STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065351	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holly Care Center	320 N 8th St Holly, CO 81047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to develop and implement a comprehensive centered care plan that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for two (#23 and #25) of six residents out of 16 sample residents. Specifically, the facility to: -Ensure a care plan and interventions were developed for Resident #23's use of a hypertensive medication; and, -Ensure a care plan and interventions were developed for Resident #25's use of insulin, an anticoagulant medication and for dialysis treatments. Findings include: I. Facility policy and procedure The Comprehensive Care Plans policy, revised on 2/28/24, was provided by the quality mentor (QM) on 8/28/24 at 12:27 p.m. The policy revealed this facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, which included measurable objectives, timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the resident's comprehensive assessment. Person-centered care meant the facility would focus on the resident as the locus (specific position) of control, support the resident in making their own choices and having control over their daily lives. The care planning process would include an assessment of the resident's strengths and needs and would incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, would be culturally competent and trauma-informed. (continued on next page)

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan would be developed within seven days after the completion of the comprehensive minimum data set (MDS) assessment. All care assessment areas (CAAs) triggered by the MDS assessment would be considered in developing the plan of care. Other factors identified by the interdisciplinary team (IDT), or in accordance with the resident's preferences, would also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning would be evidenced in the clinical record. The comprehensive care plan would be prepared by the IDT. The comprehensive care plan would include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives would be utilized to monitor the resident's progress. Alternative interventions would be documented, as needed. II. Resident #25 A. Resident status Resident #25, age 78, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included type 2 diabetes mellitus, end stage renal disease, dependence on renal dialysis and multiple fractures of the ribs on the resident's right side with an initial encounter for closed fractures. The 8/13/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) score of 10 out of 15. For the seven-day assessment period, the resident received injections everyday. The resident also received insulin injections all seven days. The resident was taking antiplatelet and hypoglycemic (including insulin) medications. The MDS assessment did not reveal the resident was on dialysis. B. Record review A physician's order, dated 2/5/24 at 1:18 p.m., revealed routine dialysis once a day every Monday, Wednesday and Friday. Staff were to check the graft site (access site for dialysis) for bleeding after the resident returned from dialysis. If bleeding occurred, staff were to apply direct pressure until the bleeding was controlled. Staff were to notify the medical provider if the bleeding lasted longer than 30 minutes or was severe. The June 2024, July 2024 and August 2024 medication administration records (MAR) revealed the resident went to dialysis as the physician ordered. -The resident's electronic medical record (EMR) did not contain a care plan for dialysis. -The facility developed a care plan for dialysis during the survey, on 8/27/24. A physician's order, dated 2/5/24 at 4:07 p.m., revealed Resident #25 was to be administered Eliquis (an anticoagulant medication) tablet 2.5 milligrams (mg) orally once a day for the use of a fistula (surgical connection between an artery and a vein in the arm that was used to access a resident's blood flow for hemodialysis treatments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The June 2024, July 2024 and August 2024 MARs revealed the resident was administered the Eliquis tablet 2.5 mg per the physician's ordered. -The resident's EMR did not contain a care plan for the use of the anticoagulant medication. -The facility developed a care plan for anticoagulant use during the survey, on 8/27/24. A physician's order, dated 6/15/24 at 10:21 p.m., revealed Resident #25 was to receive an injection of Basaglar KwikPen Subcutaneous Solution 100 units/milliliter (Insulin Glargine); 12 units subcutaneously twice a day and hold if the resident's blood sugar was less