STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065367	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Care and Rehabilitation Center, The	9221 Wadsworth Pkwy Westminster, CO 80021

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 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 one (#32) of two residents reviewed for activities out of 29 sample residents. Specifically, the facility failed to invite Resident #32 to group activities and meet the socialization needs for the resident. Findings include: I. Resident #32 A. Resident status Resident #32, age 77, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included pneumonia (lung infection), pulmonary emboli (blood clots in the lungs) and type 2 diabetes (high blood sugar). The 11/6/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of eight out of 15. She required complete assistance with hygiene, showering and dressing. The 11/6/24 MDS assessment documented that all activities were not very important to Resident #32. It was documented that her language preference was Hmong. B. Observations During a continuous observation on 12/16/24, beginning at 9:15 a.m. and ending at 10:00 a.m., the following was observed: At 9:15 a.m. Resident #32 was lying in her bed with the door open. Her eyes were open and she was looking out into the hallway. At 9:45 a.m. a balloon toss activity was going on in the living room area of the unit. Resident #32 was not invited to attend the activity. (continued on next page)

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 9:50 a.m. two certified nursing aides (CNA) went into Resident #32's room and changed her brief. The CNAs did not take the resident to the balloon activity after changing her brief. During a continuous observation on 12/16/24, beginning at 12:45 p.m. and ending at 2:20 p.m., the following was observed: At 12:45 p.m. Resident #32 was lying in her bed. The resident's bedside table was not next to her. There was a translator device at the end of the bed. There was a stack of daily chronicles in English on a nightstand next to the bed, out of reach of the resident. There were no coloring supplies or other individualized activities observed in her room. At 1:30 p.m. there was a fitness activity going on in the living room of the unit. Resident #32 was not invited to attend the activity. At 2:15 p.m. bingo was going on in the living room of the unit. Resident #32 was not invited to attend the activity. During a continuous observation on 12/17/24, beginning at 9:15 a.m. and ending at 11:10 a.m., the following was observed: At 9:15 a.m. Resident #32 was lying in her bed. She was awake and talking in her preferred language (Hmong) with the door open. The NHA walked into Resident #32's room and asked her how she was doing. The NHA did not use the translator to talk with Resident #32. At 9:30 a.m. Resident #32 started to talk in Hmong. At 10:02 a.m. Resident #32 put her call light on. At 10:12 a.m., the NHA went into Resident #32's room. The NHA spoke to her in English and did not attempt to use the translator device that was in the room. At 10:45 a.m. there was a hymnal singing activity going on in the living room of the unit. Resident #32 was not invited to attend the activity. C. Resident interview Resident #32 was interviewed utilizing the resident's translator device on 12/16/24 at 12:47 p.m. Resident #32 said she would like to get up and live a normal life but she just laid in her bed all the time. D. Record review The activity care plan, updated 10/7/24, documented the goal for Resident #32 was that she had a significant language barrier but that she did not like television and did enjoy music. Interventions included the activity team supplying the resident with daily and monthly activity guides, seeking opportunities to engage in one-on-ones with music and approved snacks, finding opportunities to engage with the resident's representative to find out how the facility could accommodate the resident and having the activity team make attempts to get the resident out to social events with music. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note written by the social worker on 12/17/24 at 7:46 a.m. documented that the social worker reached out to Resident #32's representative for a check-in regarding the resident. They discussed translation and communication cards that were provided. The representative said Resident #32 would likely not use the communication cards. II. Staff interviews CNA #1 was interviewed on 12/18/24 at 12:20 p.m. CNA #1 said Resident #32 refused to get out of bed when they offered. She said she had not seen her participate in activities. CNA #1 said she had not really used the translator device or communication cards to communicate with Resident #32. She said Resident #32 did not refuse care. -However, observations during the survey revealed staff did not attempt to invite Resident #32 to the activities that were occurring (see observations above). The activities director (AD) was interviewed on 12/18/24 at 3:23 p.m. The AD said the process for inviting residents to activities included passing out the daily chronicle the evening before and highlighting some of the activities with the residents so they could plan for the next day. She said there was also a monthly activity calendar passed out at the beginning of each month. She said it was her expectation that every resident got invited to each activity unless they specified otherwise. She said she and the activity aides went around to each resident and invited them to the activity prior to the start of the activity. She said if the resident was sleeping or receiving care, they did not bother the resident. She said she needed to work on making accommodations for residents who spoke a primary language other than English. She said she was not sure what primary language Resident #32 spoke and she was unaware of the translator device in her room. The AD said she did not invite Resident #32 to activities because of the language barrier and because sometimes Resident #32 was sleeping. She said she offered coloring sheets to Resident #32 one time but the resident did not seem interested. She said she was not sure what Resident #32's activity preferences were. She said she did not have access to her care plan or activity assessment. She said she got to know the residents by talking with them as she passed out the daily chronicles. The director of resident life services (DRLS) was interviewed on 12/19/24 at 11:30 a.m. The DRLS said it was his responsibility to oversee the activity programming on the skilled nursing side and complete all resident activity assessments and care plans. He said the AD had access to the care plans and activity assessments through the resident charting system. He said Resident #32 liked to read through the daily chronicle, color and complete word searches. He said she did not understand English very well but she could shake her head for yes/no questions. The NHA was interviewed on 12/19/24 at 1:22 p.m. The NHA said it was her expectation that all residents were to be invited to activities they would enjoy. She said to communicate with residents whose primary language was not English, she would expect staff to communicate with the translator device or communication flashcards. -However, the NHA did not use the translator device in Resident #32's room to communicate with the resident (see observations above).

