper, and spatulas as tools to prevent foodborne illness. C. Observations On 6/25/24 the lunch meal service was observed during a continuous observation, beginning at 10:00 a.m. and ending at 1:10 p.m. At 10:24 a.m. cook (CK) #1 began preparing hamburger buns for lunch service. CK #1 donned a pair of gloves and opened the plastic packaging for the buns. CK #1 pulled a sheet of hamburger buns out of the packaging and separated them using the same pair of gloves before placing them into a steam table bin. CK #1 opened the plastic packaging of the next set of hamburger buns and started separating the buns using the same pair of gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	From 11:30 a.m. to 11:42 a.m., CK #1 used the same pair of gloves to grab hamburger buns out of the steam table bin and separate the top and bottom buns and put them onto plates. CK #1 held the top of the sandwich while cutting it in half for several residents' meals before grabbing the sandwich slices and putting them onto plates. -CK #1 was handling tray cards and serving utensils between each resident's hamburger bun without changing gloves or washing hands. At 11:42 a.m. CK #1 began using tongs to take hamburger buns out of the bin and separate them. -At several points during the lunch service, CK #2 touched several hamburger buns while wearing gloves to stabilize the buns while scooping chicken onto them. -CK #2 was observed touching the bottom of the plates and serving utensils with the same pair of gloves. D. Staff interview The dietary director (DD) was interviewed on 6/26/24 at 9:31 a.m. The DD said ready-to-eat foods should be handled with tongs and kitchen staff should not cross-contaminate food by touching handles before touching ready-to-eat foods. The DD said she had re-educated the kitchen staff on the subject many times. The DD said gloves should only be worn when touching raw food or during meal preparation and kitchen staff needed to wash their hands in between glove changes. II. Maintain safe holding temperatures for food items A. Professional reference The Colorado Retail Food Establishment Regulations, effective 3/16/24, were retrieved on 7/1/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Time/temperature control for safe food cold holding shall be maintained at 5 (five) degrees Celsius (C) (41 degrees Fahrenheit) or less. Time/temperature control for safety food that is cooked to a temperature and for a time specified under SS 3-401.11 - 3-401.13 and received hot shall be at a temperature of 57 degrees C (135 degrees Fahrenheit) or above. According to the product guidelines for MedPass Fortified Nutritional Shake, retrieved on 7/1/24 from https://www.hormelhealthlabs.com/resources/for-healthcare-professionals/product-protocols/med-pass-fortified-nutritional-shake-medication-pass-program/, MedPass products can safely remain on a medication cart as long as it is kept at refrigerated temperature range 34 to 40 degrees Fahrenheit (F). Cover, label and refrigerate opened containers of MedPass products and discard after four days as long as the product has been kept at the proper refrigerated temperature range. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. Facility policy The How to Monitor and Record in Temperature and PPM (parts per million) Logbooks document, undated, was provided by the DD on 6/26/24 at 1:43 p.m. It read in pertinent part, To record a hot or cold hold temperature, insert a thermometer in food or dish on the service line and record it in the log. This should be done at least 30 to 45 minutes after to ensure that steam tables or ice baths are holding food at appropriate ranges. If hot hold temperature is out of range (below 135 degrees F) notify the dietary director and/or maintenance director directly. If cold hold temperature is out of range, food product was not placed in an adequate ice bath, more ice should be added, or the container should be submerged deeper in the ice bath. Adjust as needed. C. Observations On 6/25/24 at 12:48 p.m. final temperatures were taken of food items that were served to residents during lunch service. A batch of french fries measured 125 degrees fahrenheit (F). At 12:53 p.m. CK #1 served french fries to a resident from this batch without reheating it. -The temperature of this hot food item was below the safe temperature parameter for hot foods of 135 degrees F or above. On 6/25/24 temperatures of food items kept at the nurses' medication carts were obtained. Each medication cart had a small plastic bin with no lid and side walls approximately four inches high. At 1:03 p.m., on the D and E hall medication carts, the MedPass nutritional supplement measured 58 degrees F. The bin holding the MedPass supplement was filled with fresh ice that reached approximately halfway up the MedPass carton. -The temperature of this nutritional supplement was above the safe temperature parameter for cold foods of 41 degrees F or less. At 1:07 p.m. on the