

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51160</p> <p>Based on observations and interviews, the facility failed to ensure two (#19 and #44) of four residents out of 51 sample residents had the right to a dignified existence.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #19 was provided dignity and privacy while removing medication patches; and, -Ensure Resident #44 was not placed in the hallway facing the wall by facility staff. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Residents' Rights and Dignity policy and procedure, dated November 2023, was provided by the nursing home administrator (NHA) on 12/10/24 at 9:00 p.m. It read in pertinent part, To be treated with consideration, respect, and full recognition of his or her dignity and individuality.</p> <p>II. Resident #19</p> <p>A. Resident status</p> <p>Resident #19, age greater than 65, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), the diagnoses included dementia with anxiety and cognitive communication deficit (difficulty communicating related to attention and memory issues).</p> <p>The 9/25/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of two out of 15.</p> <p>B. Observations</p> <p>On 12/5/24 at 3:33 p.m. certified nurse aide with medication authority (CNA-Med) #1 entered the dining room during a group activity. Resident #19 was sitting in the dining room near other residents. CNA-Med #1 approached Resident #19 and asked her to lean forward in her wheelchair. CNA-Med #1 lifted her sweater and shirt which exposed her lower back and removed a lidocaine patch.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/9/24 at 3:32 p.m. CNA-Med #1 entered the dining room during a group activity, where Resident #19 was sitting near other residents. CNA-Med #1 approached Resident #19 and asked her to lean forward in her wheelchair. CNA-Med #1 then lifted her sweater and shirt which exposed her lower back and removed a lidocaine patch.</p> <p>C. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 12/10/24 at 6:24 p.m. The DON said that a medication patch underneath clothing should not be removed in the dining room. He said Resident #19 should have been taken back to their room and provided privacy prior to having a medication patch underneath her clothing removed.</p> <p>III. Resident #44</p> <p>A. Resident status</p> <p>Resident #44, age greater than 65, was admitted on [DATE]. According to the December 2024 CPO, the diagnoses included Alzheimer's disease, dementia and generalized muscle weakness.</p> <p>The 9/11/24 MDS assessment revealed the resident had short term and long term memory impairment with severe impairment in making decisions regarding tasks of daily life. She was dependent on staff for all mobility and used a wheelchair and was unable to self propel.</p> <p>B. Observations</p> <p>On 12/4/24 at 9:06 a.m. Resident #44 was sitting in her wheelchair in the back hallway, facing the wall. Resident #44 was faced away from other residents, the nurses station and the jazz music playing.</p> <p>On 12/5/24 at 10:38 a.m. Resident #44 was assisted to the back hallway and left in the corner, partially facing the wall, away from the nurses station and the common area where other residents were participating in a Christmas [NAME] sing-along activity with the chaplain.</p> <p>On 12/9/24 at 12:55 p.m. Resident #44 was sitting in her wheelchair in the back hallway, facing the wall, away from other residents. Christmas music played at the nurses station in the common area for residents.</p> <p>C. Record Review</p> <p>The communication care plan, dated 7/2/2020, read in pertinent part, be conscious of Resident #44's position when in groups, activities, dining room, to promote proper communication with others.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on record review and interviews, the facility failed to prevent abuse for one (#68) of three sample residents reviewed for abuse out of a sample of 51 residents.</p> <p>Specifically, the facility failed to ensure Resident #22 was free from physical abuse from Resident #68.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse Prevention policy and procedure, revised July 2019, was provided by the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It read in pertinent part, It is the policy of this facility that each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation.</p> <p>All employees of our facility will take action to protect and prevent abuse and neglect from occurring within the facility by ensuring the staff has the knowledge of individual residents' care needs, ensuring supervision of staff to identify inappropriate behaviors, assess residents, care plan and monitor residents with history of aggressive behaviors (such as entering other resident rooms, self-injurious behavior, communication disorders and resident totally dependent on staff).</p> <p>II. Incident of physical abuse between Resident #68 and Resident #22 on 9/2/24</p> <p>The 9/2/24 abuse investigation documented there was a physical altercation between two residents. The residents were separated and assessed. Resident #22 had a red mark on her neck. The residents were interviewed and placed on 72-hour monitoring.</p> <p>Resident #68 was interviewed on 9/2/24 and she did not recall the incident but said she needed to pack. She said that she felt safe and was not fearful.</p> <p>Resident #22 was interviewed on 9/2/24 and said she had a disagreement with a lady about her jewelry. She said she felt safe and was not fearful. Resident #22 had a small scratch on the right side of her neck that did not require medical interventions.</p> <p>Four staff members were interviewed. Licensed practical nurse (LPN) #3 said she was at the nursing station when she heard the two residents talking. She did not see what happened but she heard Resident #22 say, No, it isn' t your room and then she rushed in to separate the residents.</p> <p>Five residents were interviewed on the unit and were not able to provide any additional information.</p> <p>III. Resident #22 - victim</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A. Resident status</p> <p>Resident #22, age 83, was admitted on [DATE]. According to the December 2024 computerized physician's orders (CPO), diagnoses included unspecified dementia, type 2 diabetes and muscle weakness.</p> <p>The 11/13/24 minimum data set (MDS) assessment documented the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of six out of 15. She required supervision with eating, dressing, bathing, toileting and walking.</p> <p>B. Record review</p> <p>The care plan, initiated on 6/10/24 and revised on 12/7/24, documented Resident #22 was at risk for depression and behavior problems related to dementia, disease process and depression. Interventions included discussing with the family/caregivers about any concerns (initiated 6/10/24), encouraging the resident to express her feelings (initiated 6/10/24), following the Level II pre-admission screening and resident review program (PASARR) recommendations (which included psychiatric case management, social interactions once settled into new facility and the resident had hearing aids (initiated 6/25/24), observing and documenting any signs and symptoms of depression to the nurse (initiated 6/10/24), offering the resident a piece of chewing gum (initiated 12/7/24), offering the resident to call a friend (initiated 9/6/24), offering the resident to go outside for a walk in the courtyard (initiated 9/6/24), reminding the resident to put her light low if she was reading when others were sleeping (initiated 12/7/24) and stopping and talking to resident when passing by (initiated 9/6/24).</p> <p>The interdisciplinary team (IDT) note, dated 9/3/24, documented that the IDT reviewed the incident from 9/2/24 around 8:50 p.m. It documented Resident #68 wandered into Resident #22's room. Resident #68 began packing up Resident #22's clothing. Resident #22 got frustrated and asked Resident #68 to leave but Resident #68 reported it was her room. Resident #22 told Resident #68 it was not her room. Resident #68 then scratched Resident #22 on the neck. The residents were immediately separated by staff.</p> <p>The nursing progress note, dated 9/3/24 documented Resident #22 was on follow-up for the altercation with another resident and no new concerns were identified.</p> <p>IV. Resident #68 - assailant</p> <p>A. Resident status</p> <p>Resident #68, age 82, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included Alzheimer's disease, muscle weakness, cognitive communication deficit and hypertension (high blood pressure).</p> <p>The 9/25/24 MDS assessment documented the resident had severe cognitive impairments with a BIMS score of two out of 15. She required supervision with eating, dressing, bathing, toileting and walking.</p> <p>The assessment documented that she had other behaviors not directed toward others (physical symptoms such as hitting or scratching, self-pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes or verbal/vocal symptoms like screaming) one to three times a week.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>B. Record review</p> <p>The care plan, initiated on 3/6/23 and revised on 9/26/24, documented the resident had potential for a behavior problem related to dementia. The goal was to be able to explore the neighborhood in a safe manner. The pertinent interventions included offering her to read her Bible, providing the resident with activities, putting the television on to the gospel channel, redirecting her away from other's space, reminding her where her room was, redirecting her with one-on-one time and reorienting what belongings were hers.</p> <p>The nurse progress note, dated 3/3/23, documented Resident #68 was wandering around the neighborhood and was not able to recall where her room was. The note documented when she was wandering into others spaces, this was agitating others. The staff continued to reorient her to new surroundings and assisted her with adjusting.</p> <p>The nurse progress note, dated 3/18/23, documented, Resident #68 continued to wander into other residents' rooms which irritated some residents. Resident #68 became aggressive with redirection from other rooms. Resident #68 also attempted to not let her roommate in. The staff redirected her and let her in but she was upset.</p> <p>The activities progress note, dated 7/3/24, documented Resident #68 continued to get agitated and territorial when others went in her room. The note documented that at times she did not let anyone go in her room.</p> <p>The nurse progress note, dated 7/18/24, documented Resident #68 was packing up her roommate's belongings and staff would redirect her to her side of the room and that those items were not hers. The resident became verbally agitated. The note documented that eventually she stopped packing and calmed down. The note documented the resident returned back to her baseline.</p> <p>The nurse progress note, dated 9/2/24, documented Resident #68 and Resident #22 had a fight. Resident #68 walked into Resident #22's room and started the argument. Staff ran in to separate the residents. Resident #68 scratched Resident #22 on her neck. The medical doctor (MD), the director of nursing (DON) and both families were notified. Both residents were stable and safe at the time of the documentation. One-on-one protocol was initiated for both residents.</p> <p>The social services progress note, dated 9/3/24, documented social services checked in with Resident #68 following the incident on 9/2/24. Resident #68 did not recall the incident, however, she did say that her son was coming to pick her up so she needed to pack. Resident #68 reported that she felt safe and was not fearful. The note documented social services would continue to follow and provide support as needed.</p> <p>V. Staff interviews</p> <p>Certified nurse aide (CNA) #12 was interviewed on 12/10/24 at 9:50 a.m. CNA #12 said when residents had altercations it was important to keep them separated and to keep an eye on them. CNA #12 said the unit kept activities and movies or shows going in the common area to keep the residents busy.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CNA #12 said Resident #68 went into a lot of different rooms. CNA #12 said Resident #22 did not like it when people entered her room. CNA #12 said Resident #68 always thought she needed to pack up and get home to her children, so Resident #68 began packing up Resident #22's belongings. CNA #12 said the closets on the unit were all locked, but that Resident #68 was packing up the items that were on Resident #22's nightstand and bed.</p> <p>CNA #12 was interviewed a second time on 12/10/24 at 1:02 p.m. CNA #12 said Resident #68 was always trying to find a way out of the facility. CNA #12 said Resident #68 would get confused and agitated and go into another resident's room. CNA #12 said Resident #68 entered other residents' rooms a few times a week. CNA #12 said she could redirect Resident #68 by talking about religion or offering to call Resident #68's son. CNA #12 said when Resident #68 wandered into another resident's room, she would get agitated with that resident. CNA #12 said Resident #68 was fine when she first got to the facility but started wandering later on.</p> <p>Social worker (SW) #1 was interviewed on 12/10/24 at 1:55 p.m. SW #1 said Resident #68 knew where her room was when she first moved in and when her dementia started progressing, she started to wander around the unit more and into other residents' rooms. SW #1 said she would do this about three to four times a week. She said Resident #68 would exit seek and pack her belongings because she thought her son was coming to pick her up. She said the staff would intervene if they witnessed this occurring by offering for her to call her son, offering for her to read the Bible, redirect her to the chaplain, and listening to gospel music. She said in August 2024, she got into an altercation with another resident. She said because of that incident and the progressing dementia, she was moved into a different unit more suited for her needs. She said she was doing a lot better in terms of behaviors in the new unit.</p> <p>The DON and the CNR were interviewed together on 12/10/24 at 5:00 p.m. The DON said Resident #68 liked to walk around the unit and at one point started to wander into other residents' rooms. He said staff reported to him that Resident #68 would rummage through other residents' belongings. He said when residents start to wander, it could become a trigger for an altercation. He said the resident was redirected by staff and they utilized red stop signs banners that would be placed across a doorway. He said after the altercation between Resident #68 and Resident #22, the two residents were immediately separated and assessed. The DON said the residents were placed on 72-hour monitoring. He said Resident #68 had not shown any aggressive behaviors prior to this incident.