than 60 milligrams per deciliter (mg/dl). Staff were to call his physician if the resident's blood sugar level was above 500 mg/dl. The June 2024, July 2024 and August 2024 MARs revealed the resident was administered the Basaglar KwikPen Subcutaneous Solution per the physician's order. -The resident's EMR did not contain a care plan for the use of insulin. -The facility developed a care plan for insulin use during the survey, on 8/27/24. C. Staff interviews The nursing home administrator (NHA), the director of nursing (DON) and the QM were interviewed together on 8/28/24 at 1:30 p.m. The NHA, the DON and the QM said that Resident #25's EMR did not contain care plans for dialysis, the use of insulin nor the use of an anticoagulant medication. They agreed that care plans should have been developed for these three areas, according to the facility's policy. They agreed care plans for insulin, an anticoagulant and dialysis were developed during the survey. The DON said the IDT developed the resident's comprehensive care plans. She said the MDS coordinator and the IDT reviewed their disciplines' specific sections for accuracy or the need for further development. The DON said during the seven-day MDS assessment period, the coordinator should have developed care plans for these three areas. The DON said the care plans provided direction for the plans of care for a resident. She said the care plans listed the problem/concerns, goals and interventions to address the issues with the resident. She said the care plans were fluid and could be developed or updated as the resident changed. III. Resident #23 A. Resident status Resident #23, age 67, was admitted on [DATE] and readmitted on [DATE]. According to the August 2024 CPO, diagnoses included essential hypertension, hemiplegia, vascular dementia, anxiety and depression. The 7/17/24 minimum data set (MDS) assessment revealed the resident had severe cognitive impairments with a brief interview of mental status (BIMS) score of four out of 15. For the seven-day assessment period, the resident received an antipsychotic, antidepressant and opioid medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record review The physician's order, dated 12/1/24 at 8:31 p.m., revealed to administer a hydrochlorothiazide 25 mg tablet orally once a day for hypertension. The physician's order, dated 12/1/23 at 8:34 p.m., revealed to administer two losartan potassium 25 mg tablets orally once a day for hypertension. The June 2024, July 2024 and August 2024 MARs revealed the resident was administered the hydrochlorothiazide 25 mg tablet and the two losartan potassium 25 mg tablets for hypertension as physician ordered. -The resident's EMR did not contain a care plan for hypertension. -The facility developed a care plan for hypertension during the survey, on 8/27/24. C. Staff interviews The NHA, the DON and the QM were interviewed together on 8/28/24 at 1:30 p.m. They said that Resident #23's EMR did not contain a care plan for hypertension. They agreed that a care plan should have been developed for hypertension, according to the facility's policy. They agreed the care plan for hypertension had been developed during the survey. Registered nurse (RN) #2 was interviewed on 8/28/24 at 2:14 p.m. RN #2 said the care plans were developed to ensure staff provided the appropriate and consistent care for the residents' concerns/issues.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48458 Based on observations, record review and interviews, the facility failed to ensure one (#3) of two residents reviewed for ancillary services out of 16 sample residents received routine dental care and 24-hour emergency dental care. Specifically, the facility failed to ensure Resident #3 was provided dental services for timely replacement of her upper denture. Findings include: I. Facility policy and procedure The Ancillary Services policy, revised February 2024, was provided by the director of nursing (DON) on 8/28/24 at 2:20 p.m. It read in pertinent part, Any resident needing or requesting ancillary services such as dental, vision, audiology and podiatry will have their needs met timely. Social services/Designee will be responsible for ensuring residents needing ancillary services receive needed/requested services in a timely manner. II. Resident #3 A. Resident status Resident #3, age less than 65, was admitted on [DATE]. According to the August 2024 computerized physician orders (CPO), diagnoses included intracranial shunt (surgical procedure to place a tube in the brain), bipolar disorder (mental illness that causes extreme behavior swings), severe obesity and chronic pain. The 5/16/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #3 was