

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/25/2024
NAME OF PROVIDER OR SUPPLIER Sandrock Ridge Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 943 W 8th Dr Craig, CO 81625	

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 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47960</p> <p>Based on observations, record review and interviews, the facility failed to ensure two (#26 and #5) of six residents out of 16 sample residents received the care and services necessary to meet their nutrition needs to maintain their highest level of physical well-being.</p> <p>Resident #26 was admitted to the facility for long term care on 1/4/23 with diagnoses of dementia, hypotension (low blood pressure), hypokalemia (low potassium), hypothyroidism (low thyroid function) and depression.</p> <p>Upon admission on 1/4/23, Resident #26 weighed 152 pounds (lbs) and she reported she liked to eat eggs, coffee and sweets. Resident #26 had gradual weight gain until 4/12/24 when she weighed 190 lbs. At this time, the resident started gradually losing weight. On 9/4/24 the resident weighed 182 lbs. The resident sustained 12 lbs (6.5%) weight loss in one month, from 9/4/24 to 10/3/24, which was considered severe.</p> <p>The facility failed to implement effective person-centered nutrition interventions to address the resident's decreased oral intake and severe weight loss. On 9/27/24, Resident #26 weighed 174 lbs, which indicated the resident had lost eight lbs in 20 days. The registered dietitian (RD) recommended implementing a house nutrition supplement, however, the facility failed to obtain a physician's order for the house supplement and track the resident's acceptance of the intervention. Due to the facility's failures, Resident #26 continued to lose weight and weighed 168 lbs on 11/4/24, which indicated the resident lost 22 lbs (11.6%) in six months.</p> <p>Additionally, Resident #5 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic chronic kidney disease, anxiety, anemia (low red blood cell count) and dysphagia.</p> <p>Resident #5 sustained a weight loss of 12.8% (24 lbs) from admission on 8/5/24 through 11/4/24, which was considered severe. According to Resident #5's nutrition care plan, pertinent interventions were initiated on 8/28/24 which included a house shake once a day.</p> <p>The facility failed to implement additional person-centered effective nutritional interventions for Resident #5 and meet the resident's dietary preferences to prevent significant weight loss.</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 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the physician progress notes revealed no documentation of Resident #5's significant weight loss and poor nutritional status. There was no documentation on expected or unplanned weight loss, or updated care plan goals and appropriate interventions to improve resident's nutritional status.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Weight Assessment and Intervention policy, revised March 2022, was provided by the nursing home administrator (NHA) on 11/7/24 at 10:00 a.m. It read in pertinent part, Any weight change of five pounds or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. The threshold for significant unplanned and undesired weight loss will be based on the following criteria one month - five % weight loss is significant; greater than five % is severe. Three months - 7.5% weight loss is significant; greater than 7.5% is severe. Six months - 10% weight loss is significant; greater than 10% is severe.</p> <p>II. Resident #26</p> <p>A. Resident status</p> <p>Resident #26, over the age of 65, was admitted on [DATE]. According to the November 2024 computerized physician orders (CPO), diagnoses included dementia, hypotension , hypokalemia, hypothyroidism and depression.</p> <p>The 10/1/24 minimum data set (MDS) assessment revealed the brief interview for mental status (BIMS) was not conducted because the resident was rarely or never understood. She experienced hallucinations and wandering and required setup and clean up assistance with eating.</p> <p>The assessment documented the resident was 70 inches (five foot, ten inches) tall and weighed 174 lbs. It indicated the resident had weight loss and was not on a physician prescribed weight loss program.