</p> <p>-However, review of the resident's electronic medical record (EMR) revealed the Resident #68 had a history of behaviors (see record review above).</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51711</p> <p>Based on observations, record review and interviews, the facility failed to develop and implement an effective discharge plan for two (#362 and #466) of two residents reviewed for discharge planning out of 51 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure Resident #362 and #466 and/or their responsible party were apprised of their progress and discharge planning; and, -Ensure the discharge planning process was documented in the residents' electronic medical records (EMR). <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Discharge Planning policy and procedure, revised February 2020, was provided by the nursing home administrator (NHA) on 12/10/24 at 9:00 p.m. It read in pertinent part, It is the policy of this facility that discharge planning and evaluation will be provided by the social services staff for each resident. The discharge planning process focuses on the resident's discharge goals, the preparation of the resident to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions.</p> <p>The social services staff will ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. The social services staff member assigned to the resident regularly evaluates and re-evaluates the resident to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>Staff involved in the move in, transfer and move out process will ensure that the focus is the resident and their family and their needs and concerns.</p> <p>II. Resident #466</p> <p>A. Resident status</p> <p>Resident #466, age 77, was admitted on [DATE]. According to November 2024 computerized physician orders (CPO), diagnoses included encounters for cerebral vascular accident (CVA: medical condition that occurs when blood flow to the brain is suddenly interrupted, which can lead to brain cell death and neurological damage), muscle weakness, unsteadiness on feet and history of falls.</p> <p>The 11/15/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for a mental status (BIMS) score of 14 out of 15. He required moderate to maximum assistance with all activities of daily living (ADL).</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The assessment indicated the resident's overall goal was to be discharged back into the community and active discharge planning was occurring.</p> <p>B. Resident interview and observation</p> <p>Resident #466 was interviewed on 12/5/24 at 9:37 a.m. Resident #466 said he was frustrated he had not been kept informed of his progress and did not know what specifically he needed to do to discharge home from the facility. He said nobody was in charge of the discharge process and nobody would take responsibility. He said he had requested a criteria for the goals he needed to meet with therapy or facility goals related to his care in order to facilitate his discharge from the facility more quickly. Resident #466 said he still had not been provided the discharge criteria he requested.</p> <p>Resident #466 said it was human nature for people to pass the buck but it was the responsibility of the facility staff to make the decisions and provide him with the information. He said he was not the person to decide if he could discharge home and he wanted someone to stand up and say they were responsible for providing the discharge information to him. He said he wanted someone to have a discussion with him and tell him what they needed from him for him to be able to discharge.</p> <p>C. Record review</p> <p>The discharge care plan, initiated 11/13/24, documented the goal for Resident #466 was to be able to verbalize and communicate the services required to meet his needs before discharge. The interventions included establishing a pre-discharge plan with the resident and family/caregivers, evaluating the resident's progress, revising the discharge plan as needed, recording the resident's abilities and strengths and determining resident's gaps in abilities with the resident and family/caregivers to determine if it would affect the resident's discharge.</p> <p>The 11/13/24 skilled weekly progress note, which included the NHA, social services, therapy, the MDS coordinator and nursing, documented Resident #466 had an anticipated maximum potential to be achieved in three to four weeks.</p> <p>The resident's plan was to discharge home with his spouse and home health services.</p> <p>The 12/4/24 physician medicine and rehabilitation follow up progress note documented the resident was anxious to get an update regarding his discharge timing. The physician documented he would coordinate with the discharge team.</p> <p>The physician further documented in the 12/4/24 progress note that Resident #466's anticipated maximum potential from his skilled stay would be achieved in one to two weeks and he would discharge home with his spouse and home health services.</p> <p>-A review of the resident's electronic medical record (EMR) did not reveal documentation the facility had met with Resident #466 and/or the resident's representative to discuss the resident's progress toward discharge or his progress status.</p> <p>-The EMR did not include documentation of an active discharge plan involving Resident #466 and his representative from the time of the resident's admission to the facility to his current status.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>D. Staff interviews</p> <p>Rehabilitation transitions director (RTD) #1, who was part of the facility's social services team, was interviewed on 12/5/24 at 4:59 p.m. RTD #1 said when residents were admitted to the facility, she met with the residents and the residents' representatives, either in person or via telephone, to sign admission agreements. She said the initial care plan was created within 48-hours of the resident's admission to the facility.</p> <p>The RTD said the initial goal of all residents was to return home with their family or to their prior living arrangement. She said it was social services responsibility to develop and revise the discharge care plan throughout the resident's stay at the facility, in conjunction with their progress with rehabilitation services.</p> <p>RTD #1 said the facility staff held a meeting amongst themselves on 12/4/24 to discuss Resident #466's progress. She said it was discussed that Resident #466 had met his maximum potential for rehabilitation and the plan was to discharge the resident home early next week (week of 12/9/24). She said she had advised Resident #466 on the afternoon of 12/5/24 about the upcoming discharge, but she said she had not yet communicated with the resident's representative.</p> <p>RTD #1 said she had not met with Resident #466 and/or the resident's representative to discuss the discharge plan or provided them with the Notice of Medicare Non-Coverage (NOMNC) to inform them the resident's Medicare skilled services benefits were ending. She said she would provide them with the information and the NOMNC on 12/6/24 for a planned discharge on 12/9/24.</p> <p>RTD #1 said following the meeting with Resident #466 and the resident's representative to create the initial plan of care, she did not document discharge planning within the resident's EMR. She said attempts to meet with residents and the residents' representatives occurred as often as possible but she said it was not documented in the resident's EMR.</p> <p>51163</p> <p>III. Resident #362</p> <p>A. Resident status</p> <p>Resident #362, age 85, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included spondylosis without myelopathy or radiculopathy (condition that occurs when the spine degenerates without injuring the spinal cord or pinching a nerve) of the cervical region (neck), history of falling, cognitive communication deficit and dementia.</p> <p>The 11/25/24 MDS assessment revealed the resident had moderate cognitive impairment with a BIMS score of 11 out of 15. She required substantial to maximal assistance or was dependent with the majority of her ADLs.</p> <p>The assessment indicated the resident's overall goal was to be discharged back into the community or to go back home and active discharge planning was occurring.</p> <p>B. Resident representative interview</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #362's representative was interviewed on 12/5/24 at 11:02 a.m. The representative said he had not been included in the care planning process for Resident #362. He said he had not received any information and was not sure when the resident would discharge home. He said he would like to receive some information in order to plan for the resident's discharge.</p> <p>C. Record review</p> <p>The discharge care plan, revised 12/3/24, documented Resident #362 planned to discharge home with her spouse and home health care services. Interventions included coordinating with family to create and maintain personal shadow box; encouraging family and the resident to be involved with facility events and plan of care, establishing a pre-discharge plan with family and the resident, evaluating the resident's progress and revising the discharge plan as needed, evaluating and discussing the discharge plan with the family and the resident, identifying, discussing and addressing limitations, risks, benefits and needs for maximum independence and evaluating and recording the resident's abilities and strengths with the family to determine gaps in abilities which will affect the resident's discharge.</p> <p>The 11/22/24 progress note documented the initial care plan was verbally reviewed with social services and the resident's representative. It indicated the resident's goal was to return home with her spouse.</p> <p>The 12/9/24 progress note documented a NOMNC was issued to Resident #362 and the resident's representative. It indicated the resident's representative decided, that day (12/9/24), that the resident was to remain at the facility for long-term care.</p> <p>-However, the resident's EMR did not reveal any documentation of interdisciplinary (IDT) meetings regarding Resident #362's discharge plan or the progress that the resident was making towards discharge.</p> <p>-A review of Resident #362's EMR did not reveal documentation of an active discharge planning process. The facility did not document any meetings with the resident's representative to discuss Resident #362's progress toward discharge, a potential change to the discharge plan or to provide the resident's representative with any potential services for care at home.</p> <p>D. Staff Interviews</p> <p>RTD #1 was interviewed on 12/10/24 at 2:30 p.m. RTD #1 said within 72-hours of a resident's admission to the facility, the resident's discharge plan was reviewed with the interdisciplinary team, the family and the resident. She said all interactions and discussions regarding a resident's discharge plan should be documented in the resident's EMR.</p> <p>RTD #1 said up until she had called Resident #362's representative on 12/9/24, the resident's discharge plan was to return home with her spouse.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>RTD #1 was interviewed again on 12/10/24 at 5:30 p.m. She said she received a call from Resident #362's representative on 12/5/24, during the survey process. She said the resident's representative said he might want the resident to stay at the facility for long-term care. She said she had not had discussions related to the resident's discharge with the representative prior to the phone call on 12/5/24.</p> <p>The NHA was interviewed on 12/10/24 at 7:01 p.m. The NHA said all of the residents' discharge planning went through RTD #1's department. He said active discharge planning started at the residents' admission to the facility. He said the resident and the residents' families should be involved in the discharge planning process and it should be documented in the EMR.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51163</p> <p>Based on observations, record review and interviews, the facility failed to ensure four (#366, #370, #27 and #43) of 12 residents out of 51 sample residents were provided the appropriate care and services of activities of daily living (ADL) to maintain or improve his or her abilities.</p> <p>Specifically, the facility failed to ensure Resident #366, Resident #370, Resident #27 and Resident #43 received cueing or assistance while eating.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Assisting Diners policy and procedure, revised May 2019, was provided by the nursing home administrator (NHA) on 12/11/24 at 9:26 a.m. It read in pertinent part It is the policy of this facility that dependent diners will be assisted with all meals in a manner that meets the individual resident's needs, promotes self-esteem and the highest practical level of independence.</p> <p>If verbal prompts are needed to initiate eating, opening mouth, swallowing, do these in a calm, pleasant manner. Offer drinks of beverages throughout the meal. Offer alternatives if foods refused.</p> <p>II. Resident #366</p> <p>A. Resident status</p> <p>Resident #366, age 79, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO) diagnoses included aphasia (disorder affecting ability to understand and express language), dysphagia (difficulty swallowing) and dementia.</p> <p>The 11/24/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15. Resident #366 needed set up and clean up assistance with meals as well as partial assistance with planning regular daily activities.</p> <p>B. Observations</p> <p>During a continuous observation on 12/9/24, beginning at 9:46 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:20 p.m. Resident #366 was served a room tray for lunch of orange chicken, rice, mixed vegetables, and a cookie. An unidentified certified nurse aide (CNA) who served her the lunch tray did not offer or encourage the resident to go to the dining room. The resident took a few bites. The staff did not provide cueing or physical assistance to Resident #366 during the meal. The resident ate less than 25% of her meal.</p> <p>During a continuous observation on 12/9/24, beginning at 3:30 p.m. and ending at 7:00 p.m., the following was observed:</p> <p>At 6:28 p.m. Resident #366 was served a room tray for dinner. An unidentified CNA did not encourage the resident to eat dinner in the dining room. The staff did not provide cueing or physical assistance to Resident #366 during the meal. The resident ate about 50% of her meal.