

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Valley View Health Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 N 10th St Canon City, CO 81212	

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 - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>40960</p> <p>Based on observations and interviews, the facility failed to provide a meal service for residents in a manner and in an environment that maintained or enhanced the residents' dignity and respect in full recognition of their individuality for residents served in two of two dining rooms.</p> <p>Specifically, the facility failed to ensure an adequate system was in place to provide meal services in a timely fashion to residents waiting to be served and seated in the dining room.</p> <p>I. Facility policy</p> <p>The Frequency of Meals policy, revised July 2017, was provided by the nursing home administrator (NHA) on 5/15/24 at 1:27 p.m. It read in pertinent part, The facility will serve at least three meals or their equivalent daily at scheduled times. Meals will be served four to six hours apart to help assure that residents receive nutritional requirements. A schedule of meal times and snacks shall be posted in resident areas.</p> <p>II. Posted meals</p> <p>The posted meal times for the main dining room were scheduled to begin breakfast at 7:00 a.m. to 8:30 a.m., lunch at 11:00 a.m. to 12:30 p.m. and dinner at 5:00 p.m. to 6:30 p.m.</p> <p>III. Resident interviews</p> <p>Resident #47 was interviewed on 5/14/24 at 11:56 a.m. Resident #47 said lunch was supposed to be served at 11:00 a.m. everyday but it was always late. Resident #47 said it was quite boring sitting at the table waiting to be served his meal.</p> <p>Resident #1 was interviewed on 5/14/24 at 12:00 p.m. Resident #1 said lunch was supposed to be served at 11:00 a.m. However, he said it was always served late and he would fall asleep waiting to be served. Resident #1 said the dietary staff always served the room trays first.</p> <p>Resident #41 was interviewed on 5/14/24 at 12:22 p.m. Resident #41 said the lunch meal was always served late. She said sometimes she would have to leave her food on the table and return to her room to use the bathroom because she had to wait for so long. She said when she returned from the bathroom her meal was cold.</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 - Some</p>	<p>III. Observations</p> <p>The main dining room was observed on 5/13/24 at 10:54 a.m. The main dining room was divided into the left dining room and the right dining room. There were two residents sitting in the right dining room and four residents sitting in the left dining room. There were two tables that were broken. One was not being used and the other had one resident sitting at it.</p> <p>During a continuous observation on 5/13/24 during the lunch meal, beginning at 10:54 a.m. and ended at 12:16 p.m., the following was observed in the main dining room:</p> <p>-At 11:27 a.m. staff began to serve residents their drink of choice. Lunch had not been served.</p> <p>-At 11:59 a.m. a resident entered the dining room and was told by staff there was not a place for her to sit and she would have to wait for an empty seat.</p> <p>-At 12:16 p.m. the first resident was served lunch.</p> <p>The lunch meal service was one hour and 16 minutes late.</p> <p>During a continuous observation on 5/14/24 during the lunch meal, beginning at 11:00 a.m. and ended at 12:39 p.m., the following was observed in the main dining room:</p> <p>-At 11:00 a.m. residents started entering the dining room for lunch.</p> <p>-At 11:36 a.m there were 26 residents in the dining room waiting to be served lunch.</p> <p>-At 11:45 a.m. one resident in the right dining room was served his meal and an unidentified staff member sat with him to assist.</p> <p>-At 11:59 a.m. a certified nurse aide (CNA) asked for the first resident's lunch order.</p> <p>-At 12:05 p.m. the first resident was served in the left dining room. Four residents in the left dining room were observed sleeping. Another resident entered the dining room. However, there were no chairs available to sit in. He exited the dining room.</p> <p>-At 12:20 p.m. Resident #1 asked the staff for a yogurt and was told the facility did not have any more yogurt. Another resident asked for orange juice and was told the facility was out of orange juice.</p> <p>-At 12:22 p.m. all residents in the left dining room had received their lunch. The staff began to serve the right dining room.</p> <p>-At 12:39 p.m. the last resident was served lunch.</p> <p>The lunch meal was not completed until 12:39 p.m., one hour and 39 minutes after the posted meal time of 11:00 a.m.</p> <p>IV. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48113</p> <p>Based on interviews and record review, the facility failed to ensure one (#10) of fifteen residents reviewed for choices out of 32 sample residents remained free of resident right restrictions in order to promote and facilitate resident self- determination.