</p> <p>B. Observations</p> <p>During a continuous observation of the lunch meal service on 11/5/24, beginning at 12:01 p.m. and ending at 1:24 p.m., the following was observed:</p> <p>Resident #26 was served lunch consisting of the regular menu which consisted of grilled fish, parmesan noodles, sliced zucchini, wheat bread and a chilled fruit cup and ate approximately 50% of the meal. When the resident finished eating, she stood up from the table and walked to her room.</p> <p>-The resident was not encouraged by staff to continue eating or offered any additional snacks or food items.</p> <p>C. Record review</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The nutrition care plan, initiated on 1/18/23 and revised on 9/22/24, revealed Resident #26 had a potential nutritional problem related to hypothyroidism (low thyroid function), dementia and depression. The interventions included administering medications as ordered, (1/18/23), observing/documenting/reporting as needed any signs of dysphagia such as pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals (1/18/23), providing and serving diet as ordered and recording intake (1/18/23), providing daily menu assistance with making menu choices (1/18/23), RD to evaluate and make diet change recommendations as needed (1/18/23) and weighing the resident per facility protocol (1/18/23).</p> <p>-Review of the resident's comprehensive care plan did not reveal the facility implemented new person centered nutritional interventions after Resident #26 had sustained significant weight loss on 10/3/24 and on 1/4/24.</p> <p>Resident #26's weights were documented in the resident's electronic medical record (EMR) as follows:</p> <ul style="list-style-type: none"> -On 4/12/24, the resident weighed 190 lbs; -On 4/16/24, the resident weighed 188 lbs; -On 5/7/24, the resident weighed 188 lbs -On 6/4/24, the resident weighed 186 lbs; -On 7/1/24, the resident weighed 186 lbs; -On 8/5/24, the resident weighed 188 lbs; -On 9/4/24, the resident weighed 182 lbs; -On 9/24/24, the resident weighed 174 lbs; -On 10/3/24, the resident weighed 170 lbs; -On 10/15/24, the resident weighed 169 lbs; -On 10/22/24, the resident weighed 168 lbs; -On 10/28/24, the resident weighed 167 lbs; and, -On 11/4/24, the resident weighed 168 lbs. <p>-The resident lost 22 lbs from 8/5/24 to 11/4/24, in three months, which was considered severe.</p> <p>-The resident lost 12 lbs from 9/4/24 to 10/3/24, in one month, which was considered severe.</p> <p>-The resident lost 23 lbs from 4/12/24 to 11/4/24, in six months, which was considered severe.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/4/24 mini nutritional assessment (MNA) documented Resident #26 had no decrease in food intake or weight loss over the past three months.</p> <p>-However, Resident #26 had lost two lbs during the past three months.</p> <p>The 7/15/24 RD assessment documented Resident #26 was eating a regular diet and more than 75% of her meals. The recommendation was to continue with the current plan of care.</p> <p>A nutrition progress note, dated 9/20/24, documented the resident was discussed at the nutrition at risk (NAR) meeting because the resident had weight loss, however, her intake was adequate but due to her wandering during the day she needed to be encouraged to eat. Weekly weights were initiated.</p> <p>A nutrition progress note, dated 9/27/24, documented the resident was discussed at the NAR meeting because she had lost eight lbs. The note revealed she was sleeping more, pale and laboratory (lab) testing had been ordered. It was recommended to add house supplements to her diet once the lab results were obtained.</p> <p>-Review of the November 2024 CPO did not reveal a physician's order was implemented for a house supplement.</p> <p>The 9/28/24 progress note documented Resident #26 tested positive for COVID-19.</p> <p>-However, Resident #26 had already lost eight lbs prior to a COVID-19 diagnosis.</p> <p>The 10/4/24 RD assessment documented Resident #26 had a recent significant weight loss due to COVID-19 and poor intake while she was sick. The recommendation was for RD to monitor the resident as needed.</p> <p>-However, the facility failed to implement interventions to combat the residents' decreased intake while she had COVID-19.</p> <p>The 10/15/24 progress note documented Resident #26 was moved to the secured unit.</p> <p>The 10/21/24 certified dietary manager (CDM) nutritional assessment documented Resident #26's weight was trending down and that the resident liked to eat almost everything.