</p> <p>During a continuous observation on 12/10/24, beginning at 11:45 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 11:58 a.m. Resident #366 entered the dining room.</p> <p>At 12:16 p.m. she was served a plate of mashed potatoes, mixed vegetables, roast beef and fruit for lunch.</p> <p>At 12:21 p.m. Resident #366 had not taken a bite of lunch. The staff did not provide any physical assistance or cueing for the resident to eat.</p> <p>At 12:36 p.m. Resident #366 was asked by an unidentified nurse if she was going to eat. Resident #366 responded yes, however she still did not take a bite of food. The unidentified nurse walked away and did not provide any further cueing or assistance.</p> <p>At 12:48 p.m. Resident #366 was assisted back to the unit. She did not eat any of her meal.</p> <p>C. Record review</p> <p>The ADL care plan, revised on 11/22/24, documented Resident #366 had an ADL self-care performance deficit due to a recent fall and a diagnosis of dementia, which impacted her cognition. The interventions included providing set-up and physical assistance of one staff member with eating and encouraging the resident to eat her meals in the dining room.</p> <p>-However, according the observations during the survey process, Resident #366 was not provided the level of assistance in which the care plan documented she required.</p> <p>The nutritional risk care plan, revised on 12/1/24, documented Resident #366 was malnourished according to a mini-nutritional assessment conducted at the facility. The interventions included inviting the resident to attend activities that promote additional intakes, eating meals in the dining room, monitoring and reporting to the physician if the resident had any signs or symptoms of a decreased appetite, monitoring the resident's weights per facility policy, providing and serving supplements as ordered (Ensure Plus one carton, three times daily) and reviewing the resident's nutritional status in the nutrition at risk meeting as needed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 12/1/24 dietitian progress note documented Resident #366's meal intake was sporadic, between zero to 75%.</p> <p>The meal percentage documentation record revealed from 11/21/24 to 12/10/24, Resident #366 ate zero to 25% on 19 occasions and refused to eat on three occasions.</p> <p>III. Resident #370</p> <p>A. Resident status</p> <p>Resident #370, age 82, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included encephalopathy (brain disorder that causes brain dysfunction), dysphagia, dementia and moderate protein calorie malnutrition.</p> <p>The 11/17/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of three out of 15. Resident #370 required set up and clean up assistance with meals as well as partial assistance with planning regular daily activities.</p> <p>B. Observations</p> <p>During a continuous observation on 12/4/24, beginning at 9:45 a.m. and ending at 1:30 p.m., the following was observed:</p> <p>At 12:23 p.m. Resident #370 was served lunch of fish, green beans, rice and corn bread. Resident #370 was unable to find his silverware that was tucked in his napkin on his right hand side. He was eating with his hands.</p> <p>At 12:42 p.m. the food and nutrition resource (FNR) asked Resident #370 if he was doing okay. She did not offer any encouragement or cueing and did not offer to assist him with his silverware Resident #370 ate a few bites of his food.</p> <p>At 1:15 p.m. Resident #370 was assisted back to the common area. He had eaten less than 25% of his meal.</p> <p>During a continuous observation on 12/9/24, beginning at 3:30 p.m. and ending at 7:00 p.m., the following was observed:</p> <p>At 6:15 p.m. Resident #370 was served a room tray for dinner. He was sitting up in bed at about 80 degrees and slouched over. He took a few bites of food. The staff was not observed checking on the resident, providing cueing or any physical assistance.</p> <p>During a continuous observation on 12/10/24, beginning at 11:45 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 12:00 p.m. Resident #370 was sitting in the dining room for lunch, sleeping in his wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:15 p.m. Resident #370 received lunch of roast beef, mashed potatoes, mixed vegetables and fruit. He began to scoop up the food and eat with his knife. He did not receive any cueing or assistance from the facility staff observed in the dining room. Resident #370 finished his plate and began to scrape the plate in an attempt to get more food. Staff did not offer him any additional food.</p> <p>C. Record review</p> <p>The alteration in neurological status care plan, revised on 11/14/24, documented Resident #370 had a history of chronic microvascular ischemic (small blood vessels become damaged in the brain), dementia and a seizure disorder. The interventions included providing cueing and reorientation as needed.</p> <p>The ADL care plan, revised 11/17/24, documented Resident #370 had an ADL self-care performance deficit due to the diagnoses of encephalopathy, seizures and dementia which impacted his strength, balance, coordination, cognition and mobility. It indicated he required set up and one staff physical assistance with meals. The interventions included encouraging the resident to eat all meals in the dining room.</p> <p>The nutritional risk care plan, revised on 11/20/24, documented Resident #370 was malnourished according to a mini-nutritional assessment conducted at the facility. The interventions included inviting the resident to activities that promoted additional intakes, encouraging the resident to eat all meals in the dining room, monitoring and reporting to the physician if the resident had any signs or symptoms of decreased appetite; monitoring weights per the facility policy and reviewing as needed, providing and serving supplements as ordered (Ensure Plus one carton, three times daily, evening snack every night) and reviewing the nutritional status in the nutrition at risk meeting as needed.</p> <p>The meal intake documentation revealed Resident #370 ate 76% to 100% the majority of the time. It documented on 12/4/24, he ate 76% to 100% during lunch, however this documentation was inaccurate as observations during the survey process showed Resident #370 had eaten less than 25% (see observations above).</p> <p>IV. Resident #27</p> <p>A. Resident status</p> <p>Resident #27, age 89, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included fracture (break) of the upper left femur (thigh bone), fracture of the lower left ulna (bone in the arm) bone, stroke, dementia, dysphagia and moderate protein calorie malnutrition.</p> <p>The 11/4/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS score of seven out of 15. Resident #27 required substantial to maximal assistance with eating as well as partial assistance with planning regular daily activities.</p> <p>B. Observations</p> <p>During a continuous observation on 12/4/24, beginning at 9:45 a.m. and ending at 1:00 p.m. the following was observed:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:33 p.m. Resident #27 was in the dining room with a plate of fish, rice, green beans and corn bread. She was eating her corn bread. She did not receive any cueing or encouragement from staff.</p> <p>During a continuous observation on 12/9/24, beginning at 9:46 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 12:12 p.m. Resident #27 was observed sitting in the dining room, drinking her water.</p> <p>At 12:18 p.m. she was served lunch, which consisted of orange chicken, rice, vegetables and a cookie. Resident #27 ate small bites of her meal.</p> <p>At 12:28 p.m., Resident #27 took a small bite of her chicken and was still chewing on that same bite of chicken at 12:33 p.m.</p> <p>The staff did not provide Resident #27 any cueing or encouragement during the meal. Resident #27 ate less than 25% of her meal.</p> <p>At 3:27 p.m. an unidentified CNA removed Resident #27's meal tray.</p> <p>During a continuous observation on 12/10/24 beginning at 11:45 a.m and ending at 1:00 p.m. the following observations were made:</p> <p>At 12:13 p.m. Resident #27 was served lunch which consisted of mashed potatoes, mixed vegetables, pot roast and fruit.</p> <p>At 12:19 p.m. Resident #27 had eaten only the mashed potatoes.</p> <p>At 12:35 p.m. Resident #27 ate some fruit.</p> <p>At 12:46 p.m. an unidentified nurse asked Resident #27 if she was going to eat. Resident #27 responded, no and the nurse walked away.</p> <p>At 12:49 p.m. Resident #27 was returned to the unit. She had eaten less than 25% of her meal.</p> <p>C. Record review</p> <p>Review of the record revealed that Resident #27 was malnourished according to the 11/7/24 mini nutritional assessment (MNA).</p> <p>The meal intake documentation revealed Resident #27 ate 51% to 75% the majority of the time.</p> <p>-However, observations on 12/4/24, 12/9/24 and 12/10/24 showed Resident #27 ate 25% or less of her meals (see observations above).</p> <p>V. Resident #43</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #43, age 81, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included dementia, protein-calorie malnutrition, cognitive communication deficit and dysphasia.</p> <p>The 11/7/24 MDS assessment revealed Resident #43 had severe cognitive impairments with a BIMS score of three out of 15. TResident #43 required set up and clean-up assistance with meals.</p> <p>B. Observations</p> <p>During a continuous observation on 12/4/24, beginning at 9:45 a.m. and ending at 1:30 p.m., the following was observed:</p> <p>At 11:49 a.m. Resident #43 was in the dining room with the unidentified speech therapist. Resident #43 was served fish, green beans, rice and corn bread.</p> <p>-However, based on her dislikes documented in the electronic medical record (EMR), Resident #43 did not like fish. She was not offered a meal replacement.</p> <p>At 12:26 p.m. the unidentified speech therapist left the dining room. Resident #43 ate less than 25% of her lunch. The resident was not provided any cueing or assistance during the meal.</p> <p>On 12/9/24 during a continuous observation, beginning at 9:46 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 12:17 p.m. she was served lunch which had mechanical soft orange chicken, mixed vegetables, rice and a cookie.</p> <p>At 12:32 p.m. Resident #43 spit out a mouthful of food onto her plate. She was moving the food around her plate but did not take any bites. The staff did not provide Resident #43 with cueing or encouraged her to eat.</p> <p>At 12:54 p.m. Resident #43 was removed from the dining room. She had eaten less than 25% of her meal.</p> <p>During a continuous observation on 12/9/24, beginning at 3:30 p.m. and ending at 7:00 p.m., the following was observed:</p> <p>At 6:01 p.m. Resident #43 was in her room sleeping.</p> <p>At 6:13 p.m. an unidentified CNA delivered the resident's dinner tray to her room. Once she delivered the tray, the CNA closed the bedroom door after exiting her room.</p> <p>During a continuous observation, on 12/10/24, beginning at 11:45 a.m. and ending at 1:00 p.m., the following was observed:</p> <p>At 11:55 a.m. Resident #43 was assisted to the dining room for lunch.</p> <p>At 12:11 p.m. the resident was served her meal which consisted of mashed potatoes, mixed vegetables and pot roast. She had a few bites of her vegetables and had a couple sips of her beverage.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:18 p.m. Resident #43 stopped eating after taking a couple bites of her vegetables and roast beef. She did not receive any cueing from staff.</p> <p>At 12:33 p.m. an unidentified CNA provided a cue, the resident took one bite and the CNA walked away. She did not provide Resident #43 any additional cueing.</p> <p>At 12:50 p.m. she was wheeled from the dining room to the common area. Resident #43 ate less than 25% of her meal.</p> <p>C. Record review</p> <p>The ADL care plan, revised 11/21/24, documented Resident #43 had a self-care deficit due to her diagnoses of dementia, protein-calorie malnutrition, cognitive communication deficit, and dysphasia. It indicated the resident required set up and one person physical assistance with meals. The interventions included encouraging the resident to eat all the meals in the dining room.</p> <p>The nutritional risk care plan, revised on 12/3/24, documented Resident #43 was malnourished according to the mini-nutritional assessment completed at the facility. The interventions included offering a meal replacement if she ate less than 50%, offering snacks in between meals, monitoring and reporting to the physician if the resident had any signs or symptoms of decreased appetite, monitoring weights per facility policy and reviewing as needed, providing and serving supplements as ordered (Ensure Plus one carton, three times daily, evening snack every night) and reviewing the resident's nutritional status in the nutrition at risk meeting as needed.</p> <p>It also documented her food preferences, such as dislike of fish and likes of mashed potatoes, fruit, ice cream, Coke, cookies, chocolate, scrambled eggs, fried potatoes, tortillas and bacon. The resident was prescribed a mechanical soft diet.</p> <p>The 12/3/24 nutrition progress note documented Resident #27's meal intake was sporadic and accepted 25 to 50% of supplements. It documented the resident's family said she was overwhelmed by large amounts of food and it would be beneficial to provide smaller meal portions.</p> <p>The meal intake documentation revealed from 11/11/24 to 12/10/24, Resident #27 ate zero to 25% on 30 occasions and refused meals on 18 occasions.</p> <p>VI. Staff interviews</p> <p>CNA #14 was interviewed on 12/10/24 at 12:58 p.m. CNA #14 said the unit that Resident #366, Resident #370, Resident #27 and Resident #43 resided on, was a memory care and rehabilitation unit. She said some of the residents on the unit were independent and some needed full care. She said the CNAs got their information on the residents and the type of care that they need from the report at the beginning of their shift. She said the CNAs got some of their information from the computer and the therapy department/ She said a one person assist meant that the resident needed someone to stand by them or to give them cues either by touch or verbally. She said the amount of assistance that a resident might need can change from day to day. She said for dining assistance, the meal tickets had all the information on them which includes how much assistance they need, preferences and type of diet. She said they also watched to see who was not eating or was struggling and they would give them encouragement.