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50315 Based on record review and interviews, the facility failed to ensure two (#42 and #45) of two residents out of 29 sample residents were free of significant medication errors. Specifically, the facility failed to: -Ensure Resident #45 was administered his schizoaffective disorder medication per the physician orders; and, -Ensure Resident #42 was administered his diabetes medication per the physician orders. Findings include: I. Professional reference According to the Trihexyphenidyl dosing instructions, retrieved on 12/30/24 from https://www.goodrx.com/trihexyphenidyl/what-is#dosage, Trihexyphenidyl is an anticholinergic medication that blocks acetylcholine, a chemical that affects movement. It is used to help with tremors in adults with Parkinson's disease. It can also be used for movement-related side effects caused by other medications. Don't stop taking trihexyphenidyl unless instructed by your provider. Suddenly stopping the medication can lead to withdrawal symptoms, such as anxiety and worsening movement problems. The recommended dosage for trihexyphenidyl tablets and oral solution are the same. For movement problems, the daily dose ranges from five to 15 milligrams (mg) by mouth per day. II. Facility policy and procedure The Medication Error Reporting and Adverse Drug Reaction Prevention and Protection policy and procedure, revised January 2023, was received from the nursing home administrator (NHA) on 12/18/24 at 3:32 p.m. It documented in pertinent part, Medication errors and adverse drug reactions are assessed, documented, and reported as appropriate to the resident's attending physician and/or prescribers, the pharmaceutical services committee, the pharmacy and Food and Drug Administration Med (medication) Watch Program. In the event of a significant medication error or adverse drug reaction, immediate action is to be taken to protect the resident's safety and welfare. Actions include notifying the prescriber, monitoring the resident closely, describing the incident on shift change report to alert the staff of the need to monitor the resident and documenting an incident report which includes a factual description of the error or adverse reaction, name of prescriber and time notified, prescriber's subsequent orders and the resident's condition for 24 to 72 hours or as directed. III. Resident #45 A. Resident status (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #45, age 69, was admitted on [DATE]. According to the December 2024 computerized physician orders (CPO), diagnoses included schizoaffective disorder (mental disorder that affects mood, thoughts and behavior), depression and muscle weakness. According to the 11/15/24 minimum data set (MDS) assessment Resident #45 was cognitively intact with a brief interview for mental status score of 13 out of 15. He required partial/moderate assistance with showering, dressing, and personal hygiene. He was independent with walking and transfers. B. Resident interview Resident #45 was interviewed on 12/16/24 at 11:15 a.m. Resident #45 said he was concerned about not getting some of his medications and not getting some medications on time. He said he missed some doses of trihexyphenidyl a few weeks ago but could not remember the exact date or how many doses he missed. He said he had a mental illness and needed to take all of his medications on time. C. Record review Review of Resident #45's December 2024 CPO revealed the following physician order: Trihexyphenidyl 2 mg tablet two times daily for schizoaffective disorder, administer one tablet orally, ordered 11/10/24. Trihexyphenidyl 2 mg tablet one time daily for schizoaffective disorder, administer two tablets orally, ordered 11/10/24. Review of Resident #45's November 2024 medication administration record (MAR) revealed the following: -On 11/18/24 Resident #45 did not receive trihexyphenidyl at 9:00 p.m.; -On 11/19/24 Resident #45 did not receive trihexyphenidyl at 9:00 a.m.; -On 11/19/24 Resident #45 did not receive trihexyphenidyl at 3:00 p.m.; and, -On 11/19/24 Resident #45 did not receive trihexyphenidyl at 9:00 p.m. A nursing progress note dated 11/19/24 at 12:32 a.m. revealed Resident #45 was noted to be out of trihexyphenidyl. The nurse called the pharmacy and the pharmacy confirmed the refill. The pharmacy said the medication would arrive on 11/19/24. The progress note documented that Resident #45 was pleasant and cooperative with no delusions or hallucinations reported. A nursing progress note dated 11/20/24 at 5:03 a.m. revealed Resident #45 continued to be out of trihexyphenidyl. It was documented that the pharmacy was called and confirmed the refill. A STAT (immediate) delivery was requested and the pharmacy confirmed it would be delivered before 8:00 a.m. on 11/20/24. It was documented that Resident #45 was pleasant and cooperative at baseline with no delusions or hallucinations reported. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nursing staff failed to audit the cart and reorder the medication before the medication ran out. -The nursing staff failed to order the medication as STAT once they noticed it was missing. -There was no documentation that the resident's physician was notified after Resident #45 missed four doses of trihexyphenidyl. D. Staff interviews Licensed practical nurse (LPN) #3 was interviewed on 12/18/24 at 11:42 a.m. LPN #3 said it was the responsibility of all nurses to order medications once they were ready for refill. She said the night nurses audited the medication carts for expired medications and medications ready for refill. LPN #1 was interviewed on 12/18/24 at 11:53 a.m. LPN #1 said the medications came with a sticker on the package that had a date which indicated when they were ready for refill. She said it was the responsibility of the nurse on the cart to peel off the sticker and fax it into the pharmacy to get the medication refilled once it was available. She said there was another way to refill medications through the computer. She said if a medication was missing, she would look and see if it was in the emergency medications kit. LPN #1 said if the medication was not available in the emergency medications kit, she said she would request a STAT order refill from the pharmacy. She said the pharmacy might make overnight runs for STAT or hospice medications. She said if a medication was not available, she would also contact the NHA. The NHA and registered nurse (RN) #1 were interviewed together on 12/18/24 at 1:8 p.m. RN #1 said medications could be ordered a week in advance, prior to the medication running out. He said the order could either be faxed into the pharmacy or entered electronically through the charting system. He said if a medication was unavailable, it could be ordered STAT. The NHA said if a medication dose was missed, he would expect the nurse to notify the physician and monitor the resident for side effects, which could include increased agitation for missing trihexyphenidyl. He said Resident #45 might be more distressed from missing a medication because he was very aware of all his medications and anything missed could really throw him off his routine and make him more agitated. The NHA said there should be a progress note or medication administration note filled out by nursing any time a medication dose was not given. RN #1 said it was the expectation to order any medication as STAT once it was noticed the medication was out of stock. 31229 IV. Resident #42 A. Resident status (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42, age 76, was admitted on [DATE]. According to the December 2024 CPO, diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (a condition where multiple nerves outside the brain and spinal cord are damaged or malfunctioning simultaneously), traumatic hemorrhage of cerebrum (a collection of blood in the brain that occurs after a traumatic brain injury), and left side hemiplegia (a medical condition characterized by paralysis or weakness on one side of the body). According to the 9/29/24 MDS assessment, Resident #42 was cognitively intact with a BIMS score of 15 out of 15. He required set-up assistance with eating, supervision with oral hygiene, substantial/maximal assistance with toileting hygiene, shower/bath and upper and lower body dressing. He required substantial/maximal assistance with bed mobility and transfers. The MDS assessment documented the resident was prescribed and administered antidepressant, anticoagulant, antibiotic, opioid and hypoglycemic medications. B. Resident interview Resident #42 was interviewed on 12/16/24 at 1:15 p.m. Resident #42 said he was concerned about not getting his prescribed medication for diabetes mellitus. He said he had missed five days of metformin in December 2024. C. Record review Review of Resident #42's comprehensive care plan revealed there was no care plan focus related to the resident's diagnosis of diabetes mellitus or the prescribed medication metformin. Review of Resident #42's December 2024 CPO revealed the following physician order: Metformin ER 500 mg tablet, extended release 24 hour (two tablets/1000 mg), oral, two times daily, ordered 8/21/24. A review of Resident #42's December 2024 MAR revealed the following: -On 12/10/24 Resident #42 did not receive metformin at 8:00 a.m.; -On 12/10/24 Resident #42 did not receive metformin at 8:00 p.m.; -On 12/11/24 Resident #42 did not receive metformin at 8:00 p.m.; -On 12/12/24 Resident #42 did not receive metformin at 8:00 a.m,; -On 12/12/24 Resident #42 did not receive metformin at 8:00 p.m.; and, -On 12/13/24 Resident #42 did not receive metformin at 8:00 a.m. Nursing administration notes for the 12/10/24, 12/11/24, 12/12/24 and 12/13/24 missed doses of metformin documented the medication was not administered because the medication was not available. -The nursing staff failed to audit the cart and reorder the medication before the medication ran out. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The nursing staff failed to order the medication as STAT once they noticed it was missing. -There was no documentation that the resident's physician was notified after Resident #42 missed six doses of metformin. D. Staff interviews The MDS coordinator (MDSC) was interviewed on 12/18/24 at 9:56 a.m. The MDSC said she was not aware there was no care plan focus related to Resident #42's diagnosis of diabetes mellitus or his metformin medication. RN #1 was interviewed on 12/18/24 at 1:20 p.m. RN #1 said Resident #42's metformin was not ordered STAT. He said the medication was not delivered from the pharmacy for three days after it was ordered. He said metformin was not included in the emergency medications kit and he could not explain why a nurse documented on the December 2024 MAR that the resident's 8:00 a.m. dose of metformin was administered on 12/11/24. He said all registered and licensed nurses received additional training related to the medication ordering process on 12/17/24 (during the survey).