</p> <p>-After the CDM identified the resident's weight was trending down, the facility failed to implement person-centered effective nutritional interventions to meet the resident's dietary preferences after the resident sustained a 11.6% (22 lbs) weight loss in six months, from 4/12/24 to 11/4/24, to address the resident's significant weight loss and decline in oral intake.</p> <p>D. Staff interviews</p> <p>NA #1 was interviewed on 11/5/24 at 1:26 p.m. NA #1 said it was difficult to get the residents on the secure unit to eat if they did not want to. She said the residents consumed more food if they were able to hold the food and walk around the unit.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-However, observations did not reveal residents were given finger foods to walk around the unit with (see observations above).</p> <p>The NHA was interviewed on 11/6/24 at 2:27 p.m. The NHA said she had been watching over the kitchen for the past two months since the dietary manager left. She said the facility had been trying to hire someone to fill the position but it had been difficult since it was a small town. She said the RD visited the facility about twice a month.</p> <p>Cross reference: F801 failure to employ a full time dietitian or a qualified dietary manager.</p> <p>The RD was interviewed on 11/6/24 at 2:30 p.m. The RD said residents' preferences and nutrition interventions were not included in the care plan because she was directed not to include detailed information like that by another consultant. She said the nurse notified the physician and the residents' representatives of any weight loss. She said food preferences were communicated to the staff on the residents' food cards. She said she did not like the current form the facility was using to obtain the residents' preferences because it focused on the residents' dislikes and not their preferences. She said she would like to change it.</p> <p>The RD said when a resident was admitted to the facility, the admissions clerk collected the food preference information and if the resident was not able to identify likes and dislikes, she contacted the family for the information. She said the house supplements should only be given at meal times if the resident continued to eat the meal. She said if the resident started eating less at meal times, the supplement should be given outside of meal times.</p> <p>The RD said Resident #26 sustained significant weight loss since she had COVID-19.</p> <p>31229</p> <p>III. Resident #5</p> <p>A. Resident status</p> <p>Resident #5, age 83, was admitted on [DATE]. According to the October 2024 CPO, diagnoses included chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, type 2 diabetes mellitus with diabetic chronic kidney disease, anxiety, anemia (low red blood cell count) and dysphagia (difficulty swallowing).</p> <p>The 8/12/24 MDS assessment revealed the resident was cognitively intact with a BIMS score 14 out of 15. She required supervision with eating, and substantial/maximal assistance with transfers and ADLs.</p> <p>The MDS assessment documented the resident was 64 inches (five foot, four inches) tall and weighed 188 lbs. The resident did not have any swallowing disorders.</p> <p>The MDS assessment documented the resident had not had any recent significant weight loss or weight gain or nutritional approaches were documented.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The MDS assessment documented Resident #5 was prescribed an anticoagulant, antibiotic, diuretic, opioid and hypoglycemic medication.</p> <p>B. Resident interview and observation</p> <p>Resident #5 was interviewed on 11/4/24 at 4:45 p.m. Resident #5 said she did not like the food that was served most of the time. She said I wish I had soup (cream of potato) every evening. She said she did not like rice. She said she liked potatoes. She said she was not aware of foods that were always available in case she did not like what was served.</p> <p>During the interview, the cook (CK) approached Resident #5 and said the kitchen did not have soup in the kitchen to serve to residents.</p> <p>C. Record review</p> <p>The nutrition care plan, dated 8/8/24 revealed the resident was at risk for weight loss because of poor food intake at meals which was on average 25% to 50%. Interventions included eight oz of house shake once a day (8/28/24) and her food preferences included soups.</p> <p>-Despite the resident's food preferences, she was not served soup (see observation above).