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CNA #5 was interviewed on 12/10/24 at 5:00 p.m. CNA #5 said Resident #366, Resident #370, Resident #27 and Resident #43 all needed assistance in the dining room. She said that if she saw a resident struggling with eating she would go over to help them. She said sometimes Resident #43 would refuse any help or encouragement.</p> <p>The director of nursing (DON) was interviewed on 12/10/24 at 6:23 p.m. He said the CNAs were scheduled on the same unit every shift so that there was continuity for the residents and the staff. He said the staff should have encouraged residents to eat their meals. He said that a one person assist meant that the resident needed cueing, encouragement, cutting up their meat and assisting the resident with eating.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219</p> <p>Based on observations, record review and interviews, the facility failed to implement an activities program that met the interests of and supported the physical, mental, and psychosocial well-being of each resident for three residents (#79, #364 and #11) out of eight residents reviewed for activities of 51 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Establish activity preferences and meet the socialization needs of Resident #79 and Resident #364; and, -Invite Resident #11 to group activities and ensure accurate activity documentation. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Activity Policy and Procedure Manual, revised November 2017, was received from the clinical resource nurse (CNR) on 12/10/24 at 9:00 p.m. It read in pertinent part, Should a resident be considered medically or mentally incompetent, or physically unable to participate in such programs, an entry will be made in the resident's medical record (chart) stating fully the reason(s) for the restriction(s). Such an entry will be signed and dated by the person recording such data.</p> <p>Some activities can be adapted to accommodate the resident's change in functioning due to physical or cognitive limitations: Cognitive impairment (task segmentation, settings that recreate past experiences, smaller groups without interruption, one-to-one); Language barrier (translation tools, audio/video in the resident's language)</p> <p>Residents on a formal one-to-one program will have documentation in medical records regarding the type and length of the visit and the individual's response to the visit.</p> <p>Daily activities, including those on weekends and holidays, are provided, as well as scheduled religious and social activities. However, residents are free to choose whether or not they wish to attend any activity or other scheduled event(s).</p> <p>II. Resident #79</p> <p>A. Resident status</p> <p>Resident #79, age 78, was admitted on [DATE]. According to the December 2024 computerized physicians orders (CPO), diagnoses included Alzheimer's disease, traumatic brain compression and cognitive communication deficits.</p> <p>The 9/18/24 minimum data set (MDS) revealed the resident was severely cognitively impaired and was unable to perform a brief interview for mental status (BIMS) assessment.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The assessment revealed the resident's preferred language was Spanish and he needed an interpreter to communicate with health care staff.</p> <p>The 12/21/23 MDS revealed the resident had been interviewed to determine his activity preferences. The resident indicated it was somewhat important for him to have books, newspapers, and magazines to read, to listen to music he liked, to be around animals, to keep up with the news, to do things with groups of people, to go outside to get fresh air, to participate in religious services or practices, and to do his favorite activities.</p> <p>B. Resident representative interview</p> <p>Resident #79's representative was interviewed on 12/10/24 at 9:16 a.m. Resident #79's representative said Resident #79 did not really do much aside from sit in his wheelchair. Resident #79's representative said the facility staff assisted Resident #79 to a position in the common area next to a table by the television and sometimes gave him activities he could do like going through the newspaper. Resident #79's representative said the physical therapy team gave him puzzles he could do and provided him with therapy. Resident #79's representative said she did not think the activities staff spent time with Resident #79 and that he was mostly on his own.</p> <p>Resident #79's representative said Resident #79's first language was Spanish. Resident #79's representative said Resident #79 used to understand a small amount of English but due to his disease process, he had forgotten it. Resident #79's representative said most of the facility staff spoke English but some of the staff spoke Spanish when communicating with Resident #79 and he appeared to understand them.</p> <p>C. Observations</p> <p>On 12/4/24 at 10:07 a.m. Resident #79 was sitting in his wheelchair at a table in the common area. Resident #79 was sitting under the common area television and had his back turned to the rest of the residents in the common area. An unidentified certified nurse aide (CNA) offered the resident a stack of newspapers which were all written in English. Resident #79 was groaning and quietly crying out.</p> <p>At 4:16 p.m. Resident #79 was sitting in his wheelchair at a table in the common area. Resident #79 was sitting under the common area television and had his back turned to the rest of the residents in the common area with no meaningful activities observed.</p> <p>On 12/5/24 at 8:47 a.m. Resident #79 was sitting in his wheelchair at a table in the common area. Resident #79 was sitting under the common area television and had his back turned to the rest of the residents in the common area.</p> <p>At 8:58 a.m. activities assistant (AA) #3 entered the common area and began interacting with residents. Resident #79 was sitting in his wheelchair at a table in the common area in the same position. Resident #79 was intermittently quietly crying out.</p> <p>-AA #3 did not interact with Resident #79.</p> <p>At 9:15 a.m. Resident #79 was sitting in the same position in the common area asleep.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 9:28 a.m. Resident #79 was sitting in the same position in the common area asleep. AA #3 announced to the common area she was going to do exercises in the dining room and invited multiple residents to join her.</p> <p>-AA #3 did not invite Resident #79 to join her in the activity.</p> <p>At 9:37 a.m. licensed practical nurse (LPN) #4 assisted Resident #79 to his room for a nap.</p> <p>Resident #79 was observed during a continuous observation, beginning at 2:45 p.m. and ending at 4:15 p.m. The following was observed:</p> <p>At 2:45 p.m. Resident #79 was sitting in his wheelchair in the common area with his wheelchair angled away from the television and his back turned to the rest of the residents in the common area.</p> <p>At 3:01 p.m. AA #3 set up a table under the television in the common area so Resident #79 could look at magazines. Resident #79 was still sitting in his wheelchair angled away from the television. AA #3 told Resident #79 he could look at magazines after his shower and left him in his wheelchair approximately three feet away from the table. AA #3 announced to the common area she was going to do puzzles in the dining room and asked if anyone wanted to join her.</p> <p>-AA #3 did not directly invite Resident #79 to the puzzle activity nor wait for the resident's response when she announced the activity to the common area to see if Resident #79 would be interested in participating</p> <p>At 3:07 p.m. Resident #79 propelled himself in his wheelchair so that he was facing the television and table in the common room. Resident #79's head was down and he was groaning and intermittently crying out. CNA #10 was in the common area helping another residents but did not assist or address Resident #79.</p> <p>At 3:15 p.m. Resident #79 was slowly propelling himself toward the table and intermittently groaning and crying out. CNA #10 was sitting and doing computer work in the common area approximately ten feet away from Resident #79 but did not address Resident #79.</p> <p>At 3:18 p.m. Resident #79 reached the table and began picking up and looking at magazines which were published in English.</p> <p>At 3:22 p.m. Resident #79 was grabbing the edge of the table and trying to pull himself closer to the table.</p> <p>At 3:34 p.m. Resident #79 had propelled himself away from the table and was looking at the wall with no meaningful activity happening. AA #3 was sitting in the common area next to the resident conducting a word game. AA #3 did not attempt to include Resident #79 or interact with him.</p> <p>At 3:35 p.m. Resident #79 began to grasp the edge of the table and tried to pull the table to himself.</p> <p>At 4:05 p.m. Resident #79 was sitting in the same position in his wheelchair. An activity was being conducted in the dining room.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 10:08 a.m. CNA #11 left the hallway and the Spanish music stopped.</p> <p>At 10:09 a.m. AA #4 invited residents sitting a few feet away from Resident #79 to join her in a stretching activity.</p> <p>-AA #4 did not speak with nor invite Resident #79 to the activity.</p> <p>At 10:14 a.m. CNA #11 returned to her computer next to Resident #79 and the Spanish music resumed playing.</p> <p>At 10:16 a.m. CNA #12 spoke with Resident #79 in Spanish and the resident responded but the response was not audible. Resident #79 was smiling as he listened to the music.</p> <p>At 10:22 a.m. AA #4 was handing out coloring pages in the common area. Resident #79 was still sitting in his wheelchair in the corner of the hallway listening to music.</p> <p>At 10:28 a.m. Resident #79 was asleep in his wheelchair by the CNA's computer. The music was no longer playing.</p> <p>At 10:30 a.m. AA #4 assisted Resident #79 to the dining room in his wheelchair to participate in the coloring activity.</p> <p>D. Record review</p> <p>The communication care plan, revised 9/20/24, revealed Resident #79 was at risk for communication problems due to his traumatic brain injury and because he primarily spoke Spanish. Pertinent interventions included anticipating and meeting his needs, providing a translator as necessary and being conscious of the resident's position when in groups, activities, and the dining room in order to promote proper communication with others.</p> <p>The activities care plan, revised 1/27/24, revealed Resident #79's preferred activities were few and included listening to music, going outdoors, watching movies, and reading the daily newspaper. Pertinent interventions included providing Resident #79 with materials for independent activities, inviting and encouraging the resident to participate in all scheduled activities, and that Resident #79 liked to sit in the common area with his peers and observe others.</p> <p>An activities progress note on 8/29/24 revealed Resident #79 was asleep so a formal one-on-one engagement could not be conducted.</p> <p>An activities progress note on 9/3/24 revealed Resident #79 went outside with an unidentified activities staff member to enjoy the nice weather as part of a formal one-on-one engagement.</p> <p>An activities progress note on 9/8/24 revealed Resident #79 was asleep so a formal one-on-one engagement could not be conducted.</p> <p>An activities progress note on 9/19/24 revealed Resident #79 listened to Spanish music with an unidentified activities staff member as part of a formal one-on-one engagement.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An activities progress note on 10/3/24 revealed Resident #79 was asleep so a formal one-on-one engagement could not be conducted.</p> <p>A quarterly activity progress note, dated 10/22/24, revealed Resident #79 continued to not show interest in scheduled activities. Resident #79 sat in the common area with his peers, watched television and observed his surroundings. Resident #79 was part of the formal one-on-one engagement program with the activities staff. During the one-on-one engagements, Resident #79 enjoyed listening to music, talking about his family, and going outside.</p> <p>The formal one-on-one engagements took place at least three times per week. Resident #79 had shown interest in holiday-related social activities and going outside. Resident #79 would continue to be encouraged to join scheduled activities and be provided with materials for independent activities.</p> <p>An activities progress note on 10/24/24 revealed Resident #79 had a formal one-on-one activity in which the resident and the unidentified activities personnel listened to music and colored together.</p> <p>-Review of the resident's electronic medical record (EMR) on 12/9/24 did not reveal further documentation that Resident #37 consistently received three one-on-one activity visits per week.</p> <p>Review of Resident #79's social activity task log from 11/10/24 to 12/9/24 revealed the following:</p> <p>-On 11/11/24 at 11:36 a.m. the resident was watching television with others and participated in a snack social;</p> <p>-On 11/26/24 at 10:56 a.m. the resident was watching television with others and participated in a snack social;</p> <p>-On 12/2/24 at 11:48 a.m. the resident was watching television with others and participated in a snack social; and,</p> <p>-On 12/9/24 at 12:17 p.m. the resident was watching television with others and participated in a snack social.</p> <p>-No other activities of this kind were documented at the time of review.</p> <p>Review of Resident #79s mental activity task log from 11/10/24 to 12/9/24 revealed the following:</p> <p>-On 11/11/24 at 11:36 a.m. the resident was participating in a self-esteem workshop and reading;</p> <p>-On 11/26/24 at 10:55 a.m. the resident was participating in a self-esteem workshop;</p> <p>-On 12/2/24 at 11:47 a.m. the resident was participating in a self-esteem workshop; and,</p> <p>-On 12/9/24 at 12:16 p.m. the resident was participating in a self-esteem workshop and reading.</p> <p>Review of Resident #79's independent activity task log from 11/10/24 to 12/9/24 revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 11/11/24 at 11:37 a.m. the resident was actively participating in independent activities;</p> <p>-On 11/26/24 at 10:55 a.m. the resident was actively participating in independent activities;</p> <p>-On 12/2/24 at 11:49 a.m. the resident was actively participating in independent activities; and,</p> <p>-On 12/9/24 at 12:16 p.m. the resident was actively participating in independent activities.