independent with oral hygiene, eating, dressing and transferring self and required set-up assistance with showering. The MDS assessment revealed the resident had no dental issues. -However, Resident #3 did not have any upper teeth (see resident observation and interview below). B. Resident interview and observation Resident #3 was interviewed on 8/25/24 at 6:02 p.m. Resident #3 said her top set of dentures was left in a transportation vehicle. She said she was not sure how long ago the incident occurred, but thought it was at least a year ago. Resident #3 said she told the facility when the top denture was lost. Resident #3 said the former social worker did not assist her with obtaining new upper dentures and Resident #3 did not know if the current social worker was aware the upper denture was needed. Resident #3 said she was limited in her ability to eat because she did not have her upper denture. During the interview, Resident #3 did not have any upper teeth or dentures in place. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was interviewed again on 8/28/24 at 9:53 a.m. Resident #3 said she could not eat hamburger or bacon, lettuce and tomato sandwiches without her top denture. She said it was difficult to chew without her top denture. She said a social worker told her she could only have replacement dentures once every three years. C. Record review The dental care plan, revised 7/11/24, revealed the resident had upper dentures. The interventions included coordinating arrangements for dental care and providing transportation as needed. -A review of the resident's care plan did not indicate the resident's upper dentures were missing. A facility consultation sheet was provided by the DON on 8/28/24 at 2:53 p.m. The consultation sheet revealed Resident #3 was at a dental clinic on 3/11/24 to get upper dentures and the dentist documented they provided Resident #3 with the price of new dentures. A progress note, written by the previous social services director (SSD) on 3/12/24 at 11:51 a.m., revealed Resident #3 was seen by the dentist on 3/11/24 for top denture replacement. The progress note documented the resident's insurance would not cover dentures for seven years and the resident was not able to financially cover the cost of dentures herself. The progress note indicated the SSD was researching other options. A progress note, written by the current SSD on 3/13/24 at 10:15 a.m., revealed the SSD reviewed with Resident #3 that insurance would not cover dentures and one alternate payor would not cover it. The note documented Resident #3 said she did not have the means to pay privately or set up a payment plan fo the dentures. -A review of the resident's electronic medical record (EMR) did not reveal any additional documentation indicating the facility had assisted the resident in finding her dentures or replacing them. A progress note, written by the DON on 8/28/24 at 1:26 p.m. (during the survey), revealed a dental appointment had been scheduled for Resident #3 in September 2024 (exact date to be determined) for x-rays and impressions for the denture to be replaced. The DON indicated the bill for services would be sent to the facility and the facility would pay for the denture if an alternate payor was not possible. D. Staff interviews Certified nurse aide (CNA) #5 was interviewed on 8/27/24 at 1:09 p.m. CNA #5 said Resident #3 had dentures at one time, but did not know if Resident #3 still had them. CNA #8 was interviewed on 8/27/24 at 1:20 p.m. CNA #8 said Resident #3 had told her in the past that her dentures did not fit. CNA #8 said she was not aware the resident had lost her upper denture. Licensed practical nurse (LPN) #1 was interviewed on 8/27/24 at 1:15 p.m. LPN #1 said she was not aware Resident #3 had lost her top dentures. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON, the SSD and the nursing home administrator (NHA) were interviewed together on 8/28/24 at 11:28 a.m. The SSD said she knew the process for assisting residents with the replacement of dentures. The DON said Resident #3 had a dental appointment to replace her top dentures on 3/11/24. The DON said the denture had not been replaced as of 8/28/24. The DON said she would have expected the SSD to work with the business office and the NHA to arrange funds to obtain the upper denture replacement. The DON was interviewed again on 8/28/24 at 3:02 p.m. The DON said it was the facility's responsibility to ensure timely replacement of dentures for a resident. The DON said the current SSD was not aware when she documented her 3/13/23 progress note that she had alternative means for obtaining new dentures for residents.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48458

