STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40960

Based on interviews, observations and record review, the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced their dignity and respect for one (#35) of three residents reviewed for dignity out of 19 sample residents.

Specifically, the facility failed to ensure Resident #35's fall intervention sensor alarm was discussed with the resident on how it made her feel.

Findings include:

I. Facility policy and procedure

The Elder rights policy, revised 7/8/24, was provided by the nursing home administrator (NHA) on 9/25/24/at 2:53 p.m. It read in pertinent part,

All elders will be treated equally regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The campus will ensure that all staff members are educated on the rights of elders and the responsibility of the campus to properly care for its elders.

II. Resident status

Resident #35, age above 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnosis included unspecified dementia, abnormal posture, insomnia, repeated falls and abnormal weight loss.

The 6/30/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status score (BIMS) of 11 out of 15. She had no behaviors and did not reject care. She used a walker and a wheelchair. She required assistance with transfers and moving between surfaces. She was able to propel herself in her wheelchair and reposition herself in bed. She was always continent of bowels and bladder. She had two or more falls with injury since admission. A motion sensor alarm was used daily.

III. Resident interviews

(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: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Washington County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 599 W Greenhouse Dr Akron, CO 80720	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #35 was interviewed on 9/23/23 at 10:04 a.m. She said she felt like she was treated differently than the other residents. She said the facility used an alarm to track her movements which restricted her movements. She said when she tried to reposition herself in bed, the alarms would activate. She said she would stop moving around or have to crawl between the touch call lights that were on her bed. She said there were also two motion sensor alarms, one at the foot of the bed and one on the other side of the room that would activate when she placed her feet on the ground. She said no one had ever asked her how the alarms made her feel. She said everyone in the house knew when she was moving around. Resident #21 was interviewed on 9/25/24 at 11:49 a.m. Resident #21 said the jingle that was heard throughout the house, was Resident #35's motion sensor alarm notifying everyone that she was moving. She said staff would immediately respond to the alarm. IV. Observations On 9/23/24 at 10:00 a.m. observations of Resident #35's room revealed she had two motion sensor alarms. One at the foot of the bed and one across from the bed. On 9/24/24 at 9:34 a.m. Resident #35 was observed sitting in the common area in a recliner watching television. Two push call lights were observed. One on top of each arm of the chair. The resident tried to reposition herself and the push call light, on the right arm of the chair, fell off and activated. Staff immediately responded and asked her if she needed anything. V. Record review The September 2024 CPO revealed the resident had an order to monitor the motion sensor for proper placement and functioning every day and night shift for motion sensor use, ordered on 8/14/24. An incident note, dated 3/4/24 at 10:21 a.m., documented a motion sensor alarm was placed in Resident #35's room to alert staff when she was attempting to get up. A health status noted, dated 6/4/24 at 3:30 a.m., documented Resident #35 was restless most of the night as evidence of the motion sensor alarming frequently throughout the night When staff entered the room to ask how she was or what she needed, the resident was either quiet with no response or when asked if she was alright she responded yes. A behavior note, dated 6/20/24 at 1:00 a.m., documented Resident #35 was fidgety and up to the toilet four times since going to bed and the sensor alarm rang often throughout the night. A behavior note, dated 8/25/24 at 12:04 a.m,. documented Resident #35 had been restless as evidence of the sensor alarm chiming frequently since the resident went to bed at 6:30 p.m. VI. Staff interviews (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065309	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified nurse aide (CNA) #4 was interviewed on 9/24/24 at 9:49 a.m. CNA #4 said she did not know why Resident #35 had two touch call lights and was not aware of a motion sensor alarm. She said she usually worked in a different house. CNA #5 was interviewed on 9/24/24 at 10:05 a.m. CNA #5 said Resident #35's motion alarm was used to notify the staff that she was attempting to get out of her bed, wheelchair or recliner. She said the alarm was audible for everyone to hear. She said the alarm sounded in the common area of the facility. She said she did not feel the motion alarm was very