</p> <p>E. Staff interviews</p> <p>CNA #10 was interviewed on 12/9/24 at 6:14 p.m. CNA #10 said Resident #79 mostly spoke Spanish but spoke some English.</p> <p>CNA #12 was interviewed on 12/10/24 at 9:50 a.m. CNA #12 said Resident #79 loved to eat and it was his favorite thing to do. CNA #12 said Resident #79 liked to listen to Spanish music because the resident only spoke Spanish. CNA #12 said the activities staff brought Resident #79 a newspaper published in Spanish and the resident liked to look at the newspaper.</p> <p>-However, observations revealed the resident was provided a newspaper in English (see observations above).</p> <p>The activities supervisor (AS) was interviewed on 12/10/24 at 3:16 p.m. The AS said the facility had a daily newspaper that was able to be printed in Spanish for the facility's Spanish-speaking residents. The AS said the facility had five staff members that spoke Spanish and were able to read the daily newspaper aloud and translate it for any Spanish speaking residents. The AS said the activities assistants did a lot of one-on-one engagement with residents in Spanish, including listening to music and watching videos and movies in Spanish. The AS said most of the Spanish speaking residents also understood English and that they were able to participate in group activities in English.</p> <p>The AS said Resident #79 went outside three times a day when the weather was nice and the activities staff did one-on-one engagements with him. The AS said Resident #79 liked to talk and watch videos with the activities staff. The AS said Resident #79 liked to be in the common area, watch television, listen to music and read the newspaper. The AS said they were having issues with their daily newspaper account and had to switch to a different publication the last five days that could only be printed in English. The AS said the activities staff had been printing out the publication and reading it aloud in Spanish for the last five days. The AS said the activities staff also printed out news articles in Spanish for Resident #79. The AS said the activities staff documented their one-on-one interactions in the mental activity task log. The AS said Resident #79 was invited to all activities. The AS said Resident #79 was on a formal one-on-one program, which meant he received one-on-one engagements three times per week. The AS said the activities staff would document any refusals in the activity log.</p> <p>The nursing home administrator (NHA) was interviewed on 12/10/24 at 6:35 p.m. The NHA said the AS and her team did the activities assessments for the residents and made them resident centered. The NHA said he was not sure how often the activities team updated their assessments. The NHA said everyone should be invited to group activities.</p> <p>F. Additional information</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Beginning 12/10/24 at 4:38 p.m., multiple late entry formal one-on-one activity progress notes were entered into Resident #79's progress notes, starting on 12/7/24 and going through 8/15/24.</p> <p>50315</p> <p>III. Resident #11</p> <p>A. Resident status</p> <p>Resident #11, age 83, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included unspecified dementia, cognitive communication deficit, muscle weakness and chronic respiratory failure with hypoxia.</p> <p>The 10/22/24 MDS assessment revealed the resident had moderate cognitive impairments with a BIMS score of seven out of 15. She required partial/moderate assistance with hygiene, showering and dressing. She required supervision or touching assistance with walking and transferring.</p> <p>The MDS assessment documented that having books, magazines, and newspapers to read, listening to music, keeping up with the news, doing things with groups of people, doing her favorite activities, going outdoors and participating in religious services was very important to Resident #11.</p> <p>B. Observations</p> <p>During a continuous observation on on 12/4/24, beginning at 1:30 p.m. and ending at 4:30 p.m. the following was observed:</p> <p>At 1:30 p.m. Resident #82 was lying in her bed with the television turned on. AA #2 was walking around asking residents to attend a coloring activity in the dining room. Resident #11 was not offered to attend the activity.</p> <p>During a continuous observation on 12/5/24, beginning at 8:37 a.m. and ending at 11:00 a.m., the following was observed:</p> <p>At 8:37 a.m. Resident #11 was lying in bed with the television turned on and the door closed. AA #2 was offering hand massages to residents sitting in the living room. She did not offer a massage to Resident #11.</p> <p>At 10:22 a.m. the chaplain came to the unit and began a sing along with Christmas music. Resident #11 was not invited to the activity.</p> <p>During a continuous observation on 12/9/24, beginning at 8:30 a.m. and ending at 11:00 a.m., the following was observed:</p> <p>At 8:37 a.m. Resident #11 was lying in bed with her eyes closed and the door was closed.</p> <p>At 9:00 a.m. AA #2 was passing out daily chronicles and did not offer Resident #11 one.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 9:33 a.m. AA #2 started doing an exercise group with the residents sitting in the living room. Resident #11 was not offered to join.</p> <p>At 9:55 a.m. AA #2 was passing out snacks and did not offer resident #11 a snack.</p> <p>At 10:15 a.m. an unidentified chaplain started a church service in the living room. Resident #11 was not invited to attend. The chaplain finished the church service at 10:42 a.m.</p> <p>C. Resident interview and observation</p> <p>Resident #11 was interviewed on 12/9/24 at 2:00 p.m. Resident #11 was sitting up in bed with the television turned on and said she was hungry for a pizza. She said she liked to draw, color and watch movies. She said she loved animals and listening to music. She said she did not have time for church, but she enjoyed it. She started yelling out that she was hungry. There was an activity going on in the dining room where residents were coloring, eating snacks, listening to music and folding towels.</p> <p>-However, based on observations, Resident #11 was not invited to the activities going on in the dining room.</p> <p>D. Record review</p> <p>The quarterly activity assessment, completed 10/2/24, documented Resident #11's favorite activities were taking a nap, staying in her room and having a snack every hour, listening to music, playing bingo, balloon volleyball, sing-along, trivia, special events including holiday related activities, animal related activities, church services, community outreach, outside activities and coloring pictures.</p> <p>It was documented in the resident tasks that Resident #11 participated in a sing along and a drawing/painting activity on 12/4/24 at 4:08 p.m.</p> <p>-However, observations revealed Resident #11 was lying in her bed with the door closed alone at this time (see observations above).</p> <p>It was documented in the resident tasks that Resident #11 participated in religious services on 12/9/24 at 11:15 a.m.</p> <p>-However, observations revealed Resident #11 was lying in her bed with the door closed alone at the time of the religious service (see observations above).</p> <p>It was documented in the resident tasks that Resident #11 accepted a snack on 12/4/24 at 2:20 p.m., 12/5/24 at 9:04 a.m. and on 12/9/24 at 10:00 a.m.</p> <p>-However, Resident #11 was lying in bed with the door closed at this time. Staff was not observed offering a snack to Resident #11 at any of these times.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>It was documented in resident tasks that Resident #11 participated in watching television with others, a men's/women's/focus groups/wellness activity, meal/food/snack social, exercise group and abilities care on 12/4/24 at 4:08 p.m.</p> <p>-However, Resident #11 was lying in her bed with the door closed alone at this time.</p> <p>E. Staff interviews</p> <p>CNA #13 was interviewed on 12/9/24 at 3:45 p.m. CNA #13 said Resident #11 liked to participate in activities. She said she was able to walk by herself with supervision from staff and was forgetful and needed reminders from staff.</p> <p>AA #2 was interviewed on 12/9/24 at 4:15 p.m. AA #2 said Resident #11 used to be on a one to one program for activities but ended because staff were encouraging her to participate in group activities. She said she was actively participating in group activities and enjoyed bingo, coloring, music and church. She said she had refused the activity offered today because she wanted to take a nap.</p> <p>The AD was interviewed on 12/10/24 at 3:15 p.m. The AD said if a resident refused an activity, she would expect the staff to offer a different activity. She said if residents were not willing to participate in a group activity, staff should offer independent or one on one activities. She said Resident #11 participated in group activities lately and enjoyed music, bingo, pets and watching movies. She said if a resident refused an activity, she would expect staff to document refusals.</p> <p>The DON and the CNR were interviewed together on 12/10/24 at 5:00 p.m. The DON said Resident #11 mostly liked to be alone. The DON said she enjoyed some one to one activities, group activities and watching television. He said if she refused to participate in an activity offered, staff should document the refusal.</p> <p>51163</p> <p>IV. Resident #364</p> <p>A. Resident status</p> <p>Resident #364, age 86, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included displaced intertrochanteric fracture of the left femur (break of the left upper thigh bone), history of falling, cognitive communication deficit and dementia.</p> <p>The 11/19/24 MDS assessment revealed Resident #364 had short term and long term memory problems and her cognitive skills for daily decision making was severely impaired per staff assessment. The assessment revealed she was dependent on staff or needed substantial to maximal assistance with the majority of her ADLs.</p> <p>The MDS assessment further revealed that it was very important to her to do her favorite activities, to go outside and get fresh air and keep up with the news.</p> <p>B. Observations</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/4/24 at 3:06 p.m. an unidentified activities staff member was asking the residents if they wanted to go and play Bingo. The unidentified activities staff member did not ask Resident #364.</p> <p>At 3:54 p.m. Resident #364 was seen placing her forehead on the bedside table in the common area. The television was still playing in the common area, no other activities had been offered to her.</p> <p>During a continuous observation on 12/5/24, beginning at 10:30 a.m. and ending 5:00 p.m., the following was observed:</p> <p>At 10:50 a.m. Resident #364 was in bed and has tried to get up multiple times, each time staff has laid her back down in her bed. No one offered the resident a meaningful activity.</p> <p>During a continuous observation on 12/9/24, beginning at 3:30 p.m. and ending at 7:00 p.m., the following was observed:</p> <p>At 4:26 p.m. an unidentified activities staff member invited residents to do a word search. Resident #364 was not invited to participate.</p> <p>C. Record review</p> <p>The activities care plan, revised on 11/22/24 documented Resident #364 was dependent on staff for activities, cognitive stimulation and social interaction. The care plan documented that she preferred to watch sports, listen to music, go outdoors, gardening, conversing with others and her preferred hobby was to go shopping at the grocery stores. Interventions included inviting the resident to all scheduled activities and providing her with materials for individual activities as desired.</p> <p>The activities admission evaluation, dated 11/22/24 indicated that the resident was interested in exercise groups, sports, music, singing, shopping, going outside, and being around animals.</p> <p>According to the one on one activity tracker (11/15/24 to 12/10/24), Resident #364 had been provided one, one on one activity which was nail care on 12/6/24.</p> <p>According to the independent activity tracker, Resident #364 was active in exploring the environment, observing her surroundings, and walking/wheeling.</p> <p>D. Staff interviews</p> <p>CNA #14 was interviewed on 12/10/24 at 12:58 p.m. CNA #14 said that after the residents had been at the facility for a while the staff got to know them. She said when sundowning began to happen in the afternoon it was important to have activities to help redirect the residents. She said Resident #364 changed from day to day, she said that yesterday (12/9/24) she was up and wanted to get up and go but today she wanted to be left alone.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The activities supervisor (AS) was interviewed on 12/10/24 at 1:15 p.m. The AS said all of the residents were on a one-to-one engagement program, which was when the residents were taken out of their room and the activities staff would sit with them and play games or whatever the resident liked to do. She said for residents that were really confused, they tried to find things that really connected with them, such as with Resident #364. She said that they were still trying to figure out what she was interested in. The AS said they also asked the CNAs and the residents family members what they had noticed that the resident liked. The AS said she expected her staff to invite all of the residents to the different activities that were occurring.</p> <p>The DON was interviewed on 12/10/24 at 6:23 p.m. The DON said that both the activities staff and the CNAs should have invited all of the residents to activities. He said when residents were exit seeking due to their confusion that staff should constantly be redirecting the resident. He said the staff should be taking the residents to activities as a redirection, even if the resident was confused.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50219</p> <p>Based on record review and interviews, the facility failed to ensure one (#113) of one resident received treatment and care in accordance with professional standards of practice out of 51 sample residents.</p> <p>Specifically, the facility failed to provide timely treatment when Resident #113 was experiencing several episodes of diarrhea.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Change of Condition Reporting policy and procedure, revised October 2020, was received from the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It read in pertinent part, It is the policy of this facility that all changes in resident condition will be communicated to the physician.