</p> <p>Resident #5's weights were documented in the resident's EMR as follows:</p> <p>-On 8/6/24, the resident weighed 188 lbs;</p> <p>-On 8/12/24, the resident weighed 186 lbs;</p> <p>-On 9/4/24, the resident weighed 176 lbs;</p> <p>-On 10/9/24, the resident weighed 170 lbs; and,</p> <p>-On 11/4/24, the resident weighed 164 lbs.</p> <p>-The resident lost 12 lbs (6.4%) from 8/6/24 to 9/4/24, in one month, which was considered severe.</p> <p>-The resident lost 24 lbs (12.8%) from 8/6/24 to 11/4/24, in three months, which was considered severe.</p> <p>A review of the November 2024 CPO revealed the following physician's orders related to nutrition:</p> <p>House shake 8 oz in the morning, one time a day with breakfast for decreased meal intake, ordered on 8/28/24.</p> <p>Spironolactone oral tablet 25 mg (diuretic medication), give 25 milligrams (mg) by mouth in the morning for edema, ordered on 9/5/24.</p> <p>Torseamide oral tablet 20 mg (diuretic medication), give one tablet by mouth two times a day related to unspecified diastolic (congestive) heart failure, ordered on 8/27/24.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/8/24, the RD documented the resident was new to the facility. The RD would monitor the resident's weights while she adjusted to the facility. The resident had one plus (1+) edema to her bilateral lower extremities. The resident's weight may fluctuate. The resident's current weight was 188 lbs. The resident was at increased nutritional risk related to COPD, chronic kidney disease, diabetes and gastro esophageal reflux disease (GERD).</p> <p>On 8/27/24 the RD documented, the resident was at increased nutritional risk for weight loss as evidence by poor meal intake. She had recently gained weight related to edema. The RD documented the resident's weights may fluctuate related to diuretic use. The resident was recently started on a house shake eight oz one time a day. The RD documented the resident's recent weight gain was related to edema to her lower extremities. The RD tried to contact the physician several times. The RD documented she would continue to monitor.</p> <p>-However, the resident had lost two lbs from 8/6/24 to 8/12/24.</p> <p>On 9/5/24 the RD documented, the resident had lost weight. The resident had edema and was on diuretics. She was not eating well. The resident was at increased nutritional risk related to COPD, dementia, chronic kidney disease, diabetes and GERD. The resident's meal intake was poor.</p> <p>-However, review of the resident's EMR did not indicate changes in the resident's 1+ edema to her bilateral lower extremities.</p> <p>On 11/5/24 the RD documented, Resident #5 had 1+ edema to her bilateral lower extremities. The resident was on diuretics. She has been losing weight since admission, which could be related to fluid loss. The resident was receiving a house supplement with breakfast. The resident was at risk for weight loss as evidenced by poor intake at meals. The resident was consuming an average of 25% to 50% of her meals. The resident's weight had been trending down related to edema and diuretic use. The resident liked soup. The resident was encouraged to ask for an alternate meal option if she did not like what was being served. The RD documented she would continue to monitor as needed.</p> <p>-A review of Resident #5's EMR did not reveal physician notes related to the resident's nutritional status and weight loss.</p> <p>D. Staff interviews</p> <p>The RD was interviewed on 11/6/24 at 3:45 p.m. The RD said she did not observe Resident #5 eating her meals as she was not in the facility often. She said she participated in the NAR meetings remotely.</p> <p>E. Facility follow-up</p> <p>The facility provided documentation on 11/8/24 indicating Resident #5 was on two diuretics, she was reviewed weekly in the NAR meeting and interventions were in place.</p> <p>-However, review of Resident #5's EMR did not reveal documentation indicating the resident's edema had worsened or improved from 1+ on her bilateral lower extremities and did not include efficient supplementation to improve nutritional status.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47960</p> <p>Based on observations and interviews, the facility failed to ensure medications and biologicals were stored in accordance with accepted professional standards for one of one medication refrigerator.</p> <p>Specifically, the facility failed to ensure controlled medications were in a locked storage container that was permanently secured to the refrigerator.