effective. The director of nursing (DON) was interviewed on 9/25/24 at 10:47 a.m. The DON said Resident #35 was a difficult resident to keep free from falling. She said the facility had placed the two push call lights near the resident. She said the resident would climb around them. She said the facility then decided to place the two motion sensors along with the push call lights in the resident's room. She said the resident was able to climb around the motion sensors as well. She said the alarms were activated frequently due to the resident putting her feet on the ground or bumping the push call lights when moving. The DON said she was not aware of how the alarms affected the resident or made her feel. She said she never asked her. She said the social services director (SSD) may have spoken with her but she was not sure. She said she would speak with the resident about how it made her feel and figure out something different. The NHA was interviewed on 9/25/24 at 11:26 a.m. The NHA said she was not aware of how the motion alarms made the resident feel. She said she had never asked her. She said when the facility first decided to use the motion sensor alarm the resident was willing to try them. The NHA said they had never reassessed how the resident felt about the alarms. The SSD was interviewed on 9/25/24 at 1:22 p.m. The SSD said she was not involved with the initiation of the motion sensor alarms and had not interviewed Resident #35 on how she felt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and staff interviews, the facility failed to develop and implement a comprehensive care plan for three (#38, #24 and #3) of five residents reviewed for care plans out of 19 total sample residents. Specifically, the facility failed to: -Ensure Resident #38 had a care plan for the use of an anticoagulant medication; -Ensure Resident #24 had a care plan for the use of supplemental oxygen; and, -Ensure Resident #3 had a care plan for the use of a diuretic medication. Findings include: I. Facility policy and procedure The Care Plan policy, revised 8/12/24, was provided by the nursing home administrator (NHA) on 9/25/24 at 2:53 p.m. It read in pertinent part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes describing the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. II. Resident #38 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Washington County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 599 W Greenhouse Dr Akron, CO 80720	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #38, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), gross hematuria (blood in the urine), personal history of other venous (vein) thrombosis (blood clot) and embolism (blockage inside a blood vessel), cardiac murmur and long term current use of anticoagulants. The 9/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of six out of 10. She required moderate assistance with bathing, repositioning, dressing, personal hygiene, transfers and toilet use. The assessment indicated the resident received an anticoagulant medication daily. B. Record review The September 2024 CPO revealed the resident had a physician's order for Eliquis (a blood thinner) 5 mg (milligrams) twice a day with a start date of 7/10/24. -There was no care plan addressing the use of the anticoagulant medication or its side effects. C. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 9/24/24 at 1:41 p.m. LPN #2 said she was not sure if the use of an anticoagulant medication needed to have a care plan or not. She said the nurses gave input when there was a new admission but the management team was responsible for updating the residents' care plans. She said nurses did not have a lot to do with care plans. The director of nursing (DON) was interviewed on 9/25/24 at 10:47 a.m. The DON said a care plan should be in place to address the use of Resident #38's anticoagulant. She said the care plan should include watching for signs and symptoms of side effects related to anticoagulant medication use, such as excessive bruising, excessive bleeding and blood in the urine and stool. She said it was very important to monitor for these side effects, especially if the resident was scheduled for surgery. The DON said she would immediately ensure a care plan was initiated for the use of the anticoagulant medication. The NHA was interviewed on 9/25/24 at 11:21 a.m. The NHA said a care plan should be in place for Resident #38's anticoagulant medication use. She said an anticoagulant was a significant medication with risk factors and needed a reason for use. She said the care plan should address the monitoring of side effects or complications. She said having a care plan in place was important so all staff would know how to care for the resident and the risks involved. She said the minimum data set (MDS) coordinator was responsible for initiating the comprehensive care plans. The NHA said she did not know how the implementation of a care plan for the use of Resident #38's anticoagulant medication was missed. 