</p> <p>Specifically the facility failed to ensure Resident #10 received baths consistently according to his choice of frequency and bathing preference.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Dignity policy and procedure, revised February 2021, was provided by the nursing home administrator (NHA) on 5/15/24 at 4:30 p.m. It revealed in pertinent part, The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident' s facility stay.</p> <p>II. Resident #10</p> <p>A. Resident status</p> <p>Resident #10, age less than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included personal history of traumatic brain injury, mononeuropathy of unspecified lower limb (nerve damage), other chronic pain, other muscle spasm, polyneuropathy (nerve damage) and unspecified psychotic disorder with delusions due to known physiological condition.</p> <p>The 4/25/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score 12 out of 15. He required set-up assistance for eating and oral hygiene. He was dependent on staff for toileting hygiene. He required substantial assistance for showering and required moderate assistance for personal hygiene.</p> <p>The assessment indicated the resident did not refuse care within the review period.</p> <p>B. Resident interview</p> <p>Resident #10 was interviewed on 5/13/24 at 2:23 p.m. Resident #10 said he preferred to receive assistance with bathing on Wednesdays and Saturdays. He said he preferred to take a bath over a bed bath. He said the staff told him if they could not give him his bath on his preferred bath day they would make it up to him later in the week. He said the staff did not follow-up later in the week to give him his missed bath. Resident #10 said there were no scheduled bath aides on the weekends and the certified nurse aides (CNA) would refuse to help him bathe.</p> <p>C. Record review</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident' s bathing preferences were reviewed on 5/14/24 at 1:30 p.m. The resident' s bathing preferences documented the resident wanted to have assistance taking a tub bath on Wednesdays and Saturdays.</p> <p>The resident's activities of daily living (ADL) bathing task logs for the month of March 2024 through May 2024 (3/1/24 to 5/14/24) were reviewed on 5/14/24 at 1:35 p.m. The task logs revealed the resident did not receive his baths according to his specified day preferences of Wednesdays and Saturdays for six baths out of 17 opportunities.</p> <p>The task logs further revealed the resident did not receive one tub bath as he specified, but instead, he received a bed bath on one out of 17 opportunities.</p> <p>III. Staff interviews</p> <p>CNA #2 was interviewed on 5/15/24 at 11:37 a.m. CNA #2 said that it was hard to give all of the residents their baths/showers, especially on the weekends. She said there was no bath aide scheduled on the weekends. She said the CNAs were busy attending to the residents' other needs. CNA #2 said other CNAs often refused to give residents their baths on the weekends because they did not believe it was their responsibility and they thought the responsibility fell on the bath aide.</p> <p>CNA #2 said she had a sheet which had all of the residents' preferred shower/bath days on it. She said Resident #10 preferred to receive baths on Wednesdays and Saturdays.</p> <p>Registered nurse (RN) #1 was interviewed on 5/14/24 at 11:45 a.m. RN #1 said he was not sure why Resident #10 did not receive his baths on his preferred days. He said Resident #10 should receive baths per his preference in order to make sure the resident' s choices in his home were followed and also to give the resident a sense of control in their home. RN #1 said it was all of the staff' s responsibility to ensure the resident received baths according to his preferred days and bathing type. He said the responsibility would not only fall on the bath aide, but the CNAs should be able to help with showers/baths in addition.</p> <p>The director of nursing (DON) was interviewed on 5/15/24 at 2:14 p.m. The DON said the residents had the right to make their own choices. She said the residents should get their baths on their preferred days and preferred bathing type. The DON said the CNA staff were under the wrong impression that the bath aide was responsible for all the baths and that he had been addressing the issue through education with the staff.</p> <p>The nursing home administrator (NHA) was interviewed on 5/14/24 at 3:45 p.m. The NHA said residents' choices and or preferences should be adhered to. The NHA said the DON had provided education to the CNA staff to clarify roles and responsibilities and to ensure baths were adhered to on the residents' preferred days and according to their preferred bathing type.