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Medication Labeling and Storage policy and procedure, revised February 2023, was provided by the nursing home administrator (NHA) on 11/6/24 at 3:40 p.m. It read in pertinent part, Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>II. Observations</p> <p>On 11/5/24 at 11:09 a.m., the medication refrigerator was observed with licensed practical nurse (LPN) #1. Two vials of liquid Ativan (a benzodiazepine and a schedule IV controlled substance used to treat anxiety) were in a plastic container on the shelf.</p> <p>-The Ativan was not in a permanently affixed locked compartment inside of the refrigerator.</p> <p>III. Staff interviews</p> <p>LPN #1 was interviewed on 11/5/24 at 11:09 p.m. LPN #1 said the plastic container on the shelf in the refrigerator contained two vials of liquid Ativan two milligrams (mg), which was provided by the pharmacy for emergency use. She said anyone with access to the refrigerator could just take the Ativan out of the refrigerator because it was not locked in a separate compartment.</p> <p>The clinical nurse consultant (CNC) was interviewed on 11/6/24 at 3:11 p.m. The CNC said controlled medications should always be kept in secure compartments and double-locked. She said when controlled medications were not secured they could be taken by unauthorized persons.</p> <p>The director of nursing (DON) was interviewed on 11/6/24 at 3:15 p.m. The DON said she was not aware that the controlled medications should be in a permanently affixed locked container inside the refrigerator. She said she would speak with her maintenance supervisor and make sure it was fixed as soon as possible.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>31229</p> <p>Based on observations, record review and interviews, the facility failed to designate a person to serve as the director of food and nutrition services who was a qualified dietitian, certified dietary manager (DM), or a certified food service manager.</p> <p>Specifically, the facility failed to employ a qualified DM or have a full time registered dietitian (RD).</p> <p>Findings include:</p> <p>I. Observations</p> <p>The 11/4/24 at 11:37 a.m. kitchen tour revealed there was no dietary manager (DM) currently employed at the facility.</p> <p>II. Record review</p> <p>-The facility was unable to provide documentation that indicated there was an individual that was employed by the facility that was a qualified dietary manager.</p> <p>II. Staff interviews</p> <p>The nursing home administrator (NHA) was interviewed on 11/4/24 at 12:04 p.m. The NHA said the facility did not have a DM. She said the facility was advertising this open position, however at that moment there were no candidates that had applied for the job. She said the registered dietitian (RD) was on a consultant basis and came to the facility two times a month.</p> <p>The cook (CK) and the dietary aide (DA) were interviewed on 11/4/24 at 1:00 p.m. The CK and the DA said the last DM left more than a month ago and currently the facility did not have a qualified DM.</p> <p>The RD was interviewed on 11/5/24 at 12:00 p.m. The RD said she was not employed full or part time in the facility. She said she was on a consultant basis, coming to the facility two times a month and when needed. She said she helped with food ordering. She said the NHA ordered the food.</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** 47960</p> <p>Based on observations, record review 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 ensure housekeeping staff followed proper infection control procedures for cleaning resident rooms.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to the Centers for Disease Control and Prevention (CDC) Hand Hygiene in Healthcare Settings (1/18/21), retrieved on 11/7/24 from https://www.cdc.gov/handhygiene/providers/index.html,</p> <p>Cleaning your hands reduces the spread of potentially deadly germs to patients.</p> <p>Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers.</p> <p>Alcohol-based hand sanitizers are the preferred method for cleaning your hands in most clinical situations.</p> <p>Wash your hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom.</p> <p>When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers.</p> <p>Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of skin.</p> <p>According to the Fabuloso Original Orange with Baking Soda Safety Data Sheet (SDS) (6/14/24), retrieved on 11/19/24 from blob:https://sdsportal.ext.colpal.cloud/d49f16ab-af24-4b78-81f0-3a9cdf800118,</p> <p>Recommended use: all-purpose cleaner for household use.</p> <p>-The SDS did not indicate the cleaning product was approved for disinfection purposes in healthcare settings.</p> <p>II. Facility policy and procedure</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Sandrock Ridge Care & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 943 W 8th Dr Craig, CO 81625	