</p> <p>All symptoms and unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life threatening.</p> <p>The nurse will document the resident change of condition and response in nursing progress notes, on the 24-hour report or dashboard and update the resident care clan, as indicated in the clinical meeting.</p> <p>The licensed nurse responsible for the resident will continue assessment and documentation every shift for at least seventy-two (72) hours or until condition has stabilized.</p> <p>II. Resident #113</p> <p>A. Resident status</p> <p>Resident #113, age 71, was admitted on [DATE]. According to the November 2024 computerized physicians orders (CPO), diagnoses included cognitive communication deficits, muscle weakness, sepsis and syncope (a loss of consciousness for a short period of time, or fainting).</p> <p>The 11/18/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15.</p> <p>The MDS assessment revealed the resident was frequently incontinent of both bowel and bladder.</p> <p>B. Resident representative interview</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #113's representative was interviewed on 12/10/24 at 2:00 p.m. The representative said Resident #113 was immobile and had severe diarrhea when he first admitted to the facility. The representative said Resident #113 requested an anti-diarrheal medication on 10/31/24, 11/1/24 and 11/2/24. The representative said she received a phone call on 11/2/24 from Resident #113 and he told her he was having diarrhea. Resident #113's representative said she called the facility and requested an anti-diarrheal medication for Resident #113. She said the facility ordered the medication for the resident the next day (11/3/24).</p> <p>C. Record review</p> <p>The October 2024 and November 2024 bowel movement and bowel continence records for Resident #113 revealed the following:</p> <ul style="list-style-type: none"> -On 10/31/24 at 9:56 p.m. the resident had a large loose stool; -On 11/1/24 at 8:58 a.m. the resident had a loose stool at 8:58 a.m.; -On 11/1/24 at 3:17 p.m. the resident had a formed stool; -On 11/2/24 at 5:28 a.m. the resident had a large loose stool; -On 11/2/24 at 9:37 a.m. the resident had a loose stool; -On 11/2/24 at 4:16 p.m. the resident had a formed stool; -On 11/3/24 at 5:31 a.m. the resident had a large loose stool; -On 11/3/24 at 9:19 a.m. the resident had a large loose stool; and, -On 11/3/24 at 4:53 p.m. the resident had a formed stool. <p>A daily skilled nursing note, dated 11/1/24 at 8:42 a.m., revealed no active gastrointestinal symptoms were observed for Resident #113.</p> <p>-However, Resident #113 had an episode of a large loose stool the night before (10/31/24).</p> <p>A nursing progress note, dated 11/3/24 at 12:17 p.m., revealed Resident #113 experienced diarrhea and nausea. The nurse called the physician and received orders for an anti-nausea medication and Imodium (anti-diarrheal medication).</p> <p>-However, Resident #113 had six episodes of large loose stools between 10/31/24 and 11/3/24 before a physician's order for an antidiarrheal medication was obtained (see above).</p> <p>A grievance report, dated 11/3/24, revealed Resident #113's representative expressed her concern about the fact that Resident #113 had been having diarrhea since 11/1/24 with no medications administered. Interventions listed for this report included speaking to the floor nurse, who spoke with the physician and received an order for Imodium.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #113's November 2024 CPO revealed a physician's order for Imodium 2 milligram (mg) tablets. Give one tablet by mouth every six hours as needed for diarrhea for five days, ordered 11/3/24 at 12:19 p.m.</p> <p>The November 2024 medication administration record (MAR) revealed Resident #113 received two doses of Imodium on 11/3/24. The first dose was at 3:04 p.m. and was marked as being effective. The second dose was given at 8:18 p.m. and was marked as unknown for its efficacy.</p> <p>D. Staff interviews</p> <p>Certified nurse aide (CNA) #10 was interviewed on 12/9/24 at 6:14 p.m. CNA #10 said if a resident had diarrhea, she would alert the nurse.</p> <p>Licensed practical nurse (LPN) #5 was interviewed on 12/10/24 at 6:00 p.m. LPN #5 said if a resident had one bout of diarrhea, he would look at the bowel movement records and the resident and see if it was something concerning or maybe just a result of something the resident ate. LPN #5 said if the bowel movement was concerning he would alert the physician. LPN #5 said if a resident was having multiple bouts of diarrhea he would fill out a change of condition form in the resident's electronic medical record (EMR), alert the physician and follow the orders the physician gave.</p> <p>The director of nursing (DON) and the CNR were interviewed together on 12/10/24 at 5:12 p.m. The DON said when a resident had diarrhea, they were put on monitoring for 72-hours and the provider was notified. The DON said if the resident had any stool softeners in their orders, the stool softener would be put on hold. The DON said this procedure was done for even one bout of diarrhea.</p> <p>The DON said the provider needed to be notified if a resident had diarrhea, as the diarrhea could be occurring for a number of reasons, including medication side effects or a bacterial infection.</p> <p>The CNR said if Resident #113 was having multiple bouts of loose stools, the provider should have been notified timely. The CNR said the provider would take into account any medications the resident was on that could cause diarrhea as a side effect. The DON and the CNR reviewed Resident #113's record but were unable to locate any progress notes related to Resident #113's diarrhea prior to the note which documented the physician was notified and prescribed Imodium for the resident on 11/3/24.</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on observation, record review and interviews, the facility failed to ensure supervision and interventions to prevent accidents for one (#88) of twelve residents reviewed for accidents of 51 sample residents.</p> <p>Specifically, the facility failed to ensure fall interventions were implemented for Resident #88 who had experienced several falls.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Fall Monitoring and Management policy and procedure, revised March 2024, was received from the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It documented in pertinent part, It is the policy of this facility that residents are assessed and evaluated to identify risks for injury due to falls, residents receive necessary treatment and monitoring after a fall and interventions are implemented to minimize risks for injury due to falls. The interdisciplinary team (IDT) will place a fall IDT note in the computer with verification of interventions or new interventions.</p> <p>II. Resident #88</p> <p>A. Resident status</p> <p>Resident #88, age 77, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included unspecified dementia, history of falling, cognitive communication deficit, lack of coordination, unsteadiness on feet and muscle weakness.</p> <p>According to the 9/25/24 minimum data set (MDS) assessment, the resident had severe cognitive impairments with a brief interview for mental status (BIMS) score of three of 15. The resident suffered one fall without injury since the previous MDS assessment. She required partial/moderate assistance for hygiene, toileting, showering, dressing and transferring. She required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) for walking. She used a walker regularly in the past seven days.</p> <p>B. Observations</p> <p>During a continuous observation on 12/4/24, beginning at 9:15 a.m. and ending at 12:10 p.m. the following was observed:</p> <p>Resident #88 was in the dining room with a group of residents for an exercise activity. She wandered out of the dining room and into the hallway. She walked three laps in the hallway at 9:15 a.m. without a walker. A certified nursing aide (CNA) walked past her and did not offer a walker or assistance with ambulation. She sat down on a couch in the living room at 9:25 a.m. She was not wearing a soft helmet.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a continuous observation on 12/4/24, beginning at 1:30 p.m. and ending at 4:30 p.m., the following was observed:</p> <p>At 2:31 p.m. Resident #88 was sitting on a couch in the hallway. She got up by herself and walked toward another resident's room. She turned around and walked down the hallway. There was an unidentified CNA taking vital signs in the hallway and she did not offer to get Resident #11's walker or offer assistance with ambulation. She was not wearing a soft helmet.</p> <p>During a continuous observation on 12/9/24, beginning at 8:30 a.m. and ending at 12:40 p.m., the following was observed:</p> <p>At 8:45 a.m. Resident #88 was walking around the unit without a walker. CNA #6 walked past her and did not offer assistance with ambulation or a walker. She was not wearing a soft helmet.</p> <p>At 8:50 a.m. Resident #88 was walking around the hallway without her walker or assistance. She was not wearing her helmet.</p> <p>At 10:05 a.m. Resident #88 was observed holding onto a side railing in the hallway. A nurse was with and calling out for someone to get her a wheelchair. A CNA brought a wheelchair and they assisted the resident into a seated position into the chair. She was not wearing a soft helmet.</p> <p>At 12:30 a.m. Resident #88 was observed walking around the unit. There was an unidentified CNA that walked past the resident without offering a walker, wheelchair or assistance with ambulation. She was not wearing a soft helmet.</p> <p>C. Record review</p> <p>The care plan for falls, initiated 4/3/24 and revised 9/25/24, identified the resident had a history of dementia, seizure disorder, used high risk medications, had poor safety awareness, had muscle weakness, difficulty walking, unsteadiness on her feet, lack of coordination and history of falling. Interventions included ensuring the resident was wearing appropriate footwear when ambulating or wheeling in wheelchair (initiated 4/3/24), keeping needed items (water) in reach (initiated 4/3/24), maintaining a clear pathway free of obstacles (initiated 4/3/24) and, offering a soft helmet and hipsters (padded shorts) as resident allows (4/3/24).</p> <p>-However, observations revealed the resident was not wearing the soft helmet (see observations above).</p> <p>An additional fall care plan, initiated on 9/5/24 and revised on 11/28/24, revealed the resident had a fall related to poor balance and poor communication/comprehension.</p> <p>Interventions for the fall documented on 9/4/24 (initiated 9/5/24) included physical therapy (PT) to screen the resident, offering toileting after meals and routine blood work ordered for hyperthyroidism.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interventions for the fall documented on 9/26/24 (initiated 9/30/24) included PT to assess for new pain and report to floor nurse, recommended labs and medication review and to continue therapy. Interventions for the fall documented on 10/11/24 (initiated 10/14/24) included therapy to screen as indicated and offering rest periods after meals to address fatigue that may occur post-lunch.</p> <p>Interventions for the fall documented on 10/25/24 (initiated 10/28/24) included to continue PT/occupation therapy (OT)/speech therapy (ST) and to anticipate needs and assist to bed post lunch time as indicated.</p> <p>Interventions for the fall documented on 11/23/24 (initiated 11/25/24) included to assist with frequent repositioning in her wheelchair and to continue PT/OT/ST. Interventions for the fall documented on 11/27/24 (initiated 11/28/24) included to check for labs or urinary analysis (UA) and to continue PT/OT to address mobility and activities of daily living (ADLs).</p> <p>The December 2024 CPO indicated Resident #11 had an order to encourage to wear a soft helmet as the resident would allow, every shift for safety, ordered on 4/3/24.</p> <p>The CNA Kardex (instructions for care) identified that the resident required supervision and up to one staff participation using a gait belt for transfer and walking. It was documented to provide verbal cues for initiation and safe sequencing and to walk to/from meals and bathroom as the resident was willing.</p> <p>1. Fall incident on 9/4/24 - unwitnessed</p> <p>The progress note on 9/4/24 documented that therapy reported to the nurse that the resident was sitting in the hallway on the floor. Prior to the incident she was walking around the unit. The resident had poor safety awareness with diagnosis of dementia.</p> <p>The 9/4/24 fall investigation documented the immediate action that was taken included the registered nurse (RN) assessed the resident and there were no visible injuries noted. A wheelchair was close to where the resident was sitting. The note documented the resident could have been attempting to sit in the wheelchair and missed it and ended up sitting on the floor. The resident had non-slip socks on, the floor around the resident was dry and free of clutter and there was adequate lighting. Initial vital signs were stable, neurological checks were initiated and the guardian and the provider were notified.</p> <p>The fall assessment from 9/4/24 documented the resident was oriented to person, Predisposing factors contributing to the fall included confusion, impaired memory, incontinence and wandering behavior.</p> <p>2. Fall incident on 9/26/24 - unwitnessed</p> <p>The progress note on 9/26/24 documented that staff notified the resident sitting in the hallway, prior to that she was walking/wandering around the unit. She had dementia that made her have a poor sense of safety.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 9/26/24 fall investigation documented immediate action taken included the RN assessed the resident while she was sitting on the floor. The area was clean with no clutter and she was wearing non-slip socks. She appeared to be tired with generalized weakness. There were no neurological changes from baseline. There were no visible injuries noted. She was assisted by two staff members to a wheelchair. The provider and guardian were notified. Lab tests and medication review were recommended and neurological checks were initiated.</p> <p>The fall assessment from 9/26/24 documented the resident was oriented to person, predisposing factors contributing to the fall included gait imbalance, impaired memory, incontinence and wandering behavior.