STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on record review and interviews, the facility failed to ensure a Level II preadmission screening and resident review (PASRR) was completed for one (#27) of two residents out of 23 sample residents reviewed for PASRR to gain and maintain their highest practical medical, emotional, and psychosocial well-being. Specifically, the facility failed to ensure a Level II PASRR was in place for Resident #1. Findings include: I. Facility policy and procedure The preadmission screening and resident review (PASRR) policy, reviewed in [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 9:18 a.m. The policy revealed the facility would coordinate assessments with the pre-admission screening and resident review program to the maximum extent practicable to ensure the facility can meet the resident's needs prior to admission. If the Level I revealed, Refer for Level II this indicated that a Level II must be completed prior to admission. II. Resident status Resident #27, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included anxiety, chronic pain and unspecified mental disorder due to known psychological conditions. The [DATE] minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of six out of 15. III. Record review The PASRR Level I, dated [DATE], revealed this assessment was a 30-day hospice provisional admission. If the resident did not discharge as expected, a Level I screen must be resubmitted when the provisional admission had expired. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan for impaired cognitive function or impaired thought process related to developmentally delayed was revised on [DATE]. Pertinent interventions included for staff to monitor/document/report to her physician any changes in cognitive function, specifically changes in decision-making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and/or mental status and the staff were to provide a program of activities that accommodated the references preferences and abilities. The care plan for a history of childhood trauma was initiated on [DATE]. Pertinent interventions included continuing to offer mental health services, encouraging the resident to express their feelings/concerns/thoughts in a safe space and avoiding any care that involved private body parts. The care plan also included some of the resident's triggers: talking about intimate parts of their body, discussing any medication that invaded the residents privacy, discussing the residents childhood and talking about men and intimacy. The resident's electronic medical record was reviewed on [DATE] at 3:25 p.m. There was no evidence a Level II PASRR had been completed. The PASRR level I dated [DATE] (during the survey) indicated a Level II was needed. The description of the suspected diagnosis of intellectual or developmental disability revealed the resident had a congenital hypoxic brain injury at birth (lack of oxygen to the brain). -However, a PASRR level I should have been completed on [DATE], since the resident remained at the facility for 30 days after the provisional PASRR. IV. Staff interviews The social services director (SSD) was interviewed on [DATE] at 8:21 a.m. The SSD said the resident had intellectual disabilities related to a congenital hypoxic brain injury at birth. The SSD said the PASRR Level I dated [DATE] was provisional and the resident needed an additional PASRR Level I that should have been done 30 days after [DATE]. The SSD said the PASRR Level II told the facility who the resident was and how the facility could meet their needs. The SSD said the recommendations told the facility the services that would be beneficial to improve their quality of life. The SSD said she started the process for the PASRR Level II during the survey. The NHA was interviewed on [DATE] at 9:39 a.m. The NHA said the PASRR Level II recommendations were to help improve the resident's quality of care and of life. The NHA said recommendations might include the need for counseling, psychological visits/therapy and any additional programs or support that the resident needed. The director of nursing (DON) was interviewed on [DATE] at 11:05 a.m. The DON said a PASRR Level II was a person-centered assessment. She said it provided recommendations, so that the facility could meet the needs of the resident and improve their quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to ensure residents were provided services that meet professional standards for one (#1) of five residents out of 23 sample residents. Specifically, the facility failed to ensure Resident #1's insulin was administered according to the physician's orders. Findings include: I. Facility policy and procedure The Insulin Administration policy, revised September 2014, was provided by the nursing home administratior (NHA) on 10/2/24 at 12:32 p.m. The policy provided guidelines for the safe administration of insulin to residents with diabetes. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponded with the order on the medication sheet and the physician's order. The nurse should notify the DON and the attending physician of any discrepancies before giving the insulin. The Administering Medications policy, revised April 2019, was provided by the NHA on 10/3/24 at 12:29 p.m. The policy revealed the director of nursing (DON) supervised and directed all personnel who administered medications and/or had related functions. Medications were administered in accordance with prescriber orders, including any required time frame. If a dosage was believed to be inappropriate or excessive for a resident, or a medication had been identified as having potential adverse consequences for the resident or was suspected of being associated with adverse consequences, the person preparing or administering the medication would contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. The individual administering the medication checked the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before administering the medication. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should initial and circle the medication administration record (MAR) space provided for that drug and dose. II. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included atherosclerotic heart disease of the native coronary artery without angina pectoris, paroxysmal atrial fibrillation and type 2 diabetes without complications. The 7/3/25 minimum data set (MDS) assessment revealed the resident had severe cognitive impairment with a brief interview for mental status score (BIMS) of five out of 15. The assessment indicated the resident received insulin injections all seven days during the seven-day assessment period. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	III. Record review A physician's order, dated 7/2/24 at 12:06 p.m., revealed to administer Humalog injection solution (Insulin Lispro). Inject eight units subcutaneously (under the skin) as needed for a blood sugar level greater than 300 milligrams/deciliter (mg/dl) related to type 2 diabetes mellitus without complications. The care plan for diabetes mellitus was revised on 1/11/24. Some of the interventions were to administer diabetes medication as ordered by the physician. Staff were to monitor/document for side effects and effectiveness. The medication administration record (MAR) for July 2024 revealed Resident #1 had a blood sugar level greater than 300 mg/dl a total of 14 times. As needed eight units of Humalog insulin were administered according to the physician's orders eight times. -The facility failed to administer the as needed eight units of Humalog insulin six times when Resident #1's blood sugar level was greater than 300 mg/dl during the month of July 2024. The MAR for August 2024 revealed Resident #1 had a blood sugar level greater than 300 mg/dl a total of ten times. As needed eight units of Humalog insulin were administered according to the physician's orders five times. -The facility failed to administer the as needed eight units of Humalog insulin five times when Resident #1's blood sugar level was greater than 300 mg/dl during the month of August 2024. The MAR for September 2024 revealed Resident #1 had a blood sugar level greater than 300 mg/dl a total of 10 times. As needed eight units of Humalog insulin were not administered for any of the 10 times. -The facility failed to administer the as needed eight units of Humalog insulin 10 times when Resident #1's blood sugar level was greater than 300 mg/dl during the month of September 2024. IV. Staff interviews The director of nursing (DON) was interviewed on 10/3/24 at 11:23 a.m. The DON reviewed Resident #1's July 2024, August 2024 and September 2024 MARs. The DON acknowledged that some nurses administered the eight additional units of Humalog insulin and some did not. The DON said, according to the physician's orders, nurses were to administer eight units of Humalog insulin when Resident #1's blood sugar level was greater than 300 mg/dl. The DON said a possible outcome of not receiving the additional eight units of Humalog insulin according to the physician's orders were the resident's blood sugar levels could increase. She said the resident might experience blurred vision, have headaches, have increased voiding of urine and/or an increase in hunger. The DON said a nurse that received the physician's order would verify the order and place it onto the resident's MAR. She said a night nurse would then verify the order for accuracy. The DON said the third step in the physician's order process was that the interdisciplinary team (IDT) would review the 24-hour report together in the next morning meeting. The DON said this third step was implemented approximately one month ago (September 2024). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON said nursing staff should follow physician's orders. She said if a nurse was unsure about an order, the nurse should call the resident's physician immediately for clarification. The DON said if the insulin was not administered according to physician's orders, the nurse should have called the resident's physician and write a progress note regarding the decision to administer or not administer the insulin. The NHA was interviewed on 10/3/24 at 12:51 p.m. The NHA reviewed Resident #1's July 2024, August 2024 and September 2024 MARs. The NHA said each time the resident's blood sugar level was greater than 300 mg/dl, the resident should have been administered the as needed eight units of Humalog insulin. The NHA said the nursing staff should follow the physician's orders or get a clarification from the physician if the order was confusing. The NHA said there should be a nurse progress note for a blood sugar level greater than 300 mg/dl