Based on observations, record review and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public.

Specifically, the facility failed to:

-Ensure housekeeping staff followed appropriate infection control practices when cleaning resident rooms;

-Ensure nursing staff followed appropriate infection control practices when providing wound care; and,

-Ensure clean items, such as medications and body soap, were stored in a sanitary manner.

Findings include:

I. Failure to ensure housekeeping staff followed appropriate infection control practices when cleaning resident rooms

A. Facility policy and procedure

The Cleaning and Disinfecting Residents' Rooms policy, revised August 2013, was provided by the quality mentor (QM) on 8/27/24 at 2:43 p.m. It read in pertinent part, Use heavy duty gloves and other personal protective equipment (PPE) as indicated for housekeeping tasks. Perform hand hygiene after removing gloves.

B. Observations

On 8/27/24 at 9:06 a.m. housekeeper (HSK) #2 was cleaning room [ROOM NUMBER]. HSK #2 was not wearing gloves when she discarded the dirty mop pad. After handling the dirty mop pad, and without performing hand hygiene, HSK #2 obtained a clean mop and squeezed the end of the mop with her ungloved hands. HSK #2 finished mopping the resident's floor, then proceeded to use her ungloved hands to pull off the dirty mop pad.

-HSK #2 did not perform hand hygiene after touching the soiled mop pad.

On 8/27/24 at 9:15 a.m. HSK #2 entered room [ROOM NUMBER], she cleaned the high touch surfaces with disinfectant and then took out the trash without wearing gloves. HSK #2 did not perform hand hygiene after removing trash.

C. Staff interviews

The housekeeping supervisor (HSKS) was interviewed on 8/27/24 at 10:04 a.m. The HSKS said the housekeepers should wear gloves if they were removing trash or handling a soiled mop pad.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	HSK #2 was interviewed on 8/27/24 at 10:10 a.m. HSK #2 said she should have worn gloves when she was handling the soiled mop pad. She said she should use hand sanitizer and wear gloves when she removed trash from a resident's room. The infection preventionist (IP) was interviewed on 8/27/24 at 1:39 p.m. The IP said HSK #2 should have worn gloves and sanitized her hands while handling dirty and clean mop pads. The IP said HSK #2 should wear gloves and use hand sanitizer to prevent the spread of infection and germs. II. Failure to ensure nursing staff followed appropriate infection control practices when providing wound care A. Facility policy and procedure The Wound Care policy, undated, was provided by the director of nursing (DON) on 8/28/24 at 2:20 p.m. It read in pertinent part, Steps in procedure: -Place disposable cloth next to the resident (under the wound) to serve as a barrier and to protect bed linen; -Put on exam gloves. Loosen tape and remove dressing; and, -Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. B. Observation On 8/27/24 at 9:25 a.m., registered nurse (RN) #2 was changing Resident #5's wound dressing. RN #2 removed the soiled dressing and placed it on the clean disposable cloth that was less than six inches from the resident's uncovered wound. RN #2 then washed his hands for 10 seconds, donned (put on) new gloves, cleaned the wound and performed the remainder of the dressing change. -RN #2 did not discard the soiled dressing (which remained less than six inches from the wound on the clean field) prior to applying the new dressing. C. Staff interviews RN #2 was interviewed on 8/27/24 at 10:00 a.m. RN #2 said his hands needed to be washed for at least 20 seconds. RN #2 said he should have discarded the soiled dressing into the trash can immediately after removing it. The IP was interviewed on 8/27/24 at 1:39 p.m. The IP said the staff should wash hands for at least 20 to 30 seconds to ensure germs were removed effectively. III. Failure to ensure clean items, such as medications and body soap, were stored in a sanitary manner (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A. Facility policy and procedure The Medication Storage policy, revised February 2024, was provided by the DON on 8/28/24 at 2:20 p.m. It read in pertinent part, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication room according to manufacturer recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. B. Observations and staff interview On 8/26/24 at 1:56 p.m licensed practical nurse (LPN) #1 was observed during medication administration. LPN #1 used a key to unlock the medication storage room. She walked through a bathroom, which was located inside the medication storage room, to get to a second medication storage area contained in the room. The following items were observed in the bathroom less than two feet from the toilet: -An emergency medication kit which contained 35 medications; and, -An emergency intravenous (IV) kit which contained 18 medications. LPN #1 said the toilet in the bathroom located inside the medication storage room was sometimes used by nurses, who were the only staff members who had a key to the medication storage room. LPN #1 said the emergency medication kits should not be stored in the bathroom. LPN #1 moved the emergency medication and IV kits from the bathroom to the outer storage area of the medication room. On 8/27/24 at 10:40 a.m., the two shower rooms were observed with the HSKS. There was an opened one gallon container of body soap on the floor in each of the shower rooms. C. Additional staff interviews The IP was interviewed on 8/26/24 at 2:05 pm. The IP said the emergency medication and IV kits should not be stored in the bathroom in the medication storage room. The IP said it was an infection control risk to store them in the bathroom. The IP was interviewed again on 8/27/24 at 2:04 p.m. The IP said the body soap should not be stored on the floor of the shower rooms as it could spread infection.