</p> <p>3. Fall incident on 10/11/24</p> <p>The progress note on 10/11/24 documented the staff last saw the resident sitting on a chair in the hallway. The staff heard a noise and observed the resident sitting on the floor. The resident was assisted by two staff members back into a wheelchair and sat by the television. The resident got up again after a couple hours and fell again.</p> <p>The 10/11/24 fall investigation documented immediate action taken included the resident was assessed by a nurse and helped up by two staff. No injuries were noted. All range of motion (ROM) were active, the resident was wearing non-slip socks, hipsters and the floor was free from clutter. Neurological checks were initiated and stable. The family and provider were notified.</p> <p>The fall assessment from 10/11/24 documented the resident was oriented to person, predisposing factors contributing to the fall included confusion and wandering behavior.</p> <p>4. Fall incident on 10/25/24 - unwitnessed</p> <p>The progress note on 10/25/24 documented the resident was found sitting on the floor during rounds. The resident was unable to describe the incident due to unspecified dementia. A head to toe assessment was completed by the RN supervisor. The resident was stable and had no signs of pain or discomfort.</p> <p>The 10/25/24 fall investigation documented immediate action taken included a head to toe assessment. The resident had a black eye. She was assisted into the wheelchair with a gait belt. Neurological checks were initiated and vital signs were normal. She was at baseline for ROM. Responsible parties were notified.</p> <p>The fall assessment from 10/25/24 documented the resident was oriented to person, predisposing factors contributing to the fall included confusion, gait imbalance, impaired memory, incontinence, ambulating without assistance and wandering behavior.</p> <p>5. Fall incident on 11/23/24- witnessed</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The progress note on 11/23/24 documented the resident had a witnessed fall. Before the fall, the resident was sitting in a wheelchair close to the couch in the common area watching television. The fall occurred while the resident was attempting to self-transfer to a nearby couch. The staff were unable to prevent the fall due to its unexpected and sudden nature. The RN was notified and assessed the resident. There were no visible injuries noted. Neurological checks were initiated and vital signs were normal. Responsible parties were notified.</p> <p>The 11/23/24 fall investigation documented the immediate action taken included notifying the RN, injury assessment by the RN and assisting the resident into a safe sitting position.</p> <p>The fall assessment from 11/23/24 documented the resident was oriented to person, predisposing factors contributing to the fall included confusion, incontinence, and wandering behavior.</p> <p>6. Fall incident on 11/27/24 - unwitnessed</p> <p>The progress note on 11/23/24 documented the resident was found sitting next to her bed. The nurse went in to check on the resident and the resident had already gotten up by herself. A complete head to toe assessment was done by the RN supervisor. The resident denied any pain or discomfort. The room was well lit, free from clutter and the resident was wearing non-slip socks.</p> <p>The 11/27/24 fall investigation documented the immediate action taken included a head to toe assessment, neurological checks were initiated and vital signs were normal. Responsible parties were notified.</p> <p>The fall assessment from 11/27/24 documented the resident was oriented to person, predisposing factors contributing to the fall included confusion, incontinence, impaired memory, ambulating without assistance and wandering behavior.</p> <p>D. Staff interviews</p> <p>CNA #4 was interviewed on 12/9/24 at 2:45 p.m. CNA #4 said nobody on the unit wore a soft helmet on the unit where Resident #88 resided. He said Resident #88 needed assistance getting dressed daily and the staff assisted her in putting her hipsters on.</p> <p>CNA #13 was interviewed on 12/9/24 at 3:45 p.m. CNA #13 said Resident #88 was a high fall risk. She said she could walk but gets weak sometimes and the staff would get her a wheelchair.</p> <p>Licensed practical nurse (LPN) #2 was interviewed on 12/9/24 at 4:20 p.m. LPN #2 said Resident #88 was a high fall risk. She said interventions to prevent falls for her included offering hipsters, offering a wheelchair or walker, staff to supervise her, and for the staff to walk with her. She said the nurses and the CNAs were responsible for offering the resident to wear a soft helmet and hipsters. She said she could not find Resident #88's soft helmet.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The director of nursing (DON) and the CNR were interviewed together on 12/10/24 at 5:00 p.m. The DON said Resident #88's mood and activity level fluctuated from day to day. He said sometimes she wanted to be left alone and other times she engaged in activities with others. He said she was working with therapy and used a walker and required the assistance of one to two staff members for ambulation. He said she got up on her own often and the staff were expected to intervene and walk with her when this occurred. He said based on assessment and previous falls, she was considered a high fall risk. He said fall interventions for her included wearing hipsters, a soft helmet, a fall mat beside her bed and ensuring her bed was in the lowest position. He said with the acuity of the resident population on the unit Resident #88 lived on, the staff were not able to keep an eye on everybody at all times. He said fall interventions were continually assessed and new ones were added if old ones were no longer working.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on observation 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.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure staff followed appropriate hand hygiene during resident care; -Ensure shared vital signs equipment was sanitized between use; and, -Ensure appropriate infection control standards were followed during meals. <p>Findings include:</p> <p>I. Ensure staff followed appropriate hand hygiene during resident care and ensure shared vital signs equipment was sanitized between use</p> <p>A. Professional reference</p> <p>According to the Centers for Disease Control and Prevention (CDC) Recommendations for Hand Hygiene for Healthcare Workers, (2024), retrieved on 12/11/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, CDC provides the following recommendations for hand hygiene in healthcare settings. Know when to clean your hands: immediately before touching a patient and after touching a patient or a patient's surroundings.</p> <p>According to the CDC Recommendations for Disinfection and Sterilization in Healthcare Facilities, (2024), retrieved on 12/11/24 from https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html#:~:text=Ensure%20that%2C%20at%20a%20minimum,once%20daily%20or%20once%20weekly,Clean medical devices as soon as practical after use. Perform either manual cleaning or mechanical cleaning. Perform low-level disinfection for noncritical patient-care surfaces and equipment (blood pressure cuffs) that touch intact skin.</p> <p>B. Facility policy and procedure</p> <p>The Hand Hygiene policy and procedure, revised October 2022, was received from the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It documented in pertinent part, Hand hygiene is one of the most effective measures to prevent the spread of infection. Use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations: before and after direct contact with residents, after contact with resident's intact skin, after handling used dressings and contaminated equipment and after contact with objects (medical equipment).</p> <p>C. Observations</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Certified nursing aide (CNA) #5 was observed on 12/5/24 during a continuous observation from 2:30 p.m. until 4:30 p.m.</p> <p>At 2:50 p.m. CNA #5 was walking around the Lavender unit with the vital signs cart. She walked into the dining room where the residents were sitting watching a movie. She measured vital signs on the first resident and documented it on a clipboard. She moved the cart to the second resident in the dining room and measured vital signs. She documented it on a clipboard and moved the cart to a third resident in the dining room. She measured vital signs on the resident and documented it on a clipboard. CNA #5 moved the vital signs cart into the hallway and measured vital signs on a fourth resident sitting in the hallway. She documented the vital signs and walked away from the cart.</p> <p>-CNA #5 did not sanitize her hands after each resident care before moving to the next resident</p> <p>-CNA #5 did not sanitize the vital signs cart between residents</p> <p>D. Staff interviews</p> <p>The infection preventionist (IP) was interviewed on 12/10/24 at 1:00 p.m. The IP said she provided hand hygiene education to staff multiple times a year. She said hand hygiene should be done before and after providing resident care, including taking vital signs. The IP said shared medical equipment, including a vital signs cart should be sanitized before and after resident use.</p> <p>The director of nursing (DON) and the clinical nurse resource (CNR) were interviewed together on 12/10/24 at 5:00 p.m. The CNR said it was expected that staff sanitize hands before and after resident care. She said this included when the staff were measuring vital signs. The DON said this was important to ensure germs did not spread from one resident to another. The CNR said she would expect staff to sanitize medical equipment before and after resident use. The DON said this was important to ensure germs did not spread from one resident to another.</p> <p>51160</p> <p>II. Failed to ensure appropriate infection control standards were followed during meals</p> <p>A. Professional reference</p> <p>The CDC (2024), Clinical Safety: Hand Hygiene for Healthcare Workers, was retrieved on 12/11/24 from https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html. It read in pertinent part,</p> <p>Perform hand hygiene before touching a patient, after touching a patient or their surroundings, immediately after glove removal.</p> <p>According to Treas, L.S., [NAME], K.L., & [NAME], M.H. (2022.) Basic Nursing: Thinking, Doing and Caring, (Third edition), pages 1601, 1604-1605, Use standard precautions to prevent the transmission of infection. Implement measures to prevent healthcare-associated infections (HAIs). HAIs are the leading complication of healthcare and one of the ten leading causes of death in the United States. Hand hygiene can remove transient flora (microbes acquired by touching objects or people).</p> <p>B. Observations</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/5/24 at 3:00 p.m. CNA #3 opened a cookie from a cellophane package for Resident #24. CNA #3 handled the cookie with his bare hands as he handed it to Resident #24. CNA #3 had not performed hand hygiene prior to this interaction.</p> <p>On 12/5/24 at 3:28 p.m. CNA #3 was charting on a touch screen computer. When he was finished, he walked over to a table where Resident #54 was seated. He did not perform hand hygiene. Resident #54 had been eating peanut butter filled cheese crackers and some had fallen off of the plate onto the table. CNA #3 picked up the crackers off the table, with a bare hand, and placed them back onto the plate. CNA #3 attempted to remove the plate from the table, however Resident #54 prevented him from taking the plate as she was not finished eating. Resident #54 continued to eat the crackers.</p> <p>During a continuous observation that began on 12/9/24 at 8:20 a.m. and ended at 10:15 a.m. the following was observed:</p> <p>At 8:30 a.m. Resident #60 left the dining room leaving her plate on the table.</p> <p>At 9:03 a.m. after Resident #58 had finished his meal he propelled himself over to the table where Resident #60's plate remained. Resident #58 began to eat food from the plate and then left the dining room.</p> <p>-The staff did not redirect Resident #58 from eating off of Resident #60's plate.</p> <p>At 9:06 a.m. Resident #47 entered the dining room and sat in a chair which had Resident #60's partially eaten meal still on the table. Resident #47 began to eat the fruit from the bowl, then pushed the bowl and plate away.</p> <p>At 9:08 a.m. CNA #1 walked into the dining room and told Resident #47 that her plate had been placed on the table next to her. Resident #47 did not move from her seat and CNA #1 walked away without assisting the resident to move to the other table, or bring her plate to her where she was seated.</p> <p>At 9:13 a.m. the DON entered the dining room. After greeting Resident #47, the DON offered her a cup of coffee and a cookie. Unaware that the plate near Resident #47 was not hers, he encouraged her to eat more food, she declined.</p> <p>During a continuous observation that began on 12/9/24, at 5:33 p.m. and ended at 6:45 p.m., the following was observed:</p> <p>At 5:45 p.m. Resident #60 entered the dining room and was seated at a table. Resident #60 requested that the staff serve her only dessert.</p> <p>At 5:47 p.m. Resident #60 was served a cookie pudding dessert garnished with a wafer cookie. Resident #60 removed the wafer cookie and placed it on the table in front of her.</p> <p>At 5:58 p.m. after Resident #60 finished her first dessert and was offered a second by a staff member. Again, Resident #60 removed the wafer cookie garnish and placed it on the table in front of her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Julia Temple Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 S Lafayette St Englewood, CO 80113	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 6:23 p.m. Resident #58 seated at the next table wheeled himself over to Resident #60 and took the two wafer cookies from her table and ate them. Resident #58 had been seated at a table with Resident #74 who had received feeding assistance from an unidentified staff member during his departure from the table. The unidentified staff member did not intervene when Resident #60 took the two wafer cookies off the table.</p> <p>At 6:26 p.m. Resident #58 was redirected back to his table and meal by the unidentified staff member providing feeding assistance to Resident #74.</p> <p>C. Staff interviews</p> <p>The IP was interviewed on 12/10/24 at 1:28 p.m. The IP said hand hygiene should be performed before and after handling food. The IP said food should not be touched with bare hands, especially if hand hygiene had not been performed.