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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. 50690 Based on observations and interviews, the facility failed to maintain an infection control program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection. Specifically, the facility failed to ensure glucometers were sanitized appropriately. Findings include: I. Professional reference The Centers for Disease Control and Prevention (CDC). Considerations for Blood Glucose Monitoring and Insulin Administration (2024), was retrieved on 12/18/24 from https://www.cdc.gov/injection-safety/hcp/infection-control/index.html#:~:text=Unsafe%20practices%20during%20assisted%20monitoring,for%20more%20than%20one%20person. It read in pertinent part, Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions. Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place. II. Manufacturer's guidelines According to the Arkray Assure Platinum manufacturer guidelines, revised 09/2024, retrieved on 12/18/24 from https://arkrayusa.com/diabetes-management/professional-healthcare-products/assure/assure-platinum/, The meter should be cleaned and disinfected after use on each resident. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of bloodborne pathogens. The Super Sani-cloth wipe manufacturer's guidelines, updated 2021, was retrieved on 12/19/24 from https://pdihc.com/in-service/super-sani-cloth-instructions-for-use-ifu-sign/. It read in pertinent part, Unfold a clean wipe and thoroughly wet surface. Allow the treated surface to remain wet for two minutes. Let air dry. III. Observations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/17/24 at 10:58 a.m. during medication pass, licensed practical nurse (LPN) #1 retrieved the hallway's glucometer machine from the medication cart. She entered Resident #10's room to check his blood sugar. LPN #1 then left the resident's room and placed the glucometer on top of the medication cart without cleaning it. She continued with her medication pass for another resident and then placed the glucometer back in the medication cart drawer at 11:19 a.m. On 12/17/24 at 11:39 a.m. LPN #1 took the glucometer out of the medication cart drawer and put it on top of the cart. LPN #1 gathered the rest of the supplies needed and placed them on top of the glucometer. She then picked up the glucometer to go into Resident #208's room and check her blood sugar. - LPN #1 did not clean or sanitize the glucometer between residents. IV. Staff interviews LPN #1 was interviewed on 12/17/24 at 11:40 a.m. LPN #1 said the residents did not have their own glucometers. She said normally if she were to use the same glucometer on another resident, she would clean it in between residents with a Sani-cloth purple-top wipe. She said she forgot to clean the glucometer after using it. The nursing home administrator (NHA) and the interim assistant director of nursing (IADON) were interviewed together on 12/17/24 at 1:42 p.m. The IADON said there was one glucometer per hallway. She said one to three residents per hallway regularly used the glucometer. She said the staff were expected to wipe down the glucometer with an alcohol-based wipe in between residents. She said there was a drawer full of new glucometers and that each resident used to have their own. She was not sure why that policy changed. The NHA said the purple top Sani-cloth wipes or alcohol were used to clean the glucometers. The NHA said the glucometers should be cleaned and sanitized after each blood sugar check and then returned to the drawer. She said the proper way to clean the glucometers was to clean all sides of the glucometer, throw away the disposable items, throw the lancet (small, sharp needle used to prick the skin and obtain a blood sample) in the sharps container, then sanitize the glucometer using specific dwell times (how long the treatment surface must remain visibly wet for proper sanitation) depending on the wipe. She said the dwell times were posted near each nurse's station. The NHA said there were no residents in the facility with a transmittable blood-borne disease. She said she would ensure each resident had their own glucometer. The NHA said the nursing staff would be re-educated on expectations for glucometer cleaning. V. Facility follow-up On 12/18/24, all three medication carts were observed to have glucometers that were labeled with individual residents' names. Lists of cleaning supplies and their dwell times were posted on the wall across from each medication cart. The Sani-cloth purple top wipes were noted to require a two minute dwell time.