related to the administration or non-administration of insulin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observation, record review and interviews, the facility failed to ensure residents with a feeding tube received appropriate treatment and services to prevent complications for one (#26) of one resident reviewed for tube feeding out of 23 sample residents. Specifically, the facility failed to ensure Resident #26's physician's orders were updated and accurate; and, -Ensure Resident #26's feeding tube was flushed to maintain patency (prevent clogging). Findings include: I. Facility policy and procedure The Appropriate Use of Feeding Tubes policy, revised February 2023, was provided by the nursing home administrator (NHA) on [DATE] at 9:03 a.m It read in pertinent part, Feeding tubes (naso-gastric, gastrostomy, jejunostomy) will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The plan of care will address the use of feeding tube, including strategies to prevent complications. II. Resident #26 A. Resident status Resident #26, age 70, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), the diagnoses included intracranial (brain) injury, dysphagia (difficulty swallowing), heart disease and depression. The [DATE] 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. Resident #26 had a feeding tube. The MDS assessment indicated Resident #26 did not have signs or symptoms of a swallowing disorder, was maintaining his weight and was receiving 25% or less of total calories through tube feeding. B. Resident interview Resident #26 was interviewed on [DATE] at 2:11 p.m. Resident #26 said he still had a feeding tube in place. Resident #26 was lying in bed. C. Record review (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #26's care plan revealed instructions to flush the G-tube (gastrostomy/feeding tube) as ordered ([DATE]), and revised on [DATE] with instructions to check G tube daily for occlusion ([DATE]). Review of the [DATE] CPO revealed the following physician's order: Flush feeding tube with 30 cubic centimeters (cc) of water twice daily for patency, ordered on [DATE] and discontinued on [DATE]. -Review of the [DATE] medication administration record (MAR) did not reveal documentation that indicated the feeding tube was flushed with 30 cc water twice daily for patency per physician's order after [DATE]. Review of the [DATE] CPO revealed the following physician's orders: Enteral (tube) feed one time a day, start at 10:00 p.m, ordered on [DATE] at 7:00 p.m.; and, Regular diet, ordered on [DATE] at 1:00 p.m. -Review of the [DATE], [DATE] and [DATE] ([DATE] to [DATE]) medication administration record (MAR) revealed tube feedings were held beginning [DATE]; however, there was no documentation in the resident's EMR that indicated why the feedings were held starting on [DATE]. -Review of the EMR revealed there was no documentation of any feeding tube flushes administered from [DATE] to [DATE]. D. Staff interviews Registered nurse (RN) #2 was interviewed on [DATE] at 8:47 a.m. RN #2 said she did not know why there was an active order for Resident #26 to receive tube feedings at night. RN #2 said tube feedings had been on hold since [DATE], as the resident was able to eat and maintain weight. RN #2 said there was not an active physician order to flush Resident #26's feeding tube and there should have been an order to flush his feeding tube every day. RN #2 said she flushed the feeding tube when she was on shift. She said she did not document the flushes were completed. The medical director (MD) was interviewed on [DATE] at 9:24 a.m. The MD said Resident #26 was not currently receiving tube feedings and he did not know why there was an active order to administer tube feedings. The MD said the nurses should flush Resident #26's feeding tube with 30 milliliters (mls) of water twice daily and said this was the plan the MD described in his progress note on [DATE]. The MD said he would be concerned about patency of the feeding tube if it was not flushed. The registered dietitian (RD) was interviewed on [DATE] at 10:06 a.m. The RD said the feeding tube needed to be flushed regularly. The RD said an order was entered on [DATE] (during the survey) to start tube feeding flushes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The director of nursing (DON) was interviewed on [DATE] at 1:28 p.m. The DON said Resident #26's tube feedings were held at the end of [DATE]. The DON said the feedings had not been reinitiated, however, Resident #26 still had a gastrostomy (feeding) tube in place. The DON said there should not have been an active order for tube feedings. She said the hold order for tube feedings may have expired, which would have automatically reinitiated the active order. She said nurses documented not given for the feedings in September, 2024, and they should have reported to the provider to find out if the order should have remained on hold. The DON said Resident #26's feeding tube should be flushed for patency and documented. She said if the feeding tube was not flushed, it could clog, cause infection or gastrointestinal (stomach) issues. The DON said there was not an active order for flushing, and there was not documentation of Resident #26's feeding tube flushes for the month of September, 2024. The infection preventionist (IP) was interviewed on [DATE] at 2:02 p.m. The IP said Resident #26's feeding tube should be flushed. She said the flush ensured the tube would work if needed. The IP said if the feeding tube was not flushed, the potential for infection could be increased. The IP said feeding tubes should be flushed twice per day and staff should document when feeding tubes were flushed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 19262 Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in the main kitchen. Specifically, the facility failed to develop a maintenance program to ensure environmental concerns in the dish room, kitchen and serving area were identified and corrected in a timely manner. Findings include: I. Facility policy and procedure The Maintenance Inspection policy, reviewed on 4/13/23, was provided by the nursing home administrator (NHA) on 10/2/24 at 12:21 p.m. The policy revealed the facility utilized a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff and the public. The director of maintenance services would perform routine inspections of the physical plant using the maintenance checklist (MC). The NHA, or designee, would perform random inspections of the physical plant using the MC. All opportunities would be corrected immediately by maintenance personnel. The facility should establish quality/compliance thresholds as a benchmark for quality assurance (QA) purposes. Data recorded on the MC would be compared to established thresholds, and action plans would be generated as needed. All MCs would be filed in the director of maintenance's office and retained for a minimum of three years. II. Observations The dish room, main kitchen and serving area of the kitchen were observed on 9/30/24 at 8:46 a.m. and 10/1/24 at 12:33 p.m. The following was observed: The dish room's linoleum floor under the dish washing machine was torn in multiple areas and the connecting seam to the adjacent parts of the linoleum floor was separated. The floor under the dish machine was unkempt with debris. There were eight unused (holes) wall anchors on the wall adjacent to the dish washing machine. There was lint in the two metal exhaust vents on the wall by the dish washing machine. There was chipped paint on both sides of the door to the dish room. There were multiple areas of loose base board. The corners of the room had built up debris. There was chipped paint on the entrance door frame to the 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
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The kitchen had four small holes in the wall by the three-compartment sink. There was sheetrock damage on the wall by the fire extinguisher. There were two small holes in the wall under the fire extinguisher. There was chipped wall paint beside the electrical panel. There was one small hole in the wall near the floor under the electrical panel. There were bug remnants in one ceiling light fixture. There were four brown stained metal screens for the ceiling air vents. There was chipped wall paint on three of the room's corners. There was chipped paint on the doorframe by the ice machine. There was one small hole in the wall behind the ice machine. There was debris on the floor behind the ice machine. There was chipped paint on the wall by the walk-in refrigerator. The serving area had two missing doors under the counter by the steam table. There was sheetrock damage on the wall corner by the room tray/silverware cart. There was debris along the base of the counter at the one compartment sink. There was debris in the room corners. The base board was unkempt in multiple areas. III. Staff interviews and observations The NHA completed an environmental tour of the dish room, kitchen and serving areas on 10/1/24 at 12:44 p. m. The NHA said she would check with the maintenance staff for any work orders related to the kitchen areas that needed repair. The maintenance supervisor (MS) completed an environmental tour of the dish room, kitchen and serving area on 10/1/24 at 12:58 p.m. The MS observed the concerns in these areas. The MS said the floors were cleaned daily in the three areas. The MS said all three areas were deep cleaned three weeks ago and they were scheduled to be deep cleaned once a month. The MS said he used a power washer to clean the floors and the baseboard. The MS said he had not placed any work orders for the maintenance staff to make repairs in these three areas. The NHA was interviewed again on 10/3/24 at 8:06 a.m. The NHA said there were no work orders for any of the repairs in these three areas. The NHA said work orders should be developed for repairs in these areas. The NHA said the floors and baseboard should be clean without debris.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 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 residents were offered hand hygiene before meals in both the dining room and during the delivery of room trays. Findings include: I. Professional reference According to the Centers for Disease Control and Prevention's (CDC) Hand Hygiene in Healthcare settings, revised 2/27/24, retrieved from https://www.cdc.gov/handhygiene/index.html on 10/8/24, Patients and visitors should clean their hands before preparing or eating food. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics, and protects healthcare personnel and patients. Using an alcohol-based hand sanitizer is the preferred way for you to keep your hands clean. II. Facility policy and procedure The Resident Mealtime Hand Hygiene policy was provided by the nursing home administrator (NHA) on 10/2/24 at 12:20 p.m. It read in pertinent part, All staff assisting with meal services or snack delivery will encourage and assist residents as needed with an effective hand hygiene method prior to eating. Residents will be encouraged and assisted with an effective hand hygiene method prior to consuming meals and snacks. Hand wipes will be made available to residents in the activity room, the dining room, and when meals or snacks are delivered to residents in their rooms. III. Observations and staff interview On 9/30/24 during a continuous observation, beginning at 11:40 a.m. and ending at 12:52 p.m., residents arrived for lunch in the main dining room, some walking in, some self-propelling themselves in manual wheelchairs and some escorted in by staff. Residents in wheelchairs were observed to be handling the large wheel on their manual wheelchairs to wheel into the dining room. Residents were assisted to sit at their tables and staff in the dining room approached to offer clothing protectors to residents. Tables in the dining room had multiple residents sitting together. Of all the residents in the dining room (21 total residents), none were offered and assisted with hand hygiene. On 10/1/24 at 12:01 p.m. the dietary manager (DM) delivered the first room tray at 12:01 p.m. to room [ROOM NUMBER]. At 12:02 p.m., a meal tray was delivered to room [ROOM NUMBER]. At 12:05 p.m., a meal tray was delivered to room [ROOM NUMBER]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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	At 12:06 p.m., a meal tray was delivered to room [ROOM NUMBER]. At 12:07 p.m., a meal tray was delivered to room [ROOM NUMBER]. -There were no individual hand sanitizing packets on the room trays and the DM did not ask, encourage or assist any of the residents with washing or sanitizing their hands before the meal. The DM said he did not encourage or assist any of the residents with washing or sanitizing their hands. The DM said the facility did have hand sanitizing packets but they did not provide them on the trays that were delivered to the residents today (10/1/24). IV. Resident interviews Resident #93 was interviewed on 10/3/24 at 12:40 p.m. Resident #93 said staff had never offered hand sanitizer or to wash his hands in the dining room. Resident #18 was interviewed on 10/3/24 at 12:45 p.m. Resident #18 said staff were beginning to offer hand sanitizer before meals on this date (10/3/24), but staff had only occasionally offered hand hygiene to residents prior to this. Resident #8 was interviewed on 10/3/24 at 1:45 p.m. Resident #8 said staff did not offer hand hygiene to residents prior to meals in the dining room. She said the facility used to provide bottles of sanitizer on the tables in the dining room but this practice had been discontinued several months ago. V. Additional staff interviews Certified nurse aide (CNA) #4 was interviewed on 9/30/24 at 12:43 p.m. CNA #4 said she had not offered hand hygiene to residents who ate independently during the lunch meal. CNA #2 was interviewed on 9/30/24 at 12:52 p.m. CNA #2 said residents in the dining room were not offered hand sanitizer during the lunch meal (on 9/30/24). CNA #2 said residents should be offered hand hygiene prior to eating their meals. CNA #3 was interviewed on 9/30/24 at 12:53 p.m. CNA #3 said she had been working at the facility for one month and had not seen residents being offered hand hygiene prior to their meals in the dining room. The NHA was interviewed on 10/1/24 at 12:38 p.m. The NHA said the staff should encourage or assist any of the residents with washing or sanitizing their hands before meals. The infection preventionist (IP) was interviewed on 10/2/24 at 12:15 p.m. The IP said one of the goals of the facility was to focus on hand hygiene as it was found to be the best way to break the chain of infection. The IP said the facility had provided staff education on 10/1/24 and 10/3/24 (during the survey) which included hand hygiene for staff and residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065316	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Care Center	360 Canyon Ridge Dr Wray, CO 80758

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	The director of nursing (DON) was interviewed on 10/3/24 at 1:38 p.m. The DON said all residents should be offered hand hygiene prior to eating, including when meal trays were delivered to residents' rooms. She said using hand hygiene prevented infections and residents could contract more illnesses if they were not using hand hygiene prior to meals. The IP was interviewed again on 10/3/24 at 1:58 pm. The IP said all residents should be offered hand hygiene prior to their meals. The IP said the previous NHA had removed sanitizing wipes from the room trays. VI. Facility follow up On 10/3/24 at 2:38 p.m., the IP provided documentation of a staff inservice education signed by seven staff members on 10/1/24 and eight staff members on 10/3/24. The education was provided to ensure all residents were offered hand hygiene before eating with either soap and water, hand sanitizer or hand sanitizer wipes. The IP revealed hand hygiene education was also added to the facility's all staff meeting that was scheduled for 10/7/24.