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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>The Cleaning and Disinfecting of Environmental Surfaces policy and procedure, revised August 2019, was received from the nursing home administrator (NHA) on 11/6/24 at 3:40 p.m. It read in pertinent part,</p> <p>Housekeeping surfaces (floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled.</p> <p>Environmental surfaces will be disinfected (or cleaned) on a regular basis (daily, three times per week) and when surfaces are visibly soiled.</p> <p>Manufacturer's instructions will be followed for proper use of disinfecting (or detergent) products.</p> <p>Walls, blinds, and window curtains in resident areas will be cleaned when these surfaces are visibly contaminated or soiled.</p> <p>Perform hand hygiene after removing gloves.</p> <p>Floors shall be maintained in a clean, safe, and sanitary manner. All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures. Mop heads shall be washed with a disinfectant and rinsed well after each use. Clean mop heads must be applied when changing areas of mopping and when used in isolation rooms. Procedures for the cleaning of mop heads are maintained by the director of housekeeping services.</p> <p>III. Manufacturer's guidelines</p> <p>The manufacturer's guidelines for the Virex II 256 disinfectant used by the facility were retrieved on 11/15/24 from https://1source.diversey.com/see3/PSS064-VirexII256-LTR-env3-HRNC.pdf. It read in pertinent part,</p> <p>Virex II 256 is a one-step, quaternary disinfectant cleaner and deodorant to clean and disinfect hard surfaces. To disinfect, all surfaces must remain wet for 10 minutes.</p> <p>IV. Observations</p> <p>On 11/5/24 from 10:27 a.m. until 10:42 a.m. housekeeper (HSK) #1 and HSK #2 were cleaning the secure unit. The two were working together to sweep and mop the floors of the unit. HSK #1 was sweeping resident rooms and HSK #2 was mopping the rooms. HSK #2 mopped three rooms (rooms #27, #30 and #32), the living room and the dining room with the same mop head and mop water.</p> <p>At 10:42 a.m. HSK #2 exited the secure unit and emptied the mop bucket.</p> <p>-HSK #2 did not change the mop water or the mop head in between cleaning each resident room, the living or the dining room, despite using a non-healthcare approved cleaning product, which was not a disinfectant, in her mop bucket water (see Fabuloso Orange SDS Sheet above and interviews below).</p> <p>On 11/6/24 at 8:31 a.m. HSK #2 was cleaning room [ROOM NUMBER]. HSK #2 put on gloves and entered the resident's room.</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>-HSK #2 did not perform hand hygiene prior to putting on the gloves and beginning cleaning the room.</p> <p>HSK #2 entered the resident's bathroom and sprayed the toilet, grab bars, towel bar, sink and cabinet with Virex II 256 disinfectant. She immediately wiped the grab bars, towel bar, toilet and sink.</p> <p>-HSK #2 did not allow the disinfectant to remain wet on the surfaces in the bathroom for the manufacturer's recommended amount of time (see manufacturer's guidelines above).</p> <p>Using the same rag she used to wipe down the toilet and other surfaces in the bathroom, HSK #2 went into the resident's bedroom and wiped down the resident's two dressers.</p> <p>-HSK #2 did not change her gloves or perform hand hygiene after cleaning the toilet and bathroom before wiping the resident's dressers.</p> <p>-HSK #2 did not change rags after cleaning the toilet and bathroom before wiping the resident's dressers.</p> <p>-HSK #2 did not spray disinfectant on the dressers.</p> <p>At 8:39 a.m. HSK #2 returned to her cart and placed the Virex disinfectant on the cart. She disposed of the first rag and got a new rag. HSK #2 returned to the resident's room and wiped down the overbed table and both nightstands.</p> <p>-HSK #2 did not change her gloves or perform hand hygiene prior to returning to the room to wipe down the overbed table and nightstands.</p> <p>-HSK #2 did not spray disinfectant on the overbed table and nightstands.</p> <p>HSK #2 returned to the cart and removed her gloves and put on new ones before returning to the resident's bathroom to clean the toilet with the toilet brush.