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48113</p> <p>Based on record review and interviews, the facility failed to incorporate the recommendations from the PASRR (preadmission screening and resident review) Level II determination and evaluation report into the assessment, care planning and transition of care for one (#2) of five residents out of 32 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Take steps to ensure services were provided as recommend in Resident #2 's PASRR Level II report; and, -Ensure the PASRR recommendations were included in Resident #2 's care plan. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The PASRR Completion policy, revised 9/26/23, was provided by the nursing home administrator (NHA) on 5/16/24 at 4:30 p.m. It read in pertinent part, If the resident has a PASRR Level II, the community is responsible for ensuring that any recommendations from the PASRR Level II are implemented and care planned for the resident.</p> <p>II. Resident status</p> <p>Resident #2, age less than 65, was admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included personality change due to known physiological condition, personal history of traumatic brain injury, psychotic disorder with hallucinations due to known physiological condition and anxiety disorder.</p> <p>The 3/4/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview of mental status (BIMS) score of five out of 15.</p> <p>The assessment indicated the resident required supervision assistance with eating. He required partial assistance with oral hygiene and personal hygiene. He was dependent on staff for toileting and showering.</p> <p>The assessment indicated the resident had not been evaluated for a PASRR Level II.</p> <p>-However, the resident had been evaluated for a PASRR Level II and had recommendations (see record review below).</p> <p>III. Record review</p> <p>(continued on next page)</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Resident #2 's PASRR Level II, dated 12/21/16, revealed the resident had inappropriate social behavior and physical aggression. Resident #2 could be sexually inappropriate with staff and peers alike. He tended to touch females in their breast and buttocks region when they were close by. He also used rude gestures frequently and it was unclear if the use of these gestures was related to some type of frustration on his part. The behavior continued despite redirection and per his neuropsychological report, would likely continue on an ongoing basis given the resident 's severe cognitive impairments. When the behaviors occurred, staff was to calmly redirect Resident #2 with clear and simple directions such as please don't touch me (directions more complex would not be understood by Resident #2 given his cognitive impairments). The PASRR Level II documented it may have been helpful to observe what was going on in the environment before the behaviors occurred as the staff tried to identify the triggers for the behavior. If the triggers could be identified, staff could work to anticipate the resident 's needs and ultimately and hopefully curb the concerns. Staff needed to have a plan in place so that he was not allowed to touch his peers inappropriately. The plan should address all areas of the resident's day, to include passing others in the hall and sitting in the dining room and common areas, as well as any possible roommate concerns.</p> <p>The PASRR Level II documented the services were to be provided by a qualified community mental health professional such as individual therapy twice monthly. The facility was to offer psychotherapy to Resident #2, per his recent neuropsychological report, to monitor symptoms and to provide support for him and facility staff in dealing with inappropriate sexual behaviors.</p> <p>-A review of the comprehensive care plan, dated 3/27/24, did not reveal the resident 's PASRR Level II screening and specialized services recommendations for his mental illness.</p> <p>-The social services progress notes reviewed from 1/13/24 through 5/13/24 revealed there was no documentation to indicate the facility had reached out to a mental health provider to establish services for psychotherapy twice per month as recommended on the Level II PASRR.</p> <p>-A review of the May 2024 CPO did not reveal a physician 's order for the resident to be seen for psychotherapy twice per month.</p> <p>The performance improvement plan (PIP) was provided by the social services director (SSD) on 5/15/24 at 3:40 p.m. It was initiated March 2024, related to the Level II PASRR identification revealed the facility needed to adhere to the specialized services recommendations and integrate the Level II PASRR into the resident 's care plan. The PASRR Level II action item had a target date of 4/12/24.</p> <p>-The PIP action item related to the Level II PASRR was not completed upon review on 5/13/24.