47064 III.Resident #24 A. Resident status (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065309	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #24, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included Parkinson's (chronic brain disorder that affects movement), dementia (decrease cognitive thinking), hypoxemia (low levels of oxygen in the blood) and hypertension (increased blood pressure). The 7/21/24 MDS assessment revealed the resident was moderately cognitively impaired with a BIMS score of 10 out of 15. The assessment indicated the resident required supplemental oxygen but it did not reveal if oxygen was to be administered continuously or intermittently. B. Record review -Review of Resident #24's comprehensive care plan failed to reveal a care plan focus for supplemental oxygen use. The September 2024 CPO revealed the following physician's orders for oxygen: Supplemental oxygen per nasal cannula at 2 liters per minute (LPM) to keep oxygen at or above 90% (percent), ordered 2/1/23. May apply oxygen to continuous positive airway pressure (CPAP) machine at night if oxygen saturations (level of oxygen in the blood) were below 90%, ordered 2/16/23. The Kardex (a tool used by the certified nurse aides (CNA) to provide consistent care) failed to document how much supplemental oxygen Resident #24 was to receive. C. Staff interviews CNA #3 was interviewed on 9/24/24 at 1:56 p.m. CNA #3 said CNAs did a verbal report during shift change and that was how staff knew how much oxygen a resident should be on. LPN #1 was interviewed on 9/24/24 at 2:16 p.m. LPN #1 said she would look at the physician's orders to know how many liters of oxygen a resident should be on. LPN #1 said the use of supplemental oxygen should be care planned. LPN #1 said she was unable to locate oxygen on Resident #24's care plan. CNA #1 was interviewed on 9/25/24 at 11:16 a.m. CNA #1 said staff had access to residents' Kardex and she said the oxygen liter flow should be documented on the Kardex. CNA #1 reviewed the Kardex for Resident #24 and said she was unable to identify how much oxygen Resident #24 should be receiving. CNA #1 said she knew Resident #24 was on oxygen because she had gotten the information in report. The DON was interviewed on 9/25/24 at 12:20 p.m. The DON said it was her assistant director of nursing (ADON)/MDS coordinator's responsibility to ensure care plans were updated. The DON said care plans should include all care provided to a resident, including supplemental oxygen use. 50219 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065309	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV. Resident #3 A. Resident status Resident #3, age greater than 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included dementia and hypertensive chronic kidney disease. The 8/7/24 MDS assessment revealed the resident was significantly cognitively impaired with a BIMS score of one out of 15. The MDS did not indicate Resident #3 was taking a diuretic medication. B. Record review The incontinence care plan, revised 12/9/2020, revealed Resident #3 had mixed bladder incontinence. Pertinent interventions included encouraging fluids during the day to promote prompted voiding responses. The hypertension care plan was revised 12/9/24. Pertinent interventions included monitoring for edema, monitoring and documenting any abnormalities in urinary output and giving anti-hypertensive medications as ordered. The September 2024 CPO revealed a physician's order for Lasix (furosemide) 40 mg with instructions to give one tablet by mouth one time a day for edema, ordered 1/16/24. The 8/14/24 care plan conference notes revealed Resident #3's care plan was reviewed by the director of nursing (DON) and assistant director of nursing (ADON) but no changes were noted at that time. -The comprehensive care plan did not include a care plan focus related to chronic kidney disease or diuretic medication monitoring. C. Staff interviews LPN #1 was interviewed on 9/25/24 at 9:49 a.m. LPN #1 said Resident #3 did not have any fluid restrictions. LPN #1 said Resident #3 was prescribed Lasix and potassium and explained that Lasix was a diuretic medication. LPN #1 said Resident #3 had good fluid intake and drank well, so the nursing staff did not have to push more fluids for the resident but needed to monitor her for edema. LPN #1 said interventions related to Resident #3's hydration status would be found in the care plan. LPN #1 said all facility staff worked on the residents' care plans but they were primarily maintained by the ADON. The ADON was interviewed on 9/25/24 at 1:10 p.m. The ADON said she maintained the majority of residents' care plans but that the management team worked on them as well. The ADON said she had not put any specific care plan focus into any residents' comprehensive care plans for medications such as diuretics. The ADON said it was important to have a diuretic care plan because of the resident's risk of dehydration or fluid overload. The ADON said Resident #3 should also have a care plan focus for her chronic kidney disease.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER: Washington County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 599 W Greenhouse Dr Akron, CO 80720	

