STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065320	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Littleton Care and Rehabilitation Center	5822 S Lowell Way Littleton, CO 80123

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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 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** Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection for one of two units reviewed. Specifically, the facility failed to:-Ensure staff wore the appropriate personal protective equipment (PPE) for Resident #11, who was on enhanced barrier precautions (EBP);-Ensure proper infection control practices were followed during wound care;-Ensure hand hygiene was appropriately performed during wound care; and,-Ensure hand hygiene was appropriately performed during medication administration. Findings include:I. EBP failuresA. Professional referenceAccording to the Centers for Disease Control and Prevention (CDC) Implementation of Personal Protective Equipment (PPE) Use in Nursing Home to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, retrieved on 2/23/26 from https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (ex. central line, urinary catheter, feeding tube, tracheostomy/ventilator), or wound care (any skin opening requiring a dressing). In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because enhanced barrier precautions do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.B. ObservationsOn 2/17/26 at 11:16 a.m., a sign on the back of Resident #11's room door indicated the resident was on EBP. The sign indicated a gown and gloves must be worn for high-contact resident care activities, including: dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, and device care or use, such as central lines, urinary catheters, feeding tubes, tracheostomies, and wound care. Resident #11 had open wounds to his left buttocks and left heel.On 2/18/26 at 3:07 p.m., registered nurse (RN) #3 was observed performing wound care on Resident #11. The following observations were made:At approximately 3:10 p.m. RN #3 entered Resident #11's room. Upon entering the room, RN #3 donned (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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