</p> <p>IV. Staff interviews</p> <p>The SSD was interviewed on 5/12/24 at 4:34 p.m. The SSD said the PASRR recommendations were not followed up on according to her review of Resident #2's medical record. She said Resident #2 had not received psychotherapy twice monthly, but the resident met with a psychiatrist once per month.</p> <p>(continued on next page)</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD said the reason the facility did not identify that Resident #2 was not receiving the care and services that were recommended in the Level II PASRR was because the facility did not do a whole house audit to identify which resident 's had Level II PASRRs. She said she would audit all residents' PASRRs and ensure all recommendations were followed and maintain a spreadsheet to track PASRRs due and follow-up on all recommendations. The SSD said she would obtain the necessary psychotherapy services for the resident through a community partner that would meet weekly with Resident #2.</p> <p>The nursing home administrator (NHA) was interviewed on 5/16/24 at 3:45 p.m. The NHA said education, training and audits would be put in place to ensure the facility maintained tracking of PASRR evaluation completion and follow up on recommendations.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47064</p> <p>Based on observations, record review and interviews, the facility failed to ensure one (#23) of five residents reviewed for ancillary services out of 33 sample residents received routine dental care and 24-hour emergency dental care.</p> <p>Specifically, the facility failed to refer Resident #23 to the dentist to obtain dentures timely.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Ancillary Service policy and procedure, dated 11/4/13, was provided by the nursing home administrator (NHA) on 5/15/24 at 3:25 pm. It read in pertinent part Ancillary services, including, but not limited to dental, vision, audiology and podiatry will be provided to the resident per state and federal regulatory guidelines; at the resident/responsible family members request; and as needed.</p> <p>Any resident needing or requesting ancillary services such as dental, vision, audiology and podiatry will have their needs met timely.</p> <p>Social services/designee will be responsible for ensuring residents needing ancillary services receive needed/requested services in a timely manner.</p> <p>II. Resident Status</p> <p>Resident #23, age greater than 65, admitted on [DATE]. According to the May 2024 computerized physician orders (CPO), diagnoses included dementia (abnormal thought process), epilepsy (abnormal electrical brain activity), chronic obstructive pulmonary disease (abnormal oxygen exchange).</p> <p>The 4/30/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview of mental status (BIMS) score of 11 out of 15. He was independent of eating, transfers, toileting, dressing, and personal hygiene.</p> <p>The assessment revealed the resident did not have any broken or loose fitting full or partial dentures. The assessment documented the resident did not have any mouth or facial pain, discomfort or difficulty with chewing.</p> <p>-However, the resident was edentulous (missing all teeth).</p> <p>III. Resident interview and observations</p> <p>Resident #23 was interviewed on 5/13/24 at 1:57 p.m. Resident #23 said he was struggling to eat because he did not have dentures. Resident #23 said a staff member from the facility told him they were going to help him get dentures. He said he had still not been seen by a dentist and had been in the facility since January 2024.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #23 said he was tired of eating grilled cheese sandwiches. He said he had been eating grilled cheese sandwiches, since they were easy to chew without dentures.</p> <p>Resident #23 said he did not know how he was supposed to eat if he had no teeth.</p> <p>Resident #23 opened his mouth and only gums were observed.</p> <p>IV. Record review</p> <p>The resident had a physician's order that indicated the resident may have a podiatrist, ophthalmologist, dental and audiology as needed, ordered on 1/31/24.</p> <p>A review of Resident #23's comprehensive care plan, revised on 4/30/24, revealed the resident's dental issues were not addressed in the resident's plan of care.</p> <p>A review of Resident #23's electronic medical record (EMR) did not reveal the resident was offered or provided access to dental services.</p> <p>A physician progress note, dated 2/1/24, revealed Resident #23's needed help finding his dentures. Resident #23 was edentulous and needed upper and lower dentures.</p> <p>A food preference assessment, dated 2/3/24, revealed the resident had trouble chewing certain foods because he had no teeth.</p> <p>A social service progress note, dated 2/5/24, revealed the social service director (SSD) spoke with the social worker at the previous facility Resident #23 resided about his dentures being lost. The other facility had not located the lost dentures. The note documented Resident #23 was added to the resident list for the next dental visit.