</p> <p>-HSK #2 did not perform hand hygiene after removing her gloves prior to returning to the bathroom to clean the toilet.</p> <p>HSK #2 put Fabuloso Original Orange with Baking Soda in the toilet and cleaned the toilet. She returned the toilet brush to the cart and got a rag then went back to the resident's bathroom and wiped down the outside of the toilet.</p> <p>-HSK #2 did not change her gloves or perform hand hygiene prior to returning to the bathroom and wiping down the outside of the toilet.</p> <p>-HSK #2 did not clean the toilet bowl with a disinfectant or spray disinfectant on the outside of the toilet.</p> <p>At 8:45 a.m. HSK #2 went back to the cart, removed her gloves and used hand sanitizer. She put on new gloves and went back to the resident's room and picked up the floor and removed the trash. She placed a water bottle that was sitting on the floor on the dresser she had previously cleaned.</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>-HSK #2 did not disinfect the bottom of the water bottle prior to placing it on the dresser.</p> <p>At 8:49 a.m. HSK #2 swept the bathroom floor into the resident's room and continued sweeping the pile to the doorway of the resident's room where she swept it into the debris container.</p> <p>At 8:54 a.m. HSK #2 went to room [ROOM NUMBER], a double occupancy room, where HSK #1 had been cleaning. HSK #2 began mopping the floor in room [ROOM NUMBER]. She mopped one side of the room and most of the other side of the room before returning to the cart to change mop pads.</p> <p>-HSK did not change mop pads in between cleaning each side of the residents' room.</p> <p>HSK #2 mopped the remaining portion of room [ROOM NUMBER] and returned to the cart. HSK #2 changed her gloves and used hand sanitizer before returning to room [ROOM NUMBER].</p> <p>At 8:55 a.m. HSK #2 got a new mop pad and began mopping the bathroom floor in room [ROOM NUMBER]. She continued mopping half of the resident's room then returned to the cart and replaced the mop pad before mopping the other half of the resident's room.</p> <p>-HSK #2 did not change mop pads after mopping the bathroom floor before mopping the first half of the resident's room.</p> <p>At 8:59 a.m. HSK #2 knocked the resident's oxygen nasal cannula off of the bed and onto the floor. She picked up the nasal cannula, placed it back on the resident's bed and continued to mop the floor where the nasal cannula had fallen.</p> <p>-HSK #2 did not sanitize the resident's oxygen nasal cannula prior to putting it back on the resident's bed.</p> <p>HSK #2 completed cleaning the room at 9:00 a.m.</p> <p>V. Staff interviews</p> <p>HSK #2 was interviewed on 11/5/24 at 10:39 a.m. HSK #2 said she began working for the facility as a housekeeper three days ago (11/2/24). She said HSK #1 trained her. HSK #2 said she used Fabuloso Original Orange with Baking Soda in the mop water.</p> <p>HSK #1 was interviewed on 11/6/24 at 8:30 a.m. HSK #1 said she had been in the position of housekeeper for one month. She said she used Virex II 256 disinfectant in the wet rag bucket, Virex II 256 disinfectant spray in the spray bottles and Fabuloso Original Orange with Baking Soda in the mop water. She said no one trained her on how to clean the facility when she started, so she just did her own thing when cleaning.</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>The NHA was interviewed on 11/6/24 at 9:39 a.m. The NHA said the previous housekeeper quit without notice over a month ago and HSK #1 took over the housekeeping position to help out. She said housekeepers should change mop pads between the bathroom and different resident areas of the residents' rooms. She said cleaning rags should be changed between the same areas to prevent the spread of germs which could increase infections in the facility. The NHA said there was no reason for the housekeepers to use an unapproved residential cleaning agent such as Fabuloso Original Orange with Baking Soda because the facility had the appropriate healthcare-approved cleaning/disinfecting products available for use.</p> <p>The clinical nurse consultant (CNC) was interviewed on 11/6/24 at 3:06 p.m. The CNC said it was important to follow specific instructions when cleaning residents' rooms so as not to spread germs or infections. She said it was not appropriate to use a rag that was used to clean a residents' bathroom to clean any other areas in the residents' rooms, such as the dresser.</p>