</p> <p>The IP said residents should not eat from other resident's plates. The IP said there was a potential for a negative outcome related to food texture, food allergies and the spread of potential infection.</p> <p>The DON was interviewed on 12/10/24 at 6:24 p.m. The DON said resident food should not be handled with bare hands. The DON said a clean, gloved hand could have been used to remove food from a package or the package could have been opened to allow the resident to take the food from the package.</p> <p>The DON said residents should not eat from each other's plates. The DON said there was a potential negative outcome in consuming the wrong diet texture for a resident along with potential food allergies and potential spread of an infection.</p> <p>The DON said residents consuming other resident food could alter the accuracy of documentation of meal intake percentages of food consumed by residents that required intake monitoring for weight loss or gain. The DON said the facility staff had the responsibility to serve a resident where they were seated or move their plate for them if it was on a different table.</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315</p> <p>Based on record review and interviews, the facility failed to establish an effective antibiotic stewardship program to monitor for antibiotic use for one (#40) of one resident reviewed for antibiotic use out of 51 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Have an effective antibiotic stewardship program by mapping infections timely; and, -Have an effective antibiotic stewardship program to ensure Resident #40 was not given an antibiotic unnecessarily. <p>Findings include:</p> <p>I. Failure to have an effective antibiotic stewardship program by mapping infections timely</p> <p>A. Professional reference</p> <p>According to The Centers for Disease Control and Prevention (CDC) Core Elements of Antibiotic Stewardship for Nursing Homes, (2024), retrieved on 12/11/24 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html</p> <p>Track the amount of antibiotic used in your nursing home to review patterns of use and determine the impact of new stewardship interventions. Antibiotic use data from nursing homes to improve antibiotic stewardship is important both for individual facility improvements and for public health action.</p> <p>B. Facility policy and procedure</p> <p>The Antibiotic Stewardship Program policy and procedure, revised November 2024, was received from the clinical nurse resource (CNR) on 12/10/24 at 9:00 p.m. It documented in pertinent part, The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. At least one measure associated with antibiotic use will be tracked monthly, as prioritized from the facility ' s infection control risk assessment and other infection surveillance data.</p> <p>C. Record review</p> <p>Record of the infection mapping for the month of December 2024 was requested from the IP on 12/10/24 at 1:00 p.m. The infection preventionist (IP) said she was unable to provide the infection mapping as she did not complete it until the end of the month (see interviews below).</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The IP was interviewed on 12/10/24 at 1:00 p.m. The IP said the facility had a monthly infection control meeting and a monthly quality assurance and performance improvement (QAPI) meetings with the medical director to discuss house-acquired infections, trends in illnesses and some antibiotic review if clarification was needed. She said at the end of each month, she mapped out all the infections from that month to identify trends in infections.</p> <p>The director of nursing (DON) and the CNR were interviewed together on 12/10/24 at 5:00 p.m. The DON said infections should be mapped out as soon as they were identified. He said this was important so the facility can determine if there was a pattern in infections.</p> <p>50219</p> <p>II. Failure to have an effective antibiotic stewardship program to ensure Resident #40 was not given an antibiotic unnecessarily.</p> <p>A. Resident #40</p> <p>1. Resident status</p> <p>Resident #40, age 83, was admitted on [DATE]. According to the December 2024 computerized physicians orders (CPO), diagnoses included dementia, cognitive communication deficits and generalized muscle weakness.</p> <p>The 10/9/24 minimum data set (MDS) revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) assessment score of 11 out of 15.</p> <p>The assessment revealed the resident was always continent of bowel and bladder and required supervision or touching assistance for toileting hygiene.</p> <p>The assessment did not indicate Resident #40 was on an antibiotic.</p> <p>2. Record review</p> <p>The incontinence care plan, dated 6/3/2020, revealed Resident #40 was at risk for complications associated with incontinence and had a history of urinary tract infections (UTIs). Pertinent interventions included encouraging fluids during the day, checking the resident as required for incontinence and observing the resident for any signs or symptoms of a UTI.</p> <p>A provider note, dated 11/5/24 at 3:40 p.m., revealed Resident #40 was seen by the physician per her representative 's request. The note revealed the representatives had recently visited and noted a cognitive decline with Resident #40 and were concerned about a UTI. Resident #40 denied any urinary symptoms that day, said she felt well and appeared to be at baseline. In the assessment and plan, the note documented that the provider suspected the cognitive decline was due to the progression of Resident #40 's dementia but ordered bloodwork to rule out concern for an infection or electrolyte disturbance given the representative 's concern.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A progress note, dated 11/26/24 at 11:18 a.m., revealed Resident #40 had a change in condition. Resident #40 had a functional decline and altered mental status. Resident #40 ' s vitals were taken at that time and were within normal limits and did not have a fever. Resident #40 ' s provider and representative were notified.</p> <p>A progress note, dated 11/26/24 at 1:10 p.m., revealed there was a lab sample waiting for pickup for Resident #40.</p> <p>A progress note, dated 11/26/24 at 1:45 p.m., revealed Resident #40 ' s provider had assessed the resident and a new order to obtain a urinalysis via a straight catheter was obtained and to perform a culture and sensitivity if indicated.</p> <p>-However, Resident #40 did not meet the McGeer criteria to obtain a urine sample. Resident #40 had an acute onset of altered mental status, but did not have fluctuating behavior, altered level of consciousness, or inattention during her assessment (see below). Additionally, Resident #40 did not have a three point decrease in functional ability in her activities of daily living (ADLs), was afebrile, and did not yet have current bloodwork results available for review for elevated white blood cell counts.</p> <p>A provider note, dated 11/26/24 at 3:40 p.m., revealed Resident #40 was evaluated by the facility nurses ' request due to increased confusion and altered gait. Resident #40 was pouring sugar packets onto the table at breakfast instead of into her coffee. An unidentified certified nurse aide (CNA) reported to the provider Resident #40 was having new urinary incontinence and frequency. There was concern for infection or possible reaction to a vaccine Resident #40 had received the day prior. In her exam, Resident #40 was more confused than usual and denied any suprapubic tenderness or pain. The provider ordered bloodwork as well as a urinalysis with urine culture to evaluate further.</p> <p>A progress note dated 11/27/24 at 8:34 a.m. revealed Resident #40 ' s functional ability had improved, appetite increased, and confusion had decreased.</p> <p>A progress note dated 11/27/24 at 11:45 a.m. revealed Resident #40 ' s urinalysis results were received and reviewed by the provider. A new order was received from the provider for Bactrim (antibiotic) twice a day for five days.</p> <p>A progress note dated 11/27/24 at 11:55 a.m. revealed a change of condition form for Resident #40. The note documented Resident #40 had a UTI and vitals were assessed at that time. All vitals were within normal limits and no fever was reported. The provider and Resident #40 ' s representatives were both notified.</p> <p>An infection surveillance report dated 11/27/24 at 1:18 p.m. revealed which criteria Resident #40 met when reviewing the resident for antibiotic stewardship.</p> <p>For constitutional criteria, it was documented that Resident #40 had an acute change in mental status from baseline and an acute functional decline in ADLs.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>For ADLs, Resident #40 was marked mostly dependent for all areas for both baseline and current, and did not have any functional decline indicated. In the surveillance by body systems section, it was noted that Resident #40 had a UTI, acute dysuria (painful or uncomfortable urination), suprapubic pain, and a new or marked increase in urinary urgency.</p> <p>In the section for provider review, it was indicated that the antibiotic was reviewed with the provider to ensure it was a true infection, the right antibiotic, right dose, right route, and right duration. The infection preventionist note revealed it was a healthcare acquired infection and met criteria for infection.</p> <p>Additional notes revealed Resident #40 had a change of condition on 11/26/24 with increased confusion and decrease in functional ability. A urinalysis was ordered and the results showed +1 leukocyte esterase with a urine culture pending. The provider was notified and a new order received. Resident #40 was to start on an oral antibiotic for a UTI until 12/2/24.</p> <p>Bloodwork results for Resident #40 were reported to the facility on [DATE] at 8:44 a.m. A review of the bloodwork results revealed two abnormal values:</p> <ul style="list-style-type: none"> -Nine hundred and ninety seven cells per microliter (uL) absolute monocytes, with a normal reference range of 200-950 cells per uL; and, -Twelve cells per uL absolute eosinophils, with a normal reference range of 15-500 cells per uL. <p>Urinalysis and urine culture results for Resident #40 were reported to the facility on [DATE] at 10:11 a.m. A review of the urinalysis results revealed four abnormal values:</p> <ul style="list-style-type: none"> -One plus leukocyte esterase, with a normal reference range of zero; -Six to ten white blood cells per high power field (HPF), with a normal reference range of zero to five; -Six to ten squamous epithelial cells per HPF, with a normal reference range of zero to five; and, -One plus ketones, with a normal reference range of zero. <p>The urine culture did not have any bacterial growth.</p> <p>-However, Resident #40 remained on antibiotics after the urine culture results were received by the facility despite there being no bacterial growth on the urine culture (see interview below).</p> <p>Review of the November 2024 and December 2024 medication administration records (MAR) revealed Resident #40 received one tablet of Bactrim Ds 800-160 milligrams twice daily, starting at 7:00 p.m. on 11/27/24 and ending at 6:00 a.m. on 12/2/24.</p> <p>3. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The infection preventionist (IP) was interviewed on 12/10/24 at 1:08 p.m. The IP said the facility followed the McGeer criteria for determining infections in the facility. The IP said she spoke with the provider that ordered the antibiotic if said antibiotic was not meeting criteria, not the medical director (MD). The IP said she met with the MD once a month for an infection control meeting but would call the MD if she had any concerns. The IP said she did not call the MD to go over every antibiotic, but would get called if she had concerns and could not get ahold of the ordering provider. The IP said the MD did not review every antibiotic during their quality assessment meetings, only the antibiotics with which the IP had concerns.</p> <p>The IP said Resident #40 had a change of condition on 11/26/24, at which point the provider ordered a urinalysis. The IP said the urinalysis results came back on 11/27/24 and Resident #40 was started on Bactrim that day prior to her urine culture results coming in. The IP said Resident #40 met McGeer ' s criteria to collect a urinalysis as she had one plus leukocytes and altered mental status. The IP said Resident #40 ' s urine culture results were reviewed on 11/28/24. The IP said when a urine culture came back with no growth, they needed to discontinue the antibiotic. The IP said she was not sure how Resident #40 ' s urine culture was missed. The IP said the provider should wait for the urine culture results prior to using antibiotics so that the provider knows what bacteria has grown, if any, and so that the resident does not take an antibiotic unnecessarily. The IP said in reviewing the infection surveillance note the area indicating Resident #40 was having suprapubic pain may have been clicked by accident, as the resident did not have any pain. The IP clarified Resident #40 only had altered mental status, but did not meet any other criteria to collect a urinalysis. The IP said if Resident #40 did not meet criteria, a urinalysis should not have been ordered.</p> <p>The director of nursing (DON) and the clinical nurse resource (CNR) were interviewed on 12/10/24 at 5:12 p. m. The DON said the facility followed the McGeer criteria for determining infections in the facility. The CNR said if a physician ordered a urinalysis but the resident did not meet the McGeer criteria, the IP would notify the physician that they did not meet criteria and would document this in the medical record. The CNR said the resident had to meet McGeer ' s criteria in order to obtain a urine sample for a urinalysis.</p> <p>The DON said the IP reviewed residents ' lab work and communicated with the residents ' providers. The DON said the IP and the prescribing physician worked to make a determination with regard to the resident being on an antibiotic or if they should discontinue its use.</p> <p>The CNR said a culture and sensitivity were part of the McGeer criteria and that the provider needed to wait to see the culture results prior to starting an antibiotic. The CNR said the IP needed to look at the criteria the resident met and see if a urinalysis was indicated. The CNR said after the lab work was received, the IP needed to communicate with the resident ' s physician and tell them the labwork results and see if they could discontinue the antibiotic.</p>		