</p> <p>A nutrition assessment, dated 2/7/24, revealed that Resident #23 dentures were lost.</p> <p>A care conference progress note dated 2/13/24, documented Resident #23 had a poor appetite and had lost his dentures at the previous facility. The family attended the conference and expressed concern about his missing dentures.</p> <p>V. Staff interviews</p> <p>The SSD was interviewed on 5/15/24 at 12:06 p.m. The SSD said residents could see a dentist every six months and as needed.</p> <p>The SSD said the facility had a dentist that came to the facility, but that dentist stopped visiting the facility in December 2023 and stopped accepting Medicaid as a payment source in March 2024. The SSD said she had to find another provider to provide services on site in the facility. The SSD said she got a contract for a new dentist, but a date had been set up for the initial visit.</p> <p>The SSD said as soon as the new dentist came to the facility she would start the a post eligibility of income (PETI) process so Resident #23 could get his new dentures. She said once the PETI process was initiated it would take one to two weeks to get approved and then dentures could be ordered.</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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SSD said the new dentist was able to fit residents for new dentures. The SSD said Resident #23 had no teeth left.</p> <p>The SSD said Resident #23 had told her once he would really like to get his dentures made.</p> <p>The SSD said the facility did not send the resident to a dentist in the community, because they were waiting for the new dentist to come to the facility.</p> <p>The director of nursing (DON) was interviewed on 5/15/24 at 1:03 p.m. The DON said he was not aware that Resident #23 was missing his dentures. The DON said if a resident reported dental issues the SSD was to be notified to get services scheduled.</p> <p>The DON said if a resident had dental issues it could affect their eating.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 5/15/24 at 1:32 p.m. LPN #1 said she was not aware Resident #23 had any dental concerns or did not have dentures.</p> <p>Certified nurse aide (CNA) #1 was interviewed on 5/15/24 at 1:35 p.m. CNA #1 said she was aware Resident #23 had no teeth. CNA #1 said Resident #23 ordered grilled cheese sandwiches a lot because they were soft to chew.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/15/2024
NAME OF PROVIDER OR SUPPLIER Valley View Health Care Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 N 10th St Canon City, CO 81212	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48113</p> <p>Based on observations, record review and interviews, the facility failed to ensure food was prepared, distributed and served under sanitary conditions in the kitchen.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure the walk-in refrigerator maintained a safe operating temperature of 41 degrees Fahrenheit (F) or below to prevent food from spoiling; and, -Ensure all damaged tiles were repaired to ensure all surfaces in the kitchen were cleanable. <p>Findings include:</p> <p>I. Ensure the walk-in refrigerator maintained a safe operating temperature of 41 degrees F or below to prevent food from spoiling</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Regulations, (1/1/19), were retrieved on 5/17/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Time/temperature control for safety food cold holding shall be maintained at 5 degrees Celsius (C) (41 degrees F) or less.</p> <p>B. Facility policy and procedure</p> <p>The Kitchen Sanitation and Infection Control policy and procedure, undated, was provided by the nursing home administrator (NHA) on 5/15/24 at 4:30 p.m. It revealed in pertinent part, All local, state, and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department. All refrigerated and frozen foods will be stored and handled properly. All dry and staple food items will be stored properly. All refrigerated foods should be stored at or below 41 degrees F. Frozen foods should be stored at a temperature that keeps frozen food solid.</p> <p>C. Observations</p> <p>On 5/13/24 at 9:10 a.m. the thermometer that was hanging on a shelf in the walk-in refrigerator indicated the internal temperature was 45 degrees F. There were two cooling fans out of six total that were observed to not be functional. Two products were tested to obtain the temperature of the items. A fruit cup's temperature was taken and it measured 52.2 degrees F. A yogurt's temperature was taken and it measured 52.1 degrees F. DA #1 said all of the food would be disposed of.