I hall medication cart, the MedPass nutritional supplement measured 62 degrees F. The bin holding the MedPass supplement did not contain any ice. -The temperature of the nutritional supplement was above the safe temperature parameter for cold foods of 41 degrees F or less. D. Record review The kitchen temperature log book was reviewed on 6/25/24 at 1:10 p.m. -The temperatures from lunch service on 6/24/24 through lunch service on 6/25/24 had not been recorded. E. Staff interviews (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	CK #1 was interviewed on 6/25/24 at 12:48 p.m. CK #1 said 30 to 39 degrees F were safe holding temperatures for cold items and 160 to 170 degrees F for hot items. CK #1 said he would reheat hot foods that had fallen below the safe holding temperature prior to serving them to residents. CK #1 said he had not yet filled out the temperature logs from lunch nor breakfast that day (6/25/24). -However, CK #1 was observed serving a resident french fries that had fallen below 135 degrees F without reheating them following the interview above. The dietary director (DD) was interviewed on 6/26/24 at 9:31 a.m. The DD said she had to consistently remind the kitchen staff about time and temperature control and it was an ongoing issue. The DD said she had held weekly meetings with the kitchen staff to try to correct the issue. The DD was interviewed a second time on 6/26/24 at 12:57 p.m. The DD said safe holding temperatures for hot foods were from 150 to 165 degrees F and 40 degrees F or below for cold foods. The DD said it was not okay to serve hot foods that had fallen below safe holding temperatures and the food would need to be reheated prior to serving. The DD said she did not know the kitchen was to be involved with supplement storage on medication carts. The Dd said she did not know what temperature the nutritional supplements needed to be stored at. The DD said she assumed the supplements needed to be cold. III. Additional Information The kitchen staff disciplinary and educational records were provided by the DD on 6/27/24 at 10:01 a.m. The records revealed the following: On 4/10/24 CK #2 received education on food temperatures, cleanliness, safety, and maintaining temperature logs each shift. On 4/15/24 CK #1 received education on handwashing, food temperatures, and sanitation. On 5/20/24 CK #1 received education on safety, cleanliness, and maintaining temperature logs. On 5/20/24 all kitchen staff were educated on safety, cleanliness, cross-contamination, food temperatures, and handwashing. -However, despite the education above being provided to dietary staff on several occasions, observations during the survey revealed staff were not adhering to appropriate food handling and safe food temperature guidelines (see observations above).

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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. 47350 Based on observations, interviews and record review, 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 disease and infection on four of five units. Specifically, the facility failed to: -Ensure residents' rooms were cleaned in a sanitary manner; -Ensure residents' personal care items were labeled and stored in a sanitary manner; and, -Ensure a urinary catheter was maintained in a sanitary manner. Findings include: I. Housekeeping failures A. Professional reference The Centers for Disease Control and Prevention (CDC), Environment Cleaning Procedures (5/4/23), was retrieved on 7/1/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part, Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Clean patient areas (patient zones) before patient toilets. B. Manufacturer's recommendations According to the Lysol Power and Fresh Multi-Surface Cleaner guidelines, undated, retrieved on 7/1/24 from https://www.lysol.com/products/multi-purpose-cleaners/lysol-power-and-fresh-multi-surface-cleaner, To sanitize leave for one minute before wiping, to disinfect leave for six minutes before wiping. C. Facility policy and procedure The Cleaning Residents Rooms policy and procedure, undated, was provided by the nursing home administrator (NHA) on 6/27/24 at 10:09 a.m. It read in pertinent part, Protective gloves must be worn and changed with a sanitization between each change of the gloves throughout the entire cleaning process. Clean from clean to dirty meaning the bathroom will always be last and clean from top to bottom. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Always follow chemical specific instructions and dwell times for each individual chemical. D. Observations On 6/27/24 at 9:30 a.m. housekeeper (HSK) #1 was observed cleaning room #I-06 HSK #1 put on gloves. She obtained the toilet brush from the housekeeping cart and scrubbed the inside of the toilet bowl with Comet cleaner. She proceeded to scrub under the toilet seat with the toilet brush and placed the toilet brush handle between the toilet seat and toilet bowl with the toilet brush hanging into the toilet bowl. -HSK #1 failed to ensure that she did not proceed to a cleaner area after cleaning the inside of the toilet bowl. -HSK #1 failed to ensure the handle of the toilet brush was kept sanitary by not propping the handle of the toilet brush on top of the toilet bowl underneath the toilet seat lid. HSK #1 wiped the outside of the sink with a rag that was soaking in Lysol Power Fresh Multi-Surface disinfectant solution. She wiped the towel dispenser on the bathroom wall, along the bathroom railing and the top of the toilet tank. She used the same rag and wiped the top of the toilet lid, the top of the toilet bowl, down the sides of the toilet bowl and back to the top of the bowl. -HSK #1 failed to ensure the surfaces remained visibly wet for the six minute disinfectant time specified by the manufacturer's guidelines (see guidelines above). -HSK #1 failed to clean from higher surface areas before proceeding to lower surface areas. -HSK #1 failed to change her gloves, perform hand hygiene and use a new rag before moving to a higher or cleaner area. HSK #1 placed her used rag into the used rag container. She removed and replaced her gloves. -HSK #1 failed to perform hand hygiene after her gloves were removed before putting on a new pair of gloves. HSK #1 obtained a new rag from the disinfectant solution and wiped the light switch, top of the chest of drawers, door handles, top of the table, closet handles, window sill and remote control. -HSK #1 failed to ensure surfaces remained visibly wet for the six minute disinfectant time specified by the manufacturer's guidelines (see guidelines above). -HSK #1 failed to clean the resident's room before cleaning the bathroom. On 6/27/24 at 9:45 a.m. HSK #1 was observed cleaning room #I-05. HSK #1 donned new gloves and obtained a new rag from the disinfectant solution. She wiped the door handles, light switches, bathroom door handles, bedside table window sill and top of chairs. She disposed of the rag in the used rag container and donned new gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-HSK #1 failed to ensure surfaces remained visibly wet for the six minute disinfectant time specified by the manufacturer's guidelines (see guidelines above). -HSK #1 failed to perform hand hygiene before donning gloves to clean the room. HSK #1 obtained an uncovered toilet scrub brush lying on top of used rags. She used Comet cleaner on the inside of the toilet bowl and scrubbed the inside of the toilet bowl, top of the bowl and inside of the bowl. She proceeded to scrub under the toilet seat with the toilet brush and placed the toilet brush handle between the toilet seat and toilet bowl with the toilet brush hanging into the toilet bowl. -HSK #1 failed to ensure that she did not proceed to a cleaner area after cleaning the inside of the toilet bowl. -HSK #1 failed to ensure the handle of the toilet brush was kept sanitary by not propping the handle of the toilet brush on top of the toilet bowl underneath the toilet seat lid. HSK #1 placed the toilet brush on the used rags. She obtained a new rag from the disinfectant solution on the housekeeping cart. She wiped the bathroom handrails, soap dispenser, towel dispenser, top of the toilet tank, the raised commode seat, top of the toilet seat lid, the toilet tank, the top of the toilet seat lid, the top of the toilet bowl and down the side of the toilet bowl. -HSK #1 failed to ensure hand hygiene was performed and new gloves were donned before touching clean rags in the disinfectant solution. -HSK #1 failed to ensure surfaces remained visibly wet for the six minute disinfectant time specified by the manufacturer's guidelines (see guidelines above). -HSK #1 failed to clean from higher surface areas before proceeding to lower surface areas. -HSK #1 failed to change her gloves, perform hand hygiene and use a new rag before moving from a dirty area to a clean area. E. Staff interviews HSK #1 was interviewed on 6/27/25 at 10:00 a.m. HSK #1 said she should start with the residents' room first before she cleaned the bathroom. She said when she cleaned the bathroom she would first sanitize with the rag soaked in the disinfectant solution. She said she did not know what disinfectant was used and she said she was not sure how long the solution should stay wet on the surfaces. HSK #1 said when she cleaned the toilet, she cleaned with the toilet brush first and would prop the handle of the toilet brush under the toilet seat lid to let the toilet brush drain into the toilet bowl. She said she would use the toilet brush to scrub the toilet seat lid if it was dirty with fecal material. She said after a dirty area was cleaned, a new rag was used after hand hygiene was performed and new gloves were donned. She said after the bathroom was cleaned, hand hygiene was performed and new gloves were donned before touching clean items on the housekeeping cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, HSK #1 failed to perform hand hygiene or change her gloves appropriately while cleaning the residents' rooms (see observations above) HSK #1 said, after she used the toilet brush, she placed it on the bottom of the housekeeping cart next to the used rags. She said she was not aware of any procedure to clean or disinfect toilet brushes after they were used. The housekeeping manager (HLM) was interviewed on 6/27/24 at 10:30 a.m. The HLM said Lysol Multi Surface Cleaner was used for resident rooms and had a ten minute disinfectant time according to the label instructions. She said resident rooms should be cleaned from clean to dirty and clean areas should not be cleaned after dirty areas unless a new rag was used, hand hygiene was performed and new gloves were donned. She said resident rooms should be cleaned first before cleaning resident bathrooms. The HLM said high areas should be cleaned first before lower areas. She said, after bathrooms were cleaned, gloves should be removed and hand hygiene performed before touching clean supplies on the housekeeping cart. She said the toilet brush handle should not be propped under the toilet lid to drain because the handle should be kept as sanitary as possible. She said she was not sure of the process of disinfecting toilet brushes but they should be kept in a bag on the bottom of the cart so it did not touch anything else on the cart. She said the toilet brush should be disinfected once a day. The plant and facility operations director (PFOD) was interviewed on 6/27/24 at 10:40 a.m. The PFOD said he contacted the chemical vendor to find a cleaning solution that did not require such a long disinfectant time. He said this was to ensure that areas were cleaned in a sanitary manner and housekeepers were able to keep surface areas wet for the required disinfectant time. II. Personal items failures A. Observations On 6/24/25 at 9:15 a.m. the E hallway shower room had a cart with a Eucerin cream, lotions, shampoo, conditioners and deodorant sitting on it. -None of the personal items on the cart were labeled with a specific resident's name. On 6/26/24 at 11:00 a.m. the E hallway shower room cart had a Eucerin cream, lotions, shampoos, conditioners and personal deodorant sitting on it. -None of the personal items on the cart were labeled with a specific resident's name. On 6/26/24 at 11:05 a.m. the D hallway shower room cart had a Eucerin cream sitting on it. -The Eucerin cream was not labeled with a specific resident's name. On 6/26/24 at 11:08 a.m. the A hallway shower room cart had personal deodorant, lotions and shampoo sitting on it. -None of the personal items on the cart were labeled with a specific resident's name. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Staff interviews Registered nurse (RN) #1 was interviewed on 6/26/24 at 11:00 a.m. RN #1 said all residents' personal care items should be labeled and stored so that the items were not used on multiple residents. She said if personal items were used on multiple residents it was not a sanitary practice. She said any unlabeled used personal items in the shower room should be discarded. Certified nurse aide (CNA) #1 was interviewed on 6/26/24 at 12:00 p.m. CNA #1 said she would use only personal care items that were labeled for specific residents. She said unlabeled personal care items in the shower room should not be used and stored in the shower room. The infection preventionist (IP) was interviewed on 6/26/24 at 2:35 p.m. The IP said CNAs should label and place personal care items in an individual emesis basin if a resident shared a room with another resident. She said unlabeled personal items should not be stored in the shower rooms as this could cause personal items to be used on multiple residents. The IP said any unlabeled personal care items in the shower rooms should be discarded. III. Urinary catheter failure A. Observations On 6/24/24 at 11:03 a.m. Resident #164's urinary catheter drainage bag was observed hanging on the edge of the trash can. On 6/25/24 at 10:24 a.m. Resident #164's urinary catheter drainage bag was observed on the floor. On 6/26/25 at 10:54 a.m. Resident #164's urinary catheter drainage bag was observed on the floor. B. Staff interviews RN #1 was interviewed on 6/26/25 at 10:55 a.m. RN #1 said urinary catheter drainage bags should be kept off the floor to keep them from being contaminated by microorganisms on the floor. She said the hook on Resident #164's urinary catheter drainage bag was broken and that was why the bag was on the floor. She said the resident's urinary catheter drainage bag should be changed out with a new bag. The director of nursing (DON) was interviewed on 6/27/24 at 10:00 a.m. The DON said urinary catheter drainage bags should be kept off the floor because of the potential for contamination from microorganisms from the floor. She said urinary catheter drainage bags that were kept on the floor should be changed out with a new bag.