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40960 Based on record review and interviews, the facility failed to ensure drug regimens were free from unnecessary medications for one (#38) of five residents reviewed for unnecessary medications out of 19 sample residents. Specifically, the facility failed to ensure Resident #38 was adequately monitored and side effects were documented for the use of an anticoagulant medication. Findings include: I. Facility policy and procedure The Anticoagulant policy, revised 8/24/24, was provided by the nursing home administrator (NHA) on 9/25/24 at 2:53 p.m. It read in pertinent part, As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated. For example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation or those who have had recent joint replacement surgery. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. Assess for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding). The staff and physician will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis (bleeding from the mouth), or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated. II. Resident #38 A. Resident status Resident #38, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included atrial fibrillation (irregular heartbeat), gross hematuria (blood in the urine), personal history of other venous (vein) thrombosis (blood clot) and embolism (blockage inside a blood vessel), cardiac murmur and long term current use of anticoagulants. The 9/1/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) score of six out of 10. She required moderate assistance with bathing, repositioning, dressing, personal hygiene, transfers and toilet use. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER Washington County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 599 W Greenhouse Dr Akron, CO 80720	

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The assessment indicated the resident received an anticoagulant medication daily. B. Record review The September 2024 CPO revealed the resident had a physician's order for Eliquis (a blood thinner) 5 mg (milligrams) twice a day with a start date of 7/10/24. -There was no care plan addressing the use of the anticoagulant medication or its side effects. Cross reference F656 for failure to have a care plan for the use of an anticoagulant medication. III. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 9/24/24 at 1:41 p.m. LPN #2 said the nurses should be monitoring for side effects of the anticoagulant medication, such as increased bleeding or a change in cognition. She said she could not remember the other signs to monitor for when a resident was on an anticoagulant medication. The director of nursing (DON) was interviewed on 9/25/24 at 10:47 a.m. The DON said the care plan should include watching for signs and symptoms of side effects related to anticoagulant medication use, such as excessive bruising, excessive bleeding and blood in the urine and stool. She said it was very important to monitor for these side effects, especially if the resident was scheduled for surgery. The DON said she would immediately ensure Resident #38 was being monitored for possible side effects or complications related to the use of the anticoagulant medication. The NHA was interviewed on 9/25/24 at 11:21 a.m. The NHA said an anticoagulant was a significant medication with risk factors and needed a reason for use. She said the care plan should address the monitoring of side effects or complications. She said there should be a physician's order to monitor the resident for side effects and/or complications related to the use of an anticoagulant medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington County Nursing Home	599 W Greenhouse Dr Akron, CO 80720

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 - Few	Provide and implement an infection prevention and control program. 50219 Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases. Specifically, the facility failed to ensure nursing staff followed proper infection control procedures for a resident on enhanced barrier precautions (EBP). Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) (4/2/24), was retrieved on 9/26/24 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html. It read in pertinent part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated (when contact precautions do not otherwise apply) for residents with wounds or indwelling medical devices, regardless of MDRO colonization status. II. Facility policy and procedure The Infection Prevention and Control Program policy, revised 8/12/24, was received from the nursing home administrator (NHA) on 9/25/24 at 2:50 p.m. It read in pertinent part, The designated infection preventionist serves as a consultant to our staff on infectious diseases, elder room placement, implementing of isolation precautions, staff and elder exposures, surveillance, and epidemiological investigations of exposures of infectious diseases. Staff shall use personal protective care equipment (PPE) according to established campus policy governing the use of PPE. -The policy did not include specifics for EBP. III. Resident interview Resident #29 was interviewed on 9/24/24 at 2:29 p.m. Resident #29 said he had a urinary catheter. Resident #29 said the nursing staff helped him with his catheter care by emptying his catheter bag whenever he needed it and switching from a night bag to a leg bag each morning. Resident #29 said the nursing staff only wore gloves when they helped him perform catheter care. Resident #29 said he had not seen the nursing staff wear gowns while helping him perform catheter care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2024
NAME OF PROVIDER OR SUPPLIER: Washington County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 599 W Greenhouse Dr Akron, CO 80720	

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 - Few	IV. Observations On 9/23/24 at 10:06 a.m. there was no PPE observed in or outside Resident #29's room. On 9/24/24 at 2:29 p.m. there was no PPE observed in or outside Resident #29's room. V. Record review The incontinence care plan, revised 9/14/23, revealed Resident #29 had a urinary catheter in place. Pertinent interventions included changing Resident #29's catheter as needed, cleansing the catheter daily, and assisting Resident #29 with emptying his catheter bag and catheter care every shift and as needed. -Review of the resident's electronic medical record (EMR) did not reveal any information regarding the use of EBP or PPE while performing care. VI. Staff interviews Certified nurses aide (CNA) #6 was interviewed on 9/24/24 at 3:05 p.m. CNA #6 said the nursing staff helped Resident #29 with his urinary catheter, which included switching from his night bag to his leg bag, cleaning the bag, changing his urinary catheter, and helping Resident #29 dress his bottom half. CNA #6 said she applied gloves whenever she needed to provide catheter care for Resident #29. CNA #6 said she did not wear a gown or any other PPE while providing catheter care. Licensed practical nurse (LPN) #1 was interviewed on 9/25/24 at 9:49 a.m. LPN #1 was not sure what EBP entailed. LPN #1 said for urinary catheter care she only needed to wear gloves. LPN #1 said if a resident had any sort of infection she would be more likely to wear PPE. LPN #1 said the CNAs helped Resident #29 change his catheter bag each morning and wiped the catheter area with alcohol. LPN #1 said the CNAs only wore gloves to perform this care but that she would advise them to wear a gown just in case any urine splattered during the process. LPN #1 said the CNAs were not required to wear a gown unless the resident had something that was contagious. The infection preventionist (IP) and the NHA were interviewed together on 9/25/24 at 1:10 p.m. The IP and NHA said did not know what EBP were or what they entailed. The IP said she did not know the nursing staff needed to wear PPE unless the resident had an infection. The IP acknowledged the facility did not have a system in place to notify if residents were on EBP.