</p> <p>D. Record Review</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/13/24 at 9:15 a.m. the temperature log from 5/1/24 through 5/13/24 was reviewed. It revealed a few days were not recorded for the walk-in refrigerator. Other entries revealed the refrigerator averaged 38 degrees F. The 5/13/24 morning entry was incomplete upon survey entrance.</p> <p>D. Interviews</p> <p>Dietary aide (DA) #1 was interviewed on 5/14/24 at 9:14 a.m. DA #1 said all refrigerators should be at or below 41 degrees F. He said food could go bad if the temperature was higher than 41 degrees F. DA #1 said he did not know why the log was not completed upon survey entrance in addition to the missing entries for a few days in the month of May 2024. DA #1 said the dining staff needed to take the temperature of the refrigerator first thing in the morning to ensure the food maintained the appropriate temperature overnight. DA #1 said he needed to throw away all the products in the refrigerator because of the lack of documentation and accuracy of the log in addition to the internal temperature of food items reaching 52 degrees F. He said he could not determine how long the issue had been present. DA #1 said it was important to prevent residents from eating the food that had gone bad or had the potential to make people sick. He said the food could quickly develop Salmonella or other bacteria which would cause residents to get sick.</p> <p>The nutrition services manager (NSM) was not available for an interview on 5/14/24. However, the NSM was notified by the NHA related to the refrigerator's high holding temperature.</p> <p>The NHA was interviewed on 5/14/24 at 9:30 a.m. The NHA said it was dangerous to have food being held at 52 degrees F and she said she would ensure all products in the refrigerator were thrown away and they would fix the refrigerator and order new products. The NHA said it was important not to serve the residents spoiled food or food that was not held at safe temperature because it could cause the residents to become sick.</p> <p>The infection preventionist (IP) was interviewed on 5/15/24 at 4:11 p.m. The IP said all refrigerators need to hold food at 41 degrees F or below to make sure food was kept cold. She said food could go bad when not kept cold at appropriate temperatures and microorganisms could develop which could lead to residents getting sick and potentially even death could occur, depending on the severity of the sickness and the resident's co-morbidities and age.</p> <p>II. Ensure all damaged tiles were repaired to ensure all surfaces in the kitchen were cleanable.</p> <p>A. Professional reference</p> <p>The Colorado Retail Food Regulations, effective 1/1/19, were retrieved 5/17/24 from https://cdphe.colorado.gov/environment/food-regulations. It revealed in pertinent part, Floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.</p> <p>B. Facility policy and procedure</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Kitchen Sanitation and Infection Control policy and procedure, undated, was provided by the NHA on 5/15/24 at 4:30 p.m. It revealed in pertinent part, All local, state, and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutrition services department. The director of food and nutrition services will be responsible for providing safe foods to all individuals.</p> <p>C. Observations</p> <p>On 5/15/24 at 9:19 a.m. the floor of the kitchen, which included the dry storage room, was observed. Approximately 15 tiles were observed to be broken and no longer adhered to the floor. One floor tile by the dishwasher was missing. A few wall tiles were observed to be broken in the dry storage room. The ceiling was sagging in areas of the kitchen and was visibly dirty with brown stains and grease stains.</p> <p>D. Staff interviews</p> <p>DA #1 was interviewed on 5/13/24 at 10:12 a.m. DA #1 said the tiles in the kitchen should be cleanable which meant they could not be broken. He said not only was it an infection control issue since they could not be cleaned and there might be mold and bacteria under the tile, but it was also a slip and trip hazard working in the kitchen. DA #1 said there was water dripping from inside of the wall and that could be why the ceiling was sagging. DA #1 said the kitchen floors, walls and ceilings were visibly dirty because the kitchen staff did not clean them. DA #1 said it had been a few months since the kitchen was deep cleaned. He said it was hard to be motivated to clean and keep the kitchen looking good when the environment was in poor condition. He said he notified his supervisor and administration of both structural issues with the floor and ceiling but they had not been repaired due to the budget and the amount of money it would cost.</p> <p>The NSM was interviewed on 5/14/24 at 2:50 p.m. The NSM said she was aware of the broken tiles, dirty ceiling and walls. She said the kitchen was deep cleaned once every three months. She said she notified administration about the repairs needed and they had obtained quotes to replace the floor, walls and ceiling but it cost too much money and the corporation would not approve it. The NSM said all surfaces should be cleanable and she needed to have staff deep clean the entire kitchen and she hoped all broken walls, floor, ceiling would be repaired.</p> <p>The IP was interviewed on 5/1/24 at 4:11 p.m. The IP said the floor, walls and ceiling should be cleaned to prevent microorganisms from developing. She said broken tiles could harbor microorganisms between the broken tiles and underneath it. She said it was not a sanitary working condition and it was not safe since the broken tiles were a trip and fall hazard. The IP said, due to the broken tiles, the surfaces were not cleanable and the tiles should be repaired on all surfaces. She said the kitchen needed to be deep cleaned and a routine cleaning should occur and she would be more involved with the process to ensure the kitchen remained clean and safe.</p> <p>The NHA was interviewed on 5/15/24 at 4:45 p.m. The NHA said she was aware of the broken tiles, wall and sagging ceiling. She said she had requested a quote and sent the quotes to corporate but they refused to fix it due to the cost of the repairs. She said the kitchen needed to be gutted and cleaned up and staff needed to be educated on proper kitchen sanitation. She said the kitchen staff needed to have more oversight to ensure the kitchen ran smoothly and did not pose any health concerns or safety concerns.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep all essential equipment working safely.</p> <p>48113</p> <p>Based on interviews and observations, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in the main kitchen.</p> <p>Specifically the facility failed to:</p> <ul style="list-style-type: none"> -Ensure the kitchen's oven was maintained to function properly; -Ensure two of six burners were functioning properly; and, -Ensure the kitchen oven door was repaired to ensure the oven maintained consistent and appropriate cooking temperatures for cooked food. <p>Findings include:</p> <p>I. Facility policies and procedures</p> <p>The Kitchen Sanitation policy and procedure, undated, was provided by the nursing home administrator (NHA) on 5/15/23 at 4:30 p.m. It read in pertinent, All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrossions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair.</p> <p>II. Observation</p> <p>On 5/13/24 at 9:06 a.m. the oven door was not latched and there was approximately a one inch gap between the oven door seal and the oven. The oven door was opened with difficulty as it appeared that the bottom left latch was not attached or not functioning properly preventing the door from opening with ease. It prevented the door from closing securely. The stove top burners were observed and only four of six burners were functional.</p> <p>III. Staff interviews</p> <p>Dietary aide (DA) #1 was interviewed on 5/15/24 at 10:37 a.m. DA #1 said the oven and stove had been broken for at least a year and a half. He said he had notified his supervisor and the former facility administrator and nothing had been done due to the budget. He said the kitchen was overlooked for repairs and maintenance, which was very frustrating and made it difficult to complete his job. He said the broken burners resulted in not being able to cook as efficiently and things took a longer time to cook with the amount of burners they had functional. He said the broken oven door led to inadequate temperature control and he said it would not reach past 350 degrees Fahrenheit (F), which meant they had to cook food longer to ensure the food was cooked to the correct temperature. He said this often delayed resident meal service. DA #1 said it was a safety concern since the oven door did not close all the way and if grease or any flammable cooking products fell from the stove top into the oven then the oven could catch fire.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nutrition services manager (NSM) was interviewed on 5/14/23 at 11:25 a.m. The NSM said the oven had been broken for a long time and she had put in requests to repair the oven, but the facility refused to repair it. She said she had been informed that due to the budget, they were unable to repair the oven. The NSM said the oven's temperature was inconsistent but would not go beyond 400 degrees F. She said this led to inconsistent cooking times. She said there were broken burners on the stove that made it difficult for the cooks to complete the meals timely.</p> <p>The NHA was interviewed on 5/15/24 at 3:45 p.m. The NHA said she was aware of the broken oven and stove top burners. She said she notified the corporation but they refused to repair the oven and stove top due to budget constraints. She said she would make sure the oven and stove top burners were repaired soon to ensure